FORMATIVE RESEARCH FOR ASSISTING BEHAVIOR CHANGE

A PRACTICAL GUIDE FOR FIELD WORKERS

LEARNING ABOUT PEOPLE, PLACES & PERCEPTIONS FOR EFFECTIVE ASSISTING BEHAVIOR CHANCE (ABC) PROGRAMMING

March 2018

ACTION AGAINST HUNGER

Photo: *Catabato, 2017*

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ABBREVIATIONS

ABC	Assisting Behavior Change
BA	Barrier Analysis
CMAM	Community Management of Acute Malnutrition
DBC	Designing for Behavior Change
DSW	Deutsche Stiftung Weltbevoelkerung
FAO	Food and Agriculture Organization of the United Nations
FGD	Focus Group Discussion
KAP	Knowledge, Attitudes, Practices
IYCF	Infant and Young Child Feeding
MDM	Medecins Du Monde
NCA	Nutritional Causal-Analysis
NGO	Non-Governmental Organization
RR	Relative Risk
SMART	Standardized Monitoring and Assessment of Relief and Transitions survey
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage survey
TIPs	Trials of Improved Practices
WHO	World Health Organization

DEFINITIONS

ASSISTING BEHAVIOR CHANGE (ABC)
Action Against Hunger's approach to developing, implementing, monitoring, and assessing behavior change activities. It employs a collection of methods and practical tools grounded in psychological principles, social science theories, and scientific evidence.

ACTIVE LISTENING
Communication technique where the listener pays close attention to the speaker, to better understand what he/she means, and remember what has been said.

ATTITUDE
Personal position, feeling, or disposition toward a behavior, thing or topic. A question about attitude can explore if the respondent thinks or feels something is good/bad, harmful/beneficial, worthless/useful, pleasant/unpleasant or investigate his/her intention to do something.

BARRIER ANALYSIS
A study to identify the most important determinants influencing behaviors of doers and non-doers through quantitative and qualitative methods. Barrier analysis (BA) and doer/non-doer are similar methodologies, but BA questionnaires assess up to 12 determinants (vs 4 for doer/non-doer study).

BEHAVIOR OR PRACTICE
Behaviors (or practices) are observable actions carried out by individuals or groups under given circumstances. In this document, "practices" generally refers to the actual current practices people are performing, while "behavior" is preferred to designate the action promoted in the project (recommended behavior).

BEHAVIOR CHANGE COMMUNICATION (BCC)
A strategic use of communication to promote adoption of recommended behaviors, based on theories and models of behavior change.

CASE CONTROL STUDY
A type of study in which two existing groups, differing in condition (e.g. doer/non-doer or sick/not sick) are identified and compared on the basis of some supposed associated attribute (e.g. determinants or risk factors).

CONVENIENCE SAMPLING
A non-random sampling method where individuals are selected because of convenient accessibility and proximity to the researcher.

DETERMINANTS
Categories of reasons why someone does or does not do a behavior. Determinants represent a person's feelings, beliefs, or other elements within his or her environment that support or prevent the behavior.

DOER/NON-DOER STUDY
Doer/non-doer study is a simplified version of barrier analysis; focusing on 4 determinants influencing behaviors (vs up to 12 in barrier analysis).

FOCUS GROUP DISCUSSION (FGD)
Focused discussion with a small group (usually 6 to 12 people) of participants to record attitudes, perceptions, and beliefs pertinent to the issues being examined. A moderator introduces the topic and uses a prepared interview guide to lead the discussion and elicit discussion.

FORMATIVE RESEARCH
Research carried out before or during the project to determine and refine the design of the project, provide accurate, up-to-date and evidence-based information in order to develop strategy and activities.

INFLUENCING GROUP
The group of people that most directly influence or control the action of the Priority Group with regard to a specific behaviour. The influencing group can either support or prevent the priority group from doing a behaviour.

KNOWLEDGE Understanding of a topic. KAP surveys aim to assess the level of knowledge to identify areas where information and education efforts remain to be exerted (e.g. knowledge encompasses commonly shared knowledge, scientific knowledge and know-how, how to perform preventive actions).

LITERATURE REVIEW A review of documents that aims to summarize what is already known about a topic and identify areas that need further investigation.

MONITORING A continuous process of data collection and analysis, which takes place as the project is being implemented. The actual progress is compared to the planned outcomes and activities, in order to identify necessary remedial actions.

PRIORITY GROUP Group of people expected to practice the behavior of interest. When the behaviour concerns a young child –such as being vaccinated or sleeping under a mosquito net– the mother or caregiver becomes the Priority Group.

PURPOSIVE SAMPLING A non-random sampling method in which decisions about the individuals to be included in the sample is made by the researcher, based upon a variety of criteria.

SEMI-STRUCTURED INTERVIEW A semi-structured interview is a qualitative technique for questioning that allows the interviewer to probe and pursue topics of interest in depth (rather than just "yes/no" or multiple choices questions).

STAGES OF CHANGE MODEL The stages of change model explains people process of change by breaking it into 5 main steps: Pre-contemplation, Contemplation, Preparation, Action, and Maintenance.

STATISTICALLY SIGNIFICANT DIFFERENCE An important difference that highlights a strong association between a factor and a condition. Statistically, the probability of obtaining that difference by chance is very small (usually less than 5%).

SNOWBALL METHOD A method to build a purposive sample where sample subjects recruit or refer additional subjects from their acquaintances.

TRIANGULATION The use of several sources of information, data collection methods, or types of analysis to verify and substantiate an assessment.

Photo: Daniel Burguil, 2013

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As there has already been extensive work done on how to access, design, implement, monitor and evaluate behavior change programs, the guidelines were built on existing tools and approaches. Among others, this guide is using resources from the Food Security and Nutrition Network[1]; from the CORE Group on social behavior change, specifically the Practical Guide to Conducting a Barrier Analysis[2] and Care Groups M&E Tools; and from Action Against Hunger's ABC manuals[3] and M&E Guidelines[4], and Caregroupinfo.org M&E tools.

1 *http://www.fsnnetwork.org/*
2 *Kittle, Bonnie. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International. https://coregroup.secure.nonprofitsoapbox.com/storage/documents/Resources/Tools/Final_Practical_Guide_to_Conducting_BA_July_2014.pdf*
3 *ABC Assisting Behavior Change, Part 1 – Theories and Models Action Against Hunger 2013. https://www.actionagainsthunger.org/publication/2013/12/assisting-behaviour-change-theories-and-models-part-1*
ABC Assisting Behavior Change, Part 2 – Practical Ideas and Techniques, Action Against Hunger 2013 https://www.actionagainsthunger.org/publication/2013/12/assisting-behaviour-change-practical-ideas-and-techniques-part-2
4 *Multi-Sectoral Monitoring & Evaluation – A practical guide for fieldworkers, Action Against Hunger 2016. https://www.actionagainsthunger.org/publication/2016/08/multi-sectoral-monitoring-evaluation*

INTRODUCTION

WHY DO WE NEED TO ASSIST BEHAVIOR CHANGE?

Behavior change is an inherent part of most humanitarian and development interventions. To improve health outcomes or contribute to nutrition security, most of the time, it is necessary to influence people's behaviors. It is generally complementary to providing access to goods or services as it helps maximize their use and benefit. Furthermore, many behaviors directly contribute to disease prevention, good physical and mental health, and improving nutritional status.

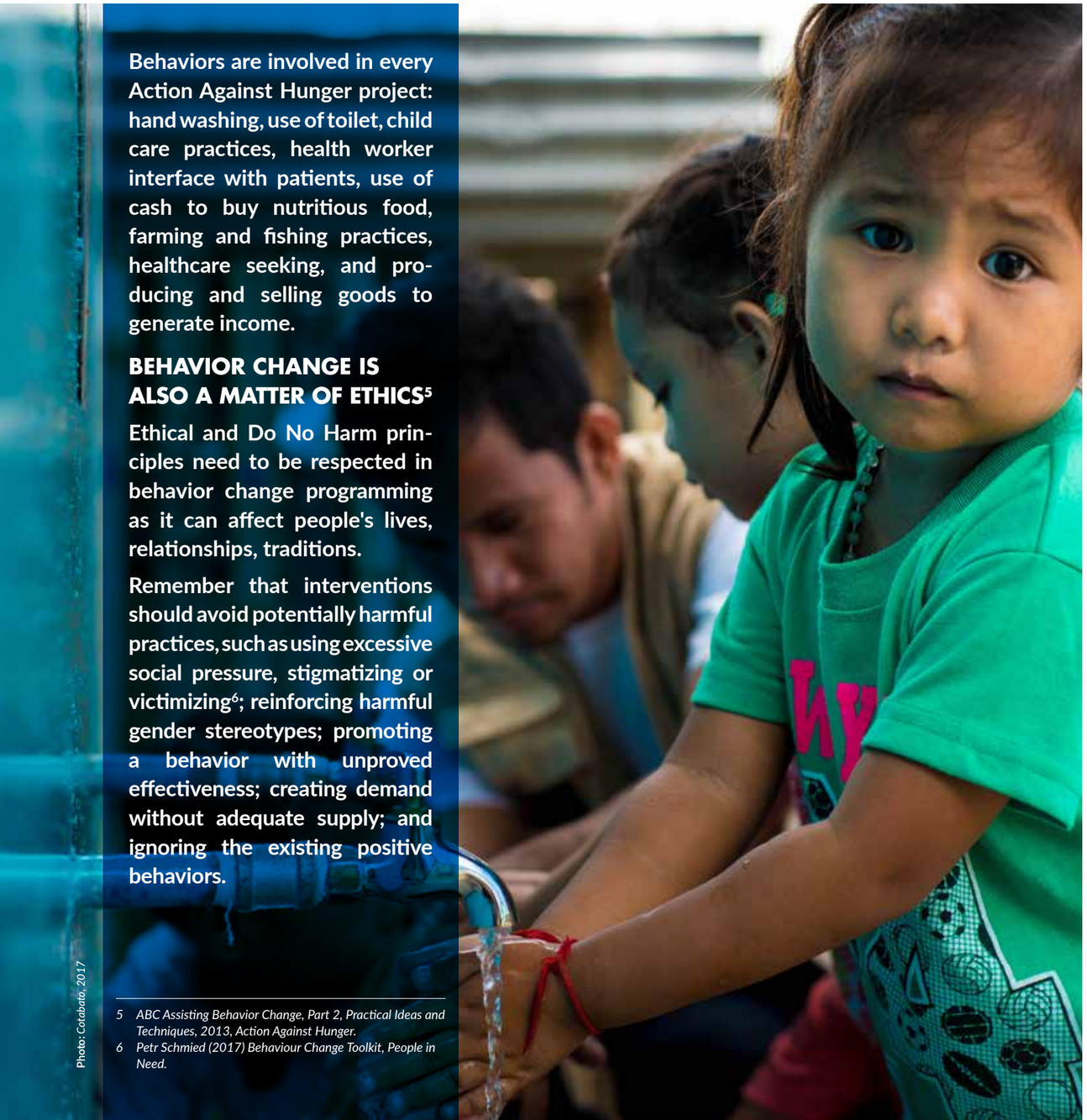


Photo: Cotabato, 2017

Behaviors are involved in every Action Against Hunger project: hand washing, use of toilet, child care practices, health worker interface with patients, use of cash to buy nutritious food, farming and fishing practices, healthcare seeking, and producing and selling goods to generate income.

BEHAVIOR CHANGE IS ALSO A MATTER OF ETHICS[5]

Ethical and Do No Harm principles need to be respected in behavior change programming as it can affect people's lives, relationships, traditions.

Remember that interventions should avoid potentially harmful practices, such as using excessive social pressure, stigmatizing or victimizing[6]; reinforcing harmful gender stereotypes; promoting a behavior with unproved effectiveness; creating demand without adequate supply; and ignoring the existing positive behaviors.

5 *ABC Assisting Behavior Change, Part 2, Practical Ideas and Techniques, 2013, Action Against Hunger.*
6 *Petr Schmied (2017) Behaviour Change Toolkit, People in Need.*

WHAT KIND OF BEHAVIORS ARE WE TALKING ABOUT?

The behaviors are the specific practices we want to promote because of their ability to solve, prevent, mitigate or cope with a problem. These "problems" can be a disease (e. g. undernutrition, cholera, HIV), a natural disaster (e.g. flood, earthquakes), or any other issue directly affecting nutrition security (e.g. low crop production). Therefore, many different types of behaviors can be involved:

- Mothers of 0-6 month babies breastfeed every time the child shows hunger signs.
- In situations of anxiety, pregnant women practice relaxing exercises or seek help from previously identified resources (e.g. husband, friend, midwife).
- Farmers replace trees they cut by planting new trees every year.
- Caretakers ensure that children under 2 years of age play in a clean and safe area.
- Pregnant women sleep under a mosquito net every night during the rainy season.
- Beneficiaries of cash transfers spend 60% of the amount on nutritious food.
- Farmers diversify their production with at least 3 kinds of crops before the dry season to anticipate potential shocks.
- Caretakers of children between 12-23 months wash their hands and the child's hands with soap and water before giving complementary food.

KEY POINTS ABOUT BEHAVIOR CHANGE

- Providing knowledge is not enough to make people adopt a new behavior.
- To achieve behavior change, there is a need to switch from giving information (awareness) to facilitating changing practices.
- Successful behavior change projects generally combine building individual's skills, peer group activity, community engagement and participatory activities, and acting upon different levels of the socio-ecological model: individual, relationship and family, community and society[7].
- Activities designed based on formative research are more likely to be effective[8].

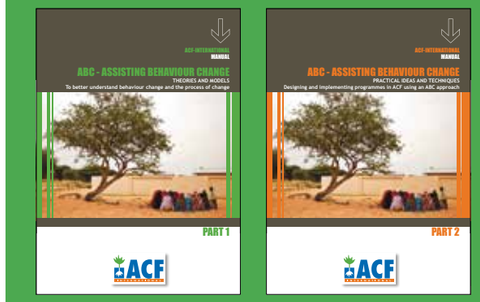
WHO IS THIS GUIDE FOR?

This guide is designed for field practitioners designing and implementing projects that assist behavior change. The methodology can be applied to investigate behaviors linked to nutrition, hygiene, sanitation and water, mental health and care practices, disaster risk management, agriculture, livelihoods, health system strengthening, and even cross-cutting issues like gender.

NUTRITION | HYGIENE, SANITATION & WATER | MENTAL HEALTH & CARE PRACTICES | DISASTER RISK MANAGEMENT | AGRICULTURE & LIVELIHOODS | HEALTH SYSTEM STRENGTHENING | GENDER

7 *Aragon & al, (2014). Interventions to Prevent or Reduce Violence Against Women and Girls: A Systematic Review of Reviews. World Bank, Washington, DC.*
8 *Strachan et al. Malar J (2016) The use of formative research to inform the design of a seasonal malaria chemoprevention intervention in northern Nigeria. 15:474*

ASSISTING BEHAVIOR CHANGE APPROACH



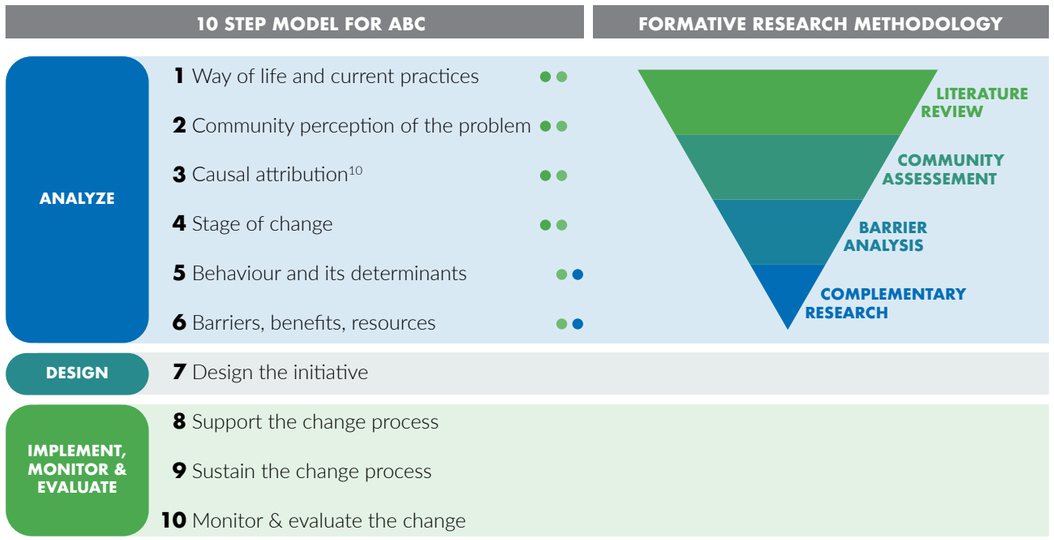
Assisting Behavior Change (ABC) is Action Against Hunger's approach to social and behavior change. ABC is based on analysis of theoretical models, evidence-based information and lessons learned from field experience. The ABC approach promotes formative research as a critical step to designing projects' strategies, activities, and for developing appropriate communication materials.

The ABC manuals provide a theoretical background and practical techniques to effective behavior change.
http://www.actionagainsthunger.org/publication/2013/12/assisting-behaviour-change-theories-and-models-part-1
http://www.actionagainsthunger.org/publication/2013/12/assisting-behaviour-change-practical-ideas-and-techniques-part-2

WHAT IS FORMATIVE RESEARCH?

Formative research is an assessment which informs the design of effective behavior change activities by gaining understanding about the local context where the behaviors take place, and by identifying key barriers and enablers. It can be conducted at the beginning of project design process, or during the project implementation to refine it. Both quantitative and qualitative methods are combined in the assessment. The methodology follows the steps of the ANALYZE block of the ABC model (see **FIGURE 1**).

FIGURE 1 *How the formative research methodology matches with ABC 10 step model*[9]



9 *Diagram adapted from Action Against Hunger Assisting for Behavior Change manual.*
10 *Causal attribution concerns the explanations people offer about the causes of an issue, disease or their own behavior.*

THE LITERATURE REVIEW aims to summarize what is already known about the local context, the priority group and its practices related to the behaviors promoted in the project. It helps to identify what information is still missing and should be investigated in the field. It informs the selection of the behavior for the barrier analysis by highlighting existing gaps in current practice.

THE COMMUNITY ASSESSMENT helps to gain a better understanding of the context where the behaviors take place and of the people involved: what they do, how, and why they do so. It contributes to the description[11] of the priority group in the design for behavior change (DBC) framework. It gives valuable information on how to communicate effectively, and with which media and communication channels. Finally, the community assessment is an opportunity to dialogue with community members and find out what would be the best solution to facilitate behavior adoption in their opinions.

THE BARRIER ANALYSIS (BA) explores determinants[12] influencing behaviors and identifies which are the most important barriers and enablers to behavior change. The BA identifies the main influencing groups for a given behavior. This is helpful for prioritizing activities and better managing resources by highlighting what is more likely to have a strong behavior change effect. Note that when the promoted behavior is totally new to the people and nobody is doing it yet, other methods such as Trials of Improved Practices[13] (TIPs) are recommended.

COMPLEMENTARY RESEARCH is often necessary to refine the formative research. Most of the time, some results are difficult to understand and require further research. The BA findings indicate who are the influencing groups and how the priority group perceives their attitudes. Conducting additional focus group discussions (FGD) with influencing groups is useful to investigate their actual attitude. Complementary research is necessary when the research highlighted the design of a tool as the main issue preventing the practice (e.g. the energy saving stove is too heavy and takes too much time to cook, so nobody wants to use it). In this case, TIPs or human-centered design approaches can be used to improve the tool's design.

11 *Main characteristics of the priority group: demographic characteristics of the priority and influencing groups; daily routine; current practices, knowledge and attitude regarding the target behavior; traditions or cultural believes linked to those practices; gender roles and dynamics and the stage of change.*
12 *The determinants are categories of reasons why someone does or does not do a behavior. Determinants represent a person's feelings, beliefs, or other elements within his or her environment that support or prevent the behavior.*
13 *Trials of Improved Practices (TIPs) Giving Participants a Voice in Program Design. Manoff group.*
https://www.manoffgroup.com/summarytips/

TABLE 1 *Type of information and methods to complete the formative research objectives*

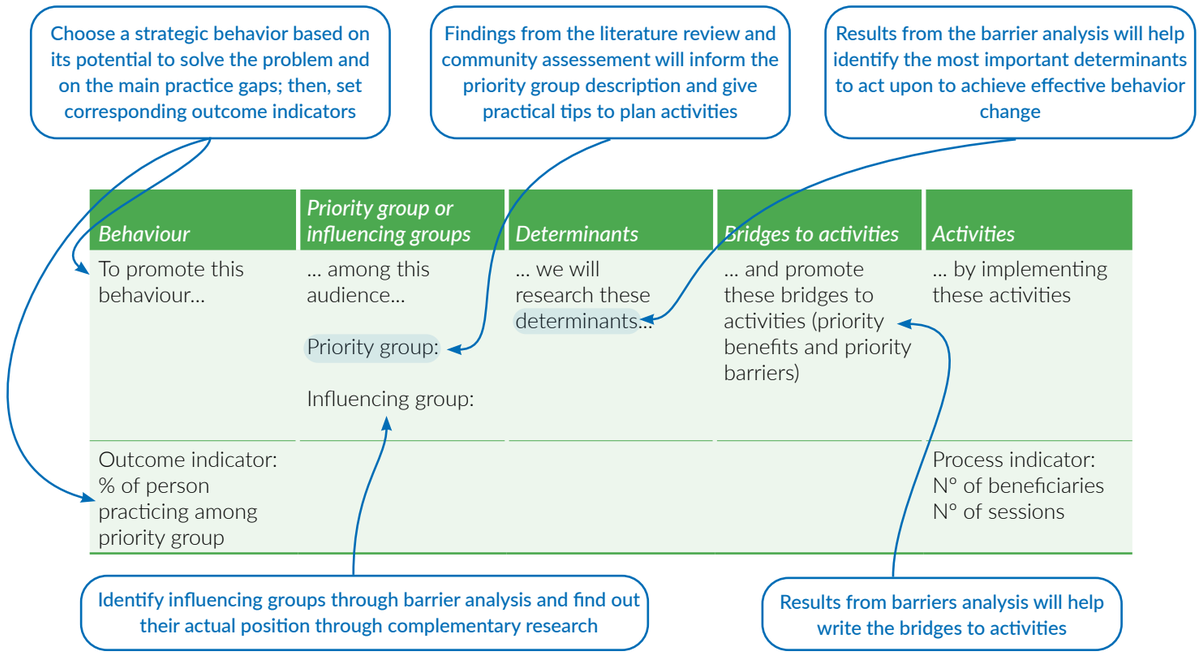
INFORMATION TO BE COLLECTED	*LITERATURE REVIEW*
DESCRIBE THE PRIORITY GROUP: GROUP OF PEOPLE EXPECTED TO PERFORM THE BEHAVIOR[14]	
Socio-demographic characteristics of the priority group • Sex and age range of the people involved • Source of income and/or livelihood • Living status (rural, urban) • Education/literacy level • Religions, ethnicities, and languages • Geographical repartition and diversity (mapping)	Literature review and community assessment
Way of life and daily routine of the priority group • Main daily activities • Weekly and seasonal activities • Participation in social gathering • Access to news/information • Use of media	Literature review and community assessment
Current practices, knowledge, attitude, and beliefs of the priority group • Description of the current practices • Presence of harmful/inadequate practices and of positive practices • Proportion of people practicing recommended practices among the priority group • Knowledge of recommended behavior • Attitude (feeling, opinion, intention) regarding the practice or a related topic • Perception of the problem of the priority group	Literature review and community assessment
Barriers and enablers • Barriers that prevent the priority group from practicing the recommended behavior • Presence of enabling factors and services that facilitate access (e.g. physical access, availability and affordability of items and services, support from family) • Adverse events (climate, security) affecting the behavior	Literature review, community assessment, barrier analysis
Stage of change of the priority group and influencing group • Identify the stage of change • Identify actions that the influencing group could do to facilitate the behavior	Literature review, community assessment, complementary assessment
RELATIONSHIP, COMMUNITY, AND SOCIETAL FACTORS	
Key actors in the community and social network of the priority group • Close relationship and social support • People that are part of the priority group's social network • People with power over the decision of doing the behavior	Literature review, community assessment, complementary research
Sociocultural local context • Perception of the problem in the community and causal attribution • Gender dynamics and roles related to the practices • Tradition, cultural belief, or social norms related to the practices • Laws or rules	Literature review, community assessment, complementary research
THE MOST IMPORTANT DETERMINANTS INFLUENCING THE BEHAVIOR	
Significant differences between doers/non-doers in the priority group • Significant barriers or enablers, preventing or facilitating the behavior • Influencing group: group having a significant influence • Main motivators of the priority group	Barrier analysis

14 *Adapted from Designing for Behavior Change Framework.*

FOR WHAT DO WE NEED THIS INFORMATION?

The information gathered will be used to complete the Designing for Behavior Change framework[15], a practical tool to help design the ABC strategy and the activities to change targeted behaviors.

FIGURE 2 *Inform the Designing for Behavior Change framework*



PRIORITY GROUP

The priority group is the group of people expected to practice the ideal behavior. Defining clearly the priority group helps to reduce the scope of the formative research and better tailors the intervention to its profile and preferences.

WAY OF LIFE AND DAILY ROUTINE

The daily routine and way of life information provides concrete tips for activity planning: when people are available, existing meeting locations and events that can be used as a platform for activities, and effective and appropriate communication channels.

KEY ACTORS AND INFLUENCING GROUPS

The key actors in the community are locally respected and influential people. They do not necessarily have a direct influence on the target behavior, but they often have an important role in communication channels and social mobilization. The "influencing groups" are people whose opinion[16] matter to the priority group and influence their practice. They are identified during the barrier analysis. Most of the time, influencing groups are part of the close social network of the priority group: family members, friends, and local leaders.

15 *Food Security and Nutrition Network Social and Behavioral Change Task Force. 2013.Designing for Behavior Change: For Agriculture, Natural Resource Management, Health and Nutrition. Washington, DC: The Technical and Operational Performance Support (TOPS)*

16 *Having relationships who matter to the priority group and influence behavior is a specific characteristic of a "social norm". Not all behaviors are conditioned to social network approval.*

Photo: Max Gabello, 2011

PROPORTION OF PEOPLE ALREADY PRACTICING THE TARGET BEHAVIOR AMONG THE PRIORITY GROUP

Knowing the prevalence of the target behaviors (e.g. % of exclusive breastfeeding) is useful to identify the main gap in practice and to monitor the progress. Behavior change indicators help to measure the efficacy of an intervention and are generally captured through pre and post Knowledge Attitude Practice (KAP) surveys.

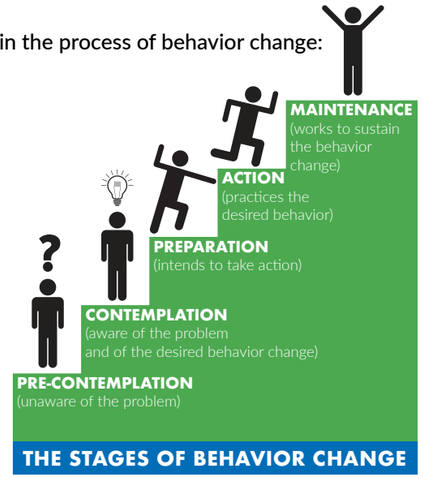
LOCAL SOCIOCULTURAL CONTEXT

Every project takes place in a specific context. It is critical to understand the perspective of the people one wishes to influence: their values, motivations and goals, perceptions of the world, how they relate to each other as individuals and as groups, and how decisions are made and who is part of the decision-making process. Understanding the sociocultural context helps to identify how to create a supportive environment.

IDENTIFY THE STAGE OF CHANGE OF THE PRIORITY GROUP OR INFLUENCING GROUP

The stages-of-change model[17] proposes 5 main stages to explain the process of behavior change:

1. **Pre-contemplation[18] ("not ready to change"):** the stage in which people are not intending to take action to change the target behavior in the next few months.
2. **Contemplation ("deciding to change"):** the stage in which people are considering the possibility of changing in the future, and they are beginning to think about the "pros" and "cons" of change.
3. **Preparation ("ready to change"):** the stage in which people are clearly intending to take action in the immediate future (days or weeks), and have begun active preparations for the behavior change.
4. **Action:** the stage in which people have actively taken explicit, overt, actions in the past weeks or months to modify their behavior.
5. **Maintenance:** the stage in which people try to maintain and stabilize change, preventing relapses.



Sources: *Grimley (1997) and Prochaska (1992)*

Individuals and groups can progress upward through these different stages, or relapse backward for various reasons. This model helps to understand the stage at which the priority group is on, the continuum of change (see assessment tool in ANNEX 7), and determines the type of intervention needed to promote change. The stages of change model can also be used to identify which behavior people are more likely, or willing to do, among a panel of behaviors. It will allow selecting behaviors to promote in priority to get quick wins.

PRESENCE OF ENABLING ENVIRONMENT, ENABLING FACTORS, AND SERVICES THAT FACILITATE ACCESS

Some behaviors need enabling factors. For instance, a minimum access to water is necessary to wash hands and availability of spare parts on the market is needed if the water-user community ought to buy it and repair a borehole. The priority group will feel frustrated and unable to perform the behavior if asked to do something out of its control. Developing activities that create an enabling environment is critical to triggering change. The environment encompasses individuals, community, and societal levels. Creating a favorable environment requires giving or facilitating physical access, as well as advocacy and policy-making.

17 *Maintenances stage is specific to behaviors that need to be performed consistently over a long period, such as hand washing, eating fruit and vegetable, or using condom. This stage does not apply to one -time behavior such as vaccination.*

18 *Stage definitions in part taken from: Prochaska, J., Velicer, W. (1997). The trans-theoretical model of health behavior change. American Journal of Health Promotion, 12 (1), p. 38–48.*

HOW TO CARRY OUT FORMATIVE RESEARCH TO INFORM A BEHAVIOR CHANGE STRATEGY?

DEFINE THE OBJECTIVES AND THE SCOPE OF THE FORMATIVE RESEARCH

Formative research can have more than one objective, but each must be a clear statement about what you want to learn from the research. Be specific and reduce the scope of the research to what is really needed. Define the scope of the assessment by selecting the behaviors to be investigated and defining the priority group: the people expected to perform these behaviors.

The research objectives should relate directly to current project challenges or future activities to implement. For an ongoing project, the best way to define relevant objectives is to discuss with field staff about the challenges they face with behavior change activities and start from concrete issues to address.

TIPS TO FORMULATE SPECIFIC RESEARCH OBJECTIVES[19]

Use active words to state your objectives, that is, what you want the research to achieve, for example:

- Describe how women search for information about nutrition and care during pregnancy.
- Determine the process men and women follow to decide how to spend money.
- Identify reasons why women cannot access the ingredients they need to cook enriched porridge.
- Clarify how peer relationships affect hygiene behaviors among teenagers.
- Clarify how grandparents and elders influence infant care practices.
- Identify reasons why some women don't use the menstrual hygiene items distributed.
- Identify doable actions men can do to support health and nutrition of children under 5 years.

Develop the research method and the data collection tools to specifically answer the research objectives (**ANNEX 1** provides an example of a term of references for formative research with generic objectives). Note that the formative research process is flexible: it includes a set of methods that can be used in different combinations and orders, depending on the objective of the research.

19 Adapted from Health Compass. How to conduct qualitative research.

1/ LITTERATURE REVIEW
GET A GLOBAL PICTURE

The literature review aims to summarize what is already known about the local context, the priority group, and its practices using existing documents. This step allows identifying what information is still missing and should be investigated, avoiding losing time in collecting the same data twice. Identifying the main gaps and prioritizing the behaviors to investigate can be done through community assessment and barrier analysis. The behaviors must be prioritized based on their potential efficacy and feasibility, and the prevalence of practice. Select a limited number of behaviors (maximum 6) to narrow the scope of the assessment and produce useful information for project design and implementation. If a project promotes more than 6 behaviors at a time, consider phasing the formative research.

OBJECTIVES OF A LITERATURE REVIEW

- To summarize existing information about the target group(s) and its practices
- To identify missing information that needs to be investigated

HOW TO DO A LITERATURE REVIEW?

Describe the local context and the priority group using information from existing documents. Refer to **TABLE 1** to get an idea of the type of information needed. Previous assessments and project proposals should already provide the humanitarian context and a problem statement. Demographic and Health Surveys (DHS), Multiple-Indicator Cluster Surveys (MICS), or similar sources can provide health and sanitation demographic indicators to describe the priority group. Gender dynamics and gender-based violence can be investigated on the UNWOMEN website for example. As much as possible, search for documents that focus on the specific area where the project will be carried out.

Existing reports from the area should be included in the review, such as: sociocultural assessments, anthropological studies, Monograph[20] of the area, Monograph of health systems, Nutritional Causal-Analysis (NCA), Water governance assessments, SQUEAC and SMART surveys[21], KAP surveys, resilience studies (e.g. Participatory Resilience Analysis and Measurement), gender analyses, and local health center data. All of these materials can provide rich information on the humanitarian situation, local causes of undernutrition, organization of stakeholders, local coping mechanisms, local prevalence of diseases and service coverage, and level of practices of different behaviors. Wikipedia or a Google search can also be a good starting point to get information on ethnic group traditions, culture, taboos, and history.

Compiling the information collected in one document will help save time. It will be easier to summarize your findings and identify missing information. For instance, developing a table in Microsoft Word or Excel with the list of sections and type of information needed could be useful. For each source, record the reference and the URL link if there is a document available online. You can use the structure proposed in **TABLE 1** above to organize the section and draft the report.

After summarizing all the existing and relevant information for the research, identify missing information that needs to be investigated in the field through community assessment. If you consider that you have all information needed, you can skip the community assessment and directly carry out the barrier analysis. Then, after conducting the barrier analysis, if you realize some results are unclear or there is a need to understand more about a current practice or belief, complementary research, interviews, or FGDs can be conducted as well.

RESOURCES

Demographic and Health Surveys (DHS) https://dhsprogram.com

Multiple-Indicator Cluster Surveys (MICS) http://mics.unicef.org/

UNWOMEN: http://www.unwomen.org/en/digital-library/

20 A monography is a document describing in detail a subject.
21 SQUEAC: Semi-Quantitative Evaluation of Access and Coverage survey; SMART: Standardized Monitoring and Assessment of Relief and Transitions survey.

Photo: 2011

2/ COMMUNITY ASSESSMENT
PEOPLE, PLACES, AND PRACTICES

The community assessment complements the literature review. It gives a better understanding of the cultural context where the behavior takes place, and of the people involved: what they do, how, and why they do so. It completes the description of the priority group[22] for the DBC framework and gives valuable information on how to conduct culturally appropriate communication, and with which media and communication channels. Thus, data collection in the field allows cross-checking the information you gathered from the literature review for triangulation, and collecting new information.

OBJECTIVES OF A COMMUNITY ASSESSMENT

The first step is to define, based on the literature review findings, which information needs to be investigated and to refine the objectives of the community assessment.

- Describe relevant characteristics of the priority group: socio-demographic characteristics; way of life and daily routine; current practices, knowledge and attitude regarding the behavior; traditions or cultural beliefs linked to those practices; gender roles and dynamics
- Understand the community perception of the problem, causes and solutions
- Identify the stage of change of the priority group

22 Main characteristics of the priority group: Demographic characteristics of the priority and influencing groups; daily routine; Current practices, knowledge and attitude regarding the behavior of; traditions or cultural believes linked to those practices; Gender roles and dynamics and the Stage of Change

HOW TO CARRY OUT A COMMUNITY ASSESSMENT?

The approach is generally qualitative. Information is gathered through semi-structured individual interviews, FGDs, informal discussions, as well as from direct observations. Community mapping, ranking exercises, problem trees, transect walks, or other participative learning tools[23] can be used as relevant to the object of the research. For example, a Venn diagram can be used to explore social networks and identify influential actors; a transect walk and community mapping could be relevant when assessing practices linked the village geography, like for disaster risk management or environmental sanitation. Pocket chart voting can be used to assess the prevalence of practice, attitude, opinion, or knowledge in a group. Note that individual interviews are more appropriate when discussing sensitive topics, allowing participants to disclose personal information in a confidential setting.

PARTICIPATORY EXERCISE WITH FIELD STAFF AND KEY ACTORS

A participatory session with field staff, partners, and key informants can help to quickly gather the main information needed to describe the characteristics of the priority group (socio-demographics; way of life and daily routine; current practices, knowledge, and attitudes regarding the behavior; traditions or cultural beliefs linked to those practices; and gender roles and dynamics) and to identify its stage of change. ANNEXES 2 and 3 provide examples of these types of activities. Note that if there is not sufficient time for a comprehensive assessment, this session could be included as part the BA training.

MAPPING THE AREA OF INTERVENTION AND THE DISTRIBUTION OF THE PRIORITY GROUP

Mapping aims to schematically plot the diversity of intervention areas. Understanding the geographical repartition of the population (ethnic group, religion, language, settlement, etc.), the political and administrative division, the health system division (catchment areas), the health centers, and the main roads and geography is important to know how diverse is the area, and identify potential factors that affect the adoption of the behavior. For instance, mapping can help to detect a geographical condition or transportation issue potentially affecting access.

The diversity of the area is an important factor when planning data collection. If your area is very diverse, you must consider collecting information from different zones and respondent profiles for your data to be representative of the diversity. This mapping can be done in a participatory session together with the staff and key stakeholders (see instructions in ANNEX 2).

SEMI-STRUCTURED INTERVIEWS

Semi-structured individual interviews are done using open questions about a specific list of topics. They are useful to gaining a general understanding of the knowledge and practices of community members. ANNEX 3 provides input on how to carry out a semi-structured interview. An example of an interview guide can be found in ANNEX 4, and an example of a questionnaire to assess the stage of change can be found in ANNEX 7.

FOCUS GROUP DISCUSSIONS

A FGD is a group interview of 6-12 people allowing for participant interactions which can provide a better understanding on a given topic. In these kinds of discussions, participants build on each other's answers, providing a comprehensive picture of a community. Participants of a focus group should have a similar profile and level of power; for everyone to feel comfortable expressing their views. FGDs can be useful for picking up on social norms, group dynamics, and concrete experiences linked to a particular behavior (e.g. how adolescent girls handle menstrual hygiene at school). See ANNEX 5 for input on how to carry out a FGD, and ANNEX 6 for an example of a FGD guide.

DIRECT OBSERVATION

Observations can be done informally as the interviews and FGDs take place; the interviewer observes the interviewees and the environment and takes notes. They can also be done in a more structured way, though a transect walk or using observation checklists. Observation checklists can help to assess evidence on the use of soap and latrines in a household, health center conditions, and child and parent interactions, for example.

Photo: Christophe Da Silva, 2018

23 *Participatory learning tools are described in ABC Assisting Behavior Change, Part 2 – Practical Ideas and Techniques, Action Against Hunger 2013 https://www.actionagainsthunger.org/publication/2013/12/assisting-behaviour-change-practical-ideas-and-techniques-part-2*

Photo: Christophe Da Silva, 2018

HOW TO ORGANIZE FIELD DATA COLLECTION?

The community assessment can be carried out by one interviewer alone, or by a team of interviewers coordinated by a supervisor. The interviewers should have good organization skills, experience in using qualitative methods, good communication skills, and understanding of the sociocultural aspects. They should also be able to speak the local language. Interviewers should be trained on the methodology to carry out such an assessment (for examples of training sessions, please refer to the Practical Guide to Conducting a Barrier Analysis[24] and How to Conduct a Community Assessment[25] guide).

Having a team of interviewers collecting the qualitative data as done in the BA methodology will save time, but will require mobilization of more logistical and human resources. It also implies conducting a training with the interviewers, and organizing debriefing sessions after field data collection. In this case, the challenge is to avoid transformation of the information, as more people are involved in the process.

The option of having one single interviewer in charge of the community assessment requires a researcher with some experience conducting qualitative research. It may take more time, but may also lead to a better overview and understanding, since the same person is directly involved in all interviews and FGDs. This person might need 1 or 2 assistants/translators to help schedule and organize interviews and FGDs. ANNEX 8 provides some tips for conducting data collection.

SAMPLE SIZE: HOW MANY INTERVIEWS AND FGDs SHOULD BE CONDUCTED?

In general, when using a qualitative approach, you continue data collection until you no longer receive new information. This stage is called the saturation point. However, this kind of assessment aims to inform operational decision making. Be aware that during a rapid assessment, saturation is not always achievable. The person responsible for the community assessment must make pragmatic decisions about the level of detail of information needed, the logistic, financial, and time constraints, and the utility of the data. He/she should focus on collecting data that he/she will be able to analyze and use to inform operational decision-making. In general, 10-15 interviews, and 3-5 FGDs for each specific topic should be sufficient to get a rough picture of the priority group and its practices.

Consider the diversity of the population concerned, by thematic interests, to cover the different types of people involved in the behavior and its viewpoints. If the population is very heterogeneous (different levels of knowledge, different ethnic groups, different life styles), one will need to conduct additional FGDs and interviews than if the population is homogenous (similar characteristics among the people of the group). If the behavior involves multiple actors, data collection should explore the view of each actor, for example, the purchase of nutritious foods may involve both men and women in places where the husband is the one controlling the household finances.

24 Kittle, Bonnie. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International. https://coregroup.secure.nonprofitsoapbox.com/storage/barrier/Practical_Guide_to_Conducting_a_Barrier_Analysis_Oct_2013.pdf

25 How to conduct community assessment, CMN http://www.coverage-monitoring.org/wp-content/uploads/2015/07/How-to-conduct-Community-Assessments-2015.pdf

SAMPLING METHODS

Purposive sampling[26] and snowball method can be used to carry out the qualitative interviews, considering most of the potential respondents are identified by key community actors. In the snowball method, a key informant is asked at the end of the interview if they can identify someone with the specific characteristics needed for an additional interview. For instance, the interviewer will ask: *You mention there is a farmer group in this community, could you tell me who is its main representative and where I can find him/her?*

The snowball technique is only appropriate when participants have no interest in orienting you toward interviewing a certain person more than another. For instance, when looking at service quality and interaction between providers and users, there might be some tension and personal interest (e.g. a health worker might suggest interviewing a mother whose child recovered rather than who died). In this case, random sampling would be more relevant. The interviewer can ask for the list of health service users and randomly pick a few, or he/she can decide to sit at the health facility and interview 1 of every ten users as they arrive in the waiting area.

EXAMPLE OF KEY INFORMANTS TO CONSIDER FOR INTERVIEWS

- Community members (M/F)
- Care takers/parents (M/F)
- Religious, traditional, and governmental authorities
- Health, agricultural, water sanitation and hygiene, or welfare district representatives
- Local leaders (M/F)
- Community-based organization representatives
- Community volunteers (M/F)
- Health workers and teachers
- Traditional birth attendants/healers
- NGO staff (M/F)
- If the behavior involves buying items: business owners, commercial agents, and suppliers

Regarding FGDs, convenience sampling can be used. Convenience sampling is a non-random sampling method where individuals are selected because of their convenient accessibility and proximity to the researcher. The interviewer will identify a place and time where the profiles he/she is looking for can be found, and invite any person matching that criteria.

TAKE GENDER INTO CONSIDERATION WHEN COLLECTING INFORMATION

In many contexts, key informants are mainly men because formal jobs and power positions are mainly occupied by men. Be sensitive to gender issues and ensure that women's points of view are fairly represented in the interviews and FGDs. When investigating a topic traditionally associated with women's roles, such as child care practices or health services, consider both the mother and father in interviews to better understand gender dynamics and their influence on practices.

26 A non-random sampling method in which decisions about the individuals to be included in the sample are taken by the researcher, based upon a variety of criteria

HOW TO ORGANIZE, CROSSCHECK, AND ANALYZE THE DATA?

Control the coherence of the data across different interviews and FGDs by confronting the information collected from different sources. As for the literature review, summarize the information collected in section by theme. Put together information collected on the field, and compare it to the literature review. Both qualitative and quantitative data is necessary to gain a comprehensive understanding of the priority group. Use qualitative data specifically to understand the context and what motivates behaviors and the quantitative data to estimate to which extent some beliefs are held, and attitudes and practices are shared by the priority group.

When writing the report, indicate clearly in the narrative which information comes from interviews and FGD data collection (quote people perceptions and opinions), which from the literature review (indicate references), and which statements reflect your own understanding and analysis.

To complement the narrative, different tools can be used to present the information in a condensed and easily understandable visual way, for example, mapping (social and geographical), graphics, and tables. Using these formats help readers to visualize and highlight interesting data. Maps are useful to show the geographical and social arrangement of key features/figures of an area. Social maps (e.g. organigrams, Venn diagrams) give an overview of the community (or institution) structure and organization, social, operational, and hierarchic links, as well as economic and decision making process.

RESOURCES

Qualitative research	*Resources*
Key concepts	How to conduct qualitative research, The Health Compass: https://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research
Qualitative Methodology	Data-collection: qualitative-methods, *Médecins Du Monde*: https://www.medecinsdumonde.org/en/actualites/publications/2011/08/06/data-collection-qualitative-methods
Participatory learning tools and research methods	ABC Assisting Behavior Change, Part 2, Practical Ideas and Techniques, Action Against Hunger: https://www.actionagainsthunger.org/publication/2013/12/assisting-behaviour-change-practical-ideas-and-techniques-part-2
Training modules on qualitative interviewing	A Practical Guide to Conducting a Barrier Analysis, Helen Keller International: https://coregroup.secure.nonprofitsoapbox.com/storage/barrier/Practical_Guide_to_Conducting_a_Barrier_Analysis_Oct_2013.pdf

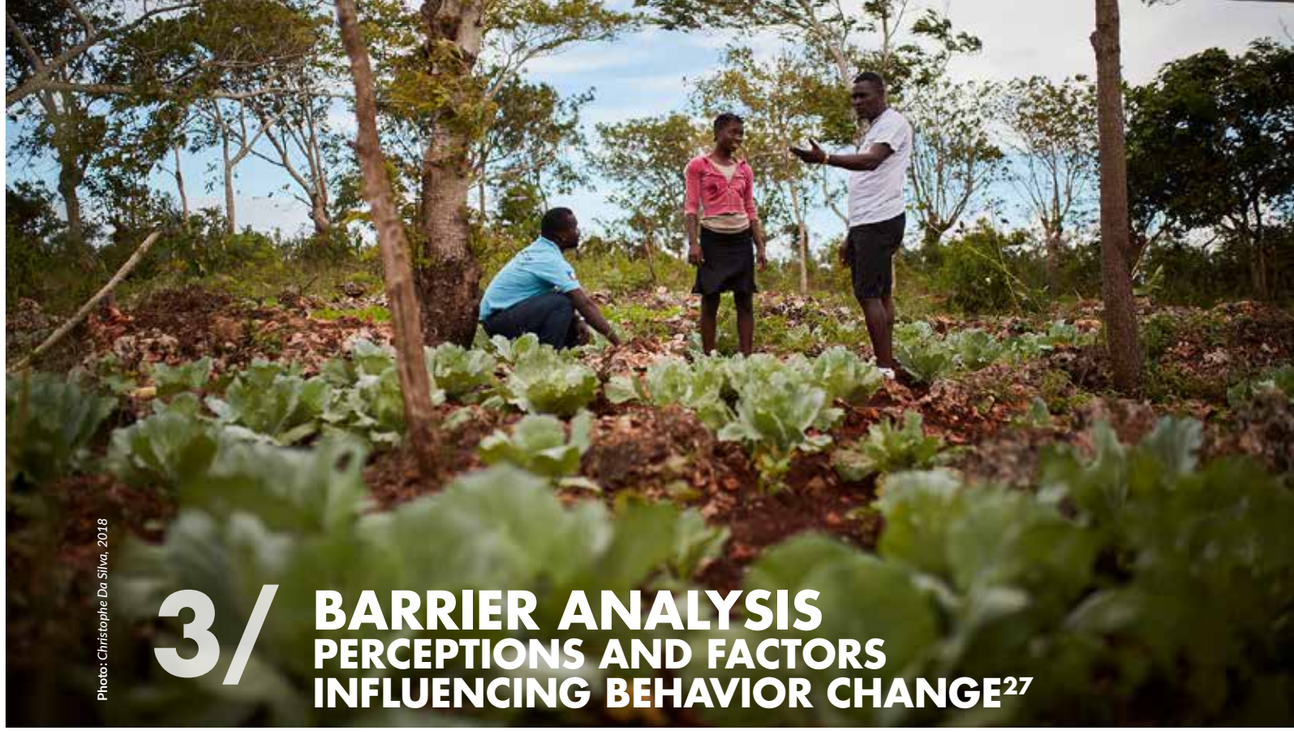


Photo: *Christophe Da Silva, 2018*

3/ BARRIER ANALYSIS
PERCEPTIONS AND FACTORS INFLUENCING BEHAVIOR CHANGE[27]

A barrier analysis (BA) is a rapid assessment that identifies factors that enable or prevent a behavior to be adopted by the priority groups. It explores up to 12 determinants influencing behaviors and helps identify which are the most important. For each determinant, this method compares those who are doing the target behavior (doers) and those who are not doing it (non-doers), to identify significant differences between both groups. The BA also identifies the main influencing groups. BA findings help to prioritize activities and better manage program resources by focusing the activities on most important determinants (main barriers and boosters). BA can be conducted at the beginning of the program to design the behavior change strategy, or during implementation, if the activities of a given intervention are not achieving behavior change.

OBJECTIVES OF BARRIER ANALYSIS

To identify the most important determinants that inhibit or facilitate the priority group from doing the behavior of interest

- To identify the most important barriers and drivers
- To identify the influencing groups
- To identify priority group motivators

BEHAVIORAL DETERMINANTS

The determinants are categories of reasons why someone does or does not do a behavior. Determinants represent a person's feelings, beliefs, or other elements within his or her environment that support or prevent the behavior. The only way to learn which determinants are most influential is by interviewing the priority group. The table below summarizes 12 determinants influencing behaviors and descriptions[28].

27 *This sectionsection summarizes barrier analysis method, based on Kittle, Bonnie. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International.*

28 *Food Security and Nutrition Network Social and Behavioral Change Task Force. 2013. Designing for Behavior Change for Agriculture, Natural Resource Management, Health, and Nutrition. Washington, DC: Technical and Operational Performance Support (TOPS) Program*

TABLE 2 *Definitions of the 12 main determinants influencing behavior*

Determinant	*Description*	*Examples of answers for this determinant*
Perceived self-efficacy/skills	An individual's belief that he or she is able to do a particular behavior given his/her current knowledge and skills. The set of knowledge, skills, abilities, and confidence necessary to perform a particular behavior. This category also encompasses perceived control, self-confidence and other aspects referring to one's self-perception.	"It is too difficult for me." "I cannot do it." "I feel discouraged." "It is not something I can change; it is not in my hands."
Perceived social norms	This determinant refers to the close relationships that matter to the priority group and influences its behavior. The perception that people important to an individual think that he/she should do the behavior or not (close relationship). Who matters most to the person on a particular issue, and what he/she perceives those people think he/she should do.	"My mother-in-law does not approve of giving colostrum to the baby." "My wife is against family planning." "My mother-in-law said we cannot marry if I don't build a latrine in our house." "My husband supports me."
Perceived positive consequences	Positive things a person thinks will happen as a result of performing a behavior. Positive consequences can be related to a healthy outcome, to improved production, or to something unrelated to the anticipated benefit.	"There is more privacy when you have a latrine." "My husband is happy because the baby cries less during the day (when I leave some breast milk in a cup for the baby)."
Perceived negative consequences	Negative things a person thinks will happen as a result of performing a behavior. This can include disapproval from the general public, or neighbors (a vague and generalized group, as opposed to the specific groups mentioned under social norms).	"Aquatab tastes horrible." "If I take the iron pills, the delivery will be difficult. The baby will be too big." "It is too hot when you sleep under the mosquito net. " "If you leave the soap next to the latrine, it will be stolen."
Access/perceived access	The degree of availability and affordability of the products or services required to adopt a given behavior. Audience's comfort in accessing desired types of products or using a service. Access can refer to access to social support, cost, distance, gender or ethnic specificities, discrimination, language, security, etc.	"It is too expensive." "I was waiting for my husband to get the permission to go to the clinic." "At the health center, there is no female staff for ante natal care; it is not appropriate." "We grow vegetables at home" "There is no veterinarian to vaccinate animals in the district." "There is no transportation. It is too far." "The nurse does not speak my language."
Cues for action/ reminders	The perception of the priority group that they can remember when to perform the behavior or how to perform the behavior. Key powerful events that triggered a behavior change in a person (e.g. a war, an epidemic).	"It is difficult to remember to take the pill every day." "It is easy to remember because the hand-washing station is in front of the toilet." "I forgot the day of the visit." "I forgot how to clean the water filter."
Perceived susceptibility/risk	A person's perception of how vulnerable they feel to the problem. Low perceived susceptibility can be linked to high self-confidence and perceived control (a person's perception that she is able to influence her immediate environment and future), or action efficacy.	"I don't think my child can get malnourished." "Anyone can get HIV." "I am not at risk, I use condoms every time." "Drought hit us every year." "My child will not get malnourished. I feed him well." "I won't get into an accident. I am a good driver."
Perceived severity	A person's perception of how much he/she would be affected if they face the problem; how severe the person feels this problem is for him/her personally.	"Diarrhea can lead to death." "It does not matter if you get diarrhea, it is easy to recover. " "Malaria is not very dangerous."
Perceived action efficacy[29]	The belief that by practicing the behavior, one will avoid the problem; the perception that the behavior is effective in solving the problem.	"I don't think vaccination can prevent polio." "I believe using a condom is 100% safe." "I don't think that eating diverse foods can really prevent undernutrition."
Perceived divine will[30]	A person's belief that the problem or its solution is the will of god, gods, or other divinities or mystic elements.	"The child will survive if it is God's will." "I cannot get HIV; God will protect me." "Our ancestor's spirit will protect us."
Policy	Laws and regulations that affect the behaviors and access to products and services. A person's perception of rules and policy.	"You must pay a fine if you don't comply." "As a teenager, you cannot access family planning if you come without your parents." "The water point is closed at 8 pm."
Culture	Set of history, customs, lifestyles, values, and practices within a self-defined group. A person's perception of traditions and taboos. May be associated with identity or lifestyle, such as gay or youth culture.	"The first week after delivery the baby should not be seen by a stranger." "Our tribe isn't used to eating dairy products." "A man and his mother-in-law can't share the same latrine."

A BA does not necessarily go through each of the 12 determinants: You can select the ones that seem more relevant to your sector of intervention. However, the most likely to be significant[31] and most important to assess are: perceived self-efficacy/skills, perceived social norms, perceived positive consequences, and perceived negative consequences. These four determinants are the ones covered by the "doer/non-doer" analysis.

29 The questions labeled under "action efficacy" can lead to answers related to "perceived control': person belief of being able to make a difference in the events that surround his/her life. Encouraging perceived -control and reinforcing self-confidence is helpful for helping a person to manage his/her stress and perform a recommended behavior.

30 Perceived divine and perceived control are often highly correlated. For instance, a person believing that it is good will for children to live or die generally also have low confidence in his/her ability to influence the event that surround his/her life.

31 Kittle, Bonnie. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International.

EXAMPLES OF UNIVERSAL MOTIVATORS

In addition, the BA explores the universal motivators of the priority group: the things that most people desire. This information is useful to identify if the universal motivator can be used to convince people to perform the behavior, and to orient communication materials on the benefit of that behavior.

- **Love**
- **Recognition**
- **Pleasure**
- **Freedom**
- **Success**
- **Security**
- **Social acceptance**
- **Comfort**
- **Peace of mind**
- **Status**
- **Power**

HOW TO CONDUCT A BARRIER ANALYSIS?[32]

DEFINE THE BEHAVIOR AND PRIORITY GROUP

The first step is to determine what behavior(s) will be assessed. It is important to be as specific as possible when defining the behavior and target group so that it is easy to differentiate and categorize doers and non-doers. The behaviors to be investigated should follow these recommendations:

- The behavior must be an observable action, specific (time, place, quantity, duration, frequency), measurable, feasible, and directly linked to an improved outcome.
- The priority group is the group of people expected to practice the behavior.
- The expected outcome should be a result analyzed from the evidence.

The behavior should be reflected by an outcome indicator, in order to measure progress in its level of adoption[33]. For example:

Priority group	*Behavior*	*Expected outcome*
Caretakers of children under 5	Caretaker washes his/her hands with soap at critical times	To decrease diarrhea in children under 5
Health workers	Health workers gives adequate amount of Ready to Use Therapeutic Foods and drugs	To reduce the treatment duration of wasted children
Farmers in drought or flood-affected areas	Farmers diversify their production with at least 4 kinds of productive activities	To reinforce the resistance to shocks
Mother of children 0-6months	Mother of children 0-6months give breastmilk on demand, day and night	Promote adequate child growth and cognitive development
Pregnant women suffering from anxiety	When feeling anxiety, the women practice the relaxing exercises or seek help from identified resources	To reinforce the ability to manage and reduce anxiety

32 SBC Task Force, Core Group. Barrier Analysis: A Food Security and Nutrition Network SBC Task Force Endorsed Method/Tool

33 If some outcome indicators can be scores, a diet diversity score for example, the behavior itself cannot be a score. It will be necessary to break down the composite indicator in several behaviors to be able to investigate barriers and enabling factors for each behavior.

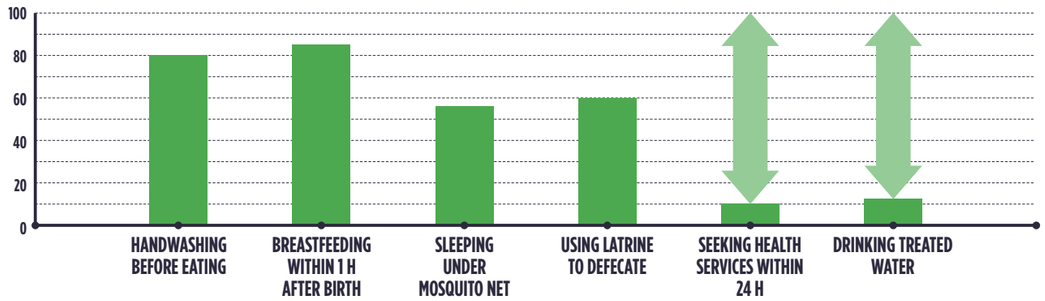
HOW TO SELECT THE BEHAVIORS TO BE INVESTIGATED IN THE BARRIER ANALYSIS?

To choose the appropriate behaviors, refer to Action Against Hunger and other organization's various sector guidelines (examples summarized below). Please note that nutrition, hygiene, and care practice recommendations are generally universal, whereas, farming practices tend to be very context specific.

Topic	*Reference to essential behaviors to promote*
Maternal and child nutrition, hygiene, and health	• Essential Nutrition Actions and Essential Hygiene Actions: https://www.fsnnetwork.org/sites/default/files/reference%20materials.pdf
Agriculture, farming, fishing, and entrepreneurship	• Low inputs agriculture, Action Against Hunger: http://www.actionagainsthunger.org/publication/2013/01/low-inputs-agriculture • Subsistence fish farming in Africa: a technical manual, Action Against Hunger: https://www.actionagainsthunger.org/publication/2013/10/subsistence-fish-farming-africa-technical-manual • Entrepreneurship Development Training Manual[31], Deutsche Stiftung Weltbevoelkerung: https://www.dsw.org/uploads/tx_aedswpublication/ENTREPRENUERSHIP_TRAINING_MANUAL.pdf
Mental health, care practices, and psychosocial support	• Care for Child Development Participant Manual, World Health Organization (WHO): https://www.unicef.org/earlychildhood/files/3.CCD_-_Participant_Manual.pdf • Caring for new born at home, World Health Organization (WHO): http://apps.who.int/iris/bitstream/handle/10665/204273/9789241549295_ParticipantManual_eng.pdf?sequence=1 • Problem management Plus, World Health Organization (WHO): http://www.who.int/mental_health/emergencies/problem_management_plus/en/

Ideally, a baseline survey provides information about the level of practice of the recommended behaviors. The BA should focus on the main gaps. For instance, in the figure below, the biggest gaps are "health seeking within 24 hours" and "drinking treated water". In the case there is no baseline survey available, discuss with partners and staff to determine the biggest gaps.

FIGURE 3 *Practices of mothers of children under 2 years*



BA is an appropriate method only for behaviors already performed by some of the population as you will need to find 45[34] people practicing the behaviors (doers) among the priority group.

When it is not possible to find 45 doers, there are different solutions according to each situation.

- There are not enough people practicing the optimal behavior, however, some people practice certain aspects of the behavior more than others. In this situation, you can "relax" the definition of the behavior and criteria to be a doer in order to be able to find 45 doers. For instance, you think that you will not be able to find enough doers if you only consider a mother as a doer who washes her hands with soap at at least 3 of the 5 critical times. You may accept a mother that washes her hands with soap at least 2 of the 5 critical times as a doer, because you think it is already an improved behavior compared to what the majority is doing.
- The behavior is not practiced at all, for instance, you are introducing the use of a new technology (e.g. sending the status of the water point via mobile phone). In this case, BA is not appropriate, you should choose a different type of research method, such as Trials of Improved Practices (TIPs), human-centered design or other methods based on participatory learning tools.
- If a new behavior is being introduced, another solution would be to launch the activities promoting the behavior and wait a few months, and then conduct a BA when a sufficient number of beneficiaries are practicing.

ALTERNATIVES TO BA

In the TIPs method, a few volunteers are needed to test the new behavior during an agreed period, and then share feedback about their experience. "Farmer Field School" is an example of a similar approach that allows participants to test news techniques in a safe space and observe the results. It can be used to introduce new farming behaviors and collect information about their advantages and disadvantages, perceived efficacy, and applicability in everyday life. If the behavior is linked to the use of a new tool to be designed and introduced, then other approaches such as "Human Centered Design" can be used to create objects that respond to participants' needs and preferences and will facilitate the practice. For agricultural practices in particular, specific approaches are available, such as Farmer Field School.

- Tools and examples of Trials of Improved Practices (TIPs):
  https://www.manoffgroup.com/wp-content/uploads/summarytips.pdf
  Designing by dialogue, Chapter 6: TIPs
  http://nutritionatthecenter.care2share.wikispaces.net/file/view/Designing%2520by%2520Dialogue.pdf
- Manual for the Field Farmer School (FFS), Food and Agriculture Organization of the United Nations (FAO):
  http://www.fao.org/docrep/016/i2561e/i2561e00.htm
- Toolkit for human-centered design, IDEO:
  http://www.designkit.org/human-centered-design. IDEO website includes a number of case studies around water businesses, sanitation services, and financial literacy.

34 *Having 45 doers and 45 non-doers is the optimal sample for this study, that allows identifying easily statistically significant differences.*

EXAMPLES OF SITUATIONS

From the KAP survey, 30% of parents of children under 2 years seek health care within 24 hours. It is an important gap; the behavior is an essential action for child care, and it seems possible to find enough doers to conduct a barrier analysis.
→ **Conduct a BA**

Only 2% of people are practicing the optimal behavior "eating iron rich food every day". It is not likely that you will easily find doers, however, some people are doing better than others. You might decide "to relax" the behavior to be studied: you will accept as a doer a person that is doing an improved practice compared to others. The relaxed behavior will be eating an iron rich source at least 3 times per week.
→ **Relax the behavior to conduct a BA**

DEVELOP BA DATA COLLECTION TOOL

The data collection tool is a questionnaire composed of 2 sections. Section A categorizes respondents into doers or non-doers. Section B contains questions exploring the determinants (example provided in **ANNEX 9**).

1. DEVELOP THE SCREENING QUESTIONS: SECTION A

This first set of non-leading questions aims to verify if a respondent is among the priority group and determine if he/she is a doer or a non-doer.

Priority group	*Criteria to be doer*	*Criteria to be non-doer*
Mother of children aged 6-23 months	The mother washes her hands with soap at least 4 or 5 of the 5 critical times and soap is available at home.	The mother washes her hands with soap less than 4 of the 5 critical times, or there is no soap available at home.
Pregnant women	The pregnant woman eats 4 times per day, 4 meals per day or more, or at least 3 meals and 1 snack.	The pregnant woman eats fewer than 4 times per day.
Pregnant women suffering from anxiety and receiving psychological care	The pregnant woman practiced one relaxing exercise or sought help from identified resources for 3/3 last situations of anxiety, in the past 2 weeks.	The pregnant woman was unable to practice relaxing exercises or seek help from previously identified resources in a stressful situation at 1 or more times over the last 3 situations of anxiety.
Farmers using a forest as a resource	The farmer replaces the trees he/she cuts by planting new trees every year and replacing at least 80% of those cut.	The farmer doesn't replace the trees he/she cuts every year or replaces fewer than 80% of those cut.

Be consistent when defining doers and non-doers during the study. Make sure the screening questions effectively categorize someone from the priority group as a doer or a non-doer, and exclude those who are not part of the priority group.

EXAMPLE: SECTION A - DOER/NON-DOER SCREENING QUESTIONS

1. Are you pregnant?
- ☐ a. Yes
- ☐ b. No ⟶ End interview and look for another respondent
- ☐ c. Do not know / no response ⟶ End interview and look for another respondent

2. Since you noticed you were pregnant; did you increase the quantity of food you take every day?
- ☐ a. Yes
- ☐ b. No
- ☐ c. Do not know / no response ⟶ End interview and look for another respondent

3. I would like you to think about how many times you ate yesterday. How many meals did you have?.....
Did you have additional snacks? How many times did you have a snack yesterday?.....
- ☐ a. 4 meals (or 3 meals + at least 1 snack)
- ☐ b. 3 meals only or less than 3 meals ⟶ Mark as non-doer
- ☐ c. Do not know / no response ⟶ *End interview and look for another respondent*

FIGURE 4 *Classification table in section A*

DOER /NON-DOER CLASSIFICATION TABLE

DOER (all of the following)	Non-Doer (any ONE of the following)	Do Not Interview (any ONE of the following)
Question 1 = A		Question 1 = B or C
Question 2 = A		Question 2 = C
Question 3 = A	Question 3 = B	Question 3 = C

Group: ❑ Doer ❑ Non-doer

Section A ends with a doer/non-doer classification table (see **FIGURE 4**). This table allows you to classify the respondent as a doer, a non-doer, or someone not to be interviewed, according to the responses they gave to the screening questions. If the optimal behavior is practiced by very few people, you may have to "relax" the definition of the behavior and criteria to be a doer, to be able to find 45 doers. Note that the decision of relaxing the behavior or not, has to be made at the first stage of questionnaire development.

2. DEVELOP THE RESEARCH QUESTION: SECTION B

A database with examples of questionnaires[35] is available online on the Food Security and Nutrition Network. It includes behaviors related to nutrition, food security and livelihoods, hygiene and sanitation, community management of acute malnutrition (CMAM) treatment, gender, and other sectors. Questionnaires will have to be modified according to the behavior statement you require.

Tips:

- Use the model from the data base questionnaire.
- Identify one or two questions for each of the determinants being studied.
- Be careful when translating, and make sure the meaning of the question or statement is not lost.
- During interviewers training put emphasis on the importance of probing and asking clarifying questions.

The quality of the data collected for open-ended questions (section B) is highly dependent on the ability of interviewers to probe and ask clarifying questions. Two days are generally needed for interviewers to understand the questionnaires, review and discuss translation, and practice the qualitative interviewing techniques.

35 http://www.fsnnetwork.org/barrier-analysis-questionnaires-0

3. SAMPLE SIZE AND SAMPLING METHOD

A sample size of 90 individual interviewees (45 doers and 45 non-doers)[36] is sufficient for the BA. Convenience sampling is used to identify doers and non-doers. It is good to include respondents from different areas and characteristics (age, sex, ethnicity, socio-economic level) to ensure that all sub-groups within the priority group are represented. Note: because the sampling is not conducted at random, the results of a BA cannot be used to estimate prevalence.

4. ORGANIZE AND CONDUCT DATA COLLECTION

This involves the logistics of planning a field visit, identifying the people to be interviewed, and ensuring there is a space available for the interviews to be held. For detailed instructions, see ANNEX 10 *How to plan field data collection for barrier analysis*.

During data collection, the survey coordinator should track the number of doers and non-doers interviewed against the number required for each site. He/she should maintain communication with each data collection team to track the total numbers of doers and non-doers. He/she should inform data collectors which type of respondent (doers or non-doers) they should seek out to reach 45 of each. For detailed instructions, see ANNEX 10 *How to plan field data collection for barrier analysis* and ANNEX 11 *Supervisor checklists* and the Practical Guide to Conducting a Barrier Analysis.

5. CODE, TABULATE, ANALYZE AND INTERPRET THE RESULTS

Coding is the process of examining the responses to a given question, looking for ways to categorize them according to similar meaning, then assigning a code that represents this set of similar reasons. For instance, when exploring the difficulty to wash hands with soap, the following answers, "I don't have soap," "there is no soap," and "no soap at home," can be grouped under the code, "No soap at home." The words used by the respondents should not be summarized in a concept but should be used literally to build the code. The coding of the answers is done manually, together with the interviewers. Each interviewer interprets his/her own questionnaire. The coding should be done while the interviewers still have the interviews fresh in mind. Note that this step is very demanding in terms of concentration for the interviewers. Refer to the ANNEX 12 to get more detailed guidance on how to conduct the coding session.

The results of the coding session are entered into the "BA tabulation worksheet" (Excel sheet with ready to use formulas), which automatically calculates the significance of the results. This spreadsheet generates the estimated Relative Risk (RR); which estimates how many times more likely it is that doers mention a reason to do or not to do a behavior, as compared to a non-doer (or how many times more likely it is that non-doers mention a determinant as compared to doers).

The p-value generated helps to decide whether the response is statistically significant. If the p-value is less than 0.05, the difference between doers and non-doers is probably not due to chance, and that is statistically significant. If this is the case, it is important to focus on activities related to this determinant because it has more potential to influence the behavior we want to change. If the p-value is greater than 0.05, there is probably not a real difference between doers and non-doers, and the activities should not focus on it as a priority.

The BA Tabulation Worksheet 2016 can be found at:
http://caregroups.info/wp-content/uploads/2016/06/Final-Computerized-Tabulation-Sheets-June-2016.xlsx

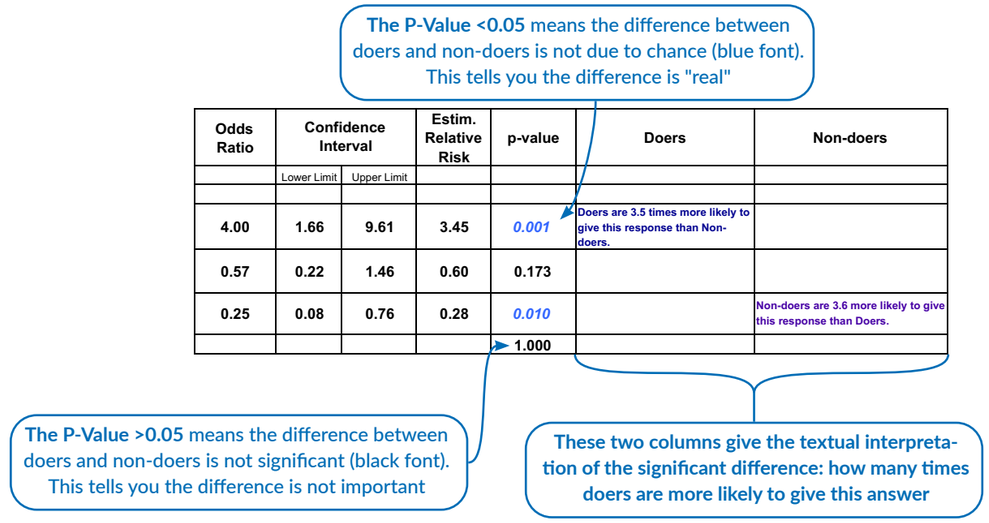
How to use the tabulation sheet:
https://www.fsnnetwork.org/document/explanation-using-barrier-analysis-excel-calculation-sheet

The video explaining the methodology gives a quick overview of how the barrier analysis works:
http://caregroupinfo.org/vids/bavid/player.html

36 BA follows a "case-control" study design. The objective is to assess factors associated to doers and non-doers conditions, not to estimate prevalence within the general population. This is why there is no need to use population-based sampling as for population-based surveys.

The instruction sheet in ANNEX 13 gives information on how to input the data, analyze, and interpret the results of interviews. The findings to report are the significant differences between doers and non-doers. It is not necessary to be an expert in statistics to find a significant result and interpret it. The important differences appear in blue in the tabulation sheet. For instance, if the Relative Risk is 7.8, the tabulation sheet will display: "***doers are 7.8 more likely to give this answer*** (than non-doers)". To approximate if an answer is important, measure the point difference between doers and non-doers. If there is a 15 percentage point or more difference between doers and non-doers the result is likely statistically significant.

Example of interpretation of p-value using the EXCEL tabulation spreadsheet.



6. PRESENT AND DISCUSS THE FINDINGS

Select the significant results and classify them by determinant and by order of importance. In the report, highlight the most important reasons given by the interviewees, doers and non-doers, using their own words. This gives insight on how to communicate with beneficiaries and motivate them to adopt the behavior. It does not matter if the reasons why doers practice the behavior are not the reasons why the project promote it. For example, doers may wash their hands to demonstrate good manners and smell good when the project's aim is to promote hands washing to reduce diarrhea. Use the reasons given by the interviewees for the significant determinants; use their own words and arguments to convince more people to practice.

7. RECOMMENDATIONS BASED ON THE BA RESULTS

Key principles to consider when formulating recommendations:

- Recommendations must be based on the findings (statistically significant results)
- Recommendations must be specific, realistic, and concrete
- Recommendations must focus on addressing the most important barriers and enablers

8. DEVELOP RECOMMENDATIONS FROM THE BA

1. Select actionable, significant results of the BA
2. For each significant result, write a specific "change objective" (bridges to activities) that addresses the barrier or strengthens the enabling factor
3. Identify needs for complementary research

TIPS TO FORMULATE A CHANGE OBJECTIVE ADDRESSING SIGNIFICANT DETERMINANTS
Use the formulation technique of the DBC framework to write "Bridge to activities"[37].
A **Bridge to Activity** usually **begins with a directional verb** (such as increase, decrease, improve, or reinforce) and often **proposes to change the perception of the Priority Group**, based on the barrier analysis results.

BRIDGE TO ACTIVITY STATEMENT

Directional verb (increase, decrease, improve, reduce, reinforce)
+ the perception that…
or the ability to… (self-efficacy or cue for action)
or the availability of…

37 *Food Security and Nutrition Network Social and Behavioral Change Task Force. 2013.* Designing for Behavior Change for Agriculture, Natural Resource Management, Health, and Nutrition. *Washington, DC: Technical and Operational Performance Support (TOPS) Program.*

Photo: ACF, 2010

4/ COMPLEMENTARY RESEARCH TO DRAFT AND TEST SOLUTIONS

Complementary research is sometimes necessary to finalize the formative research and answer a new research question that appears during the study:

- What is the actual attitude of the influencing group toward the behavior?
- Is the influencing group willing to support the priority group, and what concrete actions can be done?
- How can the tools and environment be improved to make the practice easier and acceptable?

CORROBORATING THE ACTUAL ATTITUDE OF THE INFLUENCING GROUP TOWARD THE TARGET BEHAVIOR

BA findings indicate who are the influencing groups and if the priority group perceives this influence as in favor or against the behavior. Interviews and FGDs can be used to investigate the actual attitudes and opinions of the influencing group.

EXAMPLE
In a context where talking about sexual and reproductive life is taboo, women might find it difficult to use contraceptive methods because they think their husbands do not approve of family planning. However, it does not mean the husbands are against it. Further research is needed to find out the actual perceptions of husbands. Another common example is religious tenets regarding health topics. Sometimes, people will assume that God disapproves of a practice. In this case, interviewing a religious leader and searching for references in their holy books (as part of a literature review) will be necessary to understand if the perception is grounded or not, and what religious argument supports/inhibits a practice.

IDENTIFYING SOLUTIONS TO CREATE A SUPPORTIVE ENVIRONMENT

Certain behaviors cannot be practiced by the priority group due to their immediate environment and relationships. For instance, the main barrier to exclusive breastfeeding is generally the lack of time and workload of women. To enable the behavior, it is necessary to provide women with the support and time to participate in this activity. Further discussion is needed with the woman and her relatives to find concrete and feasible solutions. For example, a research question for this situation is what are some concrete actions that husbands/fathers can do to support good child care and feeding practices, and among them, which ones would be doable and acceptable for them to do? Participatory learning and action (PLA) tools can be used to list, rank, and select the actions needed to create a supportive environment.

Learn more about participatory learning and action (PLA) tools and other methods formative research: ABC assisting Behavior Change, Part 2, Action Against Hunger, 2013: http://files.ennonline.net/attachments/2304/ACF_BC_PART-2_2013.gb.pdf

FACILITATING THE BEHAVIOR BY IMPROVING THE TOOLS OR PROCESS

Complementary research is also needed when the main barrier to behavior adoption is one linked to the design of the tools needed to perform the behavior. For example, the energy-saving stove promoted is too heavy and takes too much time to cook food; women working out of home are willing to express breastmilk for their baby but they have difficulties to keep it cool because the weather is very hot; the recipe of enriched porridge is not very tasty and children don't like it. In this case, TIPs or other human-centered design methods can be used to facilitate the behavior by improving the design of the stove, finding a concrete solution to conserve the breastmilk, or improving the taste of the porridge.

Photo: *Max Cabello, 2011*

5/ USING FORMATIVE RESEARCH FINDINGS TO DESIGN A BEHAVIOR CHANGE STRATEGY

Findings from the community assessment, literature review, and secondary data collection will help describe the priority group and inform the Designing for Behavior Change Program Framework (see below). The BA findings enable one to fill out the determinants' column, to identify the influencing group and to formulate the change objectives (bridges to activities).

TABLE 2 *How findings will inform the Designing for Behavior Change (DBC) Framework*[38]

Choose strategic behaviors based on their potential to solve the problem and on the main practice gaps; then, set corresponding outcome indicators

Findings from the literature review and community assessement will inform the priority group description and give practical tips to plan activities

Results from the barrier analysis will help identify the most important determinants to act upon to achieve effective behavior change

Behaviour	*Priority group or influencing groups*	*Determinants*	*Bridges to activities*	*Activities*
To promote this behaviour...	... among this audience... Priority group: Influencing group:	... we will research these determinants...	... and promote these bridges to activities (priority benefits and priority barriers)	... by implementing these activities
Outcome indicator: % of person practicing among priority group				Process indicator: N° of beneficiaries N° of sessions

Identify influencing groups through barrier analysis and find out their actual position through complementary research

Results from barrier analysis will help write the bridges to activities

When all of the above is completed, it is the time to develop specific and detailed activities to match the change objectives (also called bridges to activities). Note that an activity can address more than one bridges to activities at a time.

38 *Food Security and Nutrition Network Social and Behavioral Change Task Force. 2013.Designing for Behavior Change: For Agriculture, Natural Resource Management, Health and Nutrition. Washington, DC: The Technical and Operational Performance Support (TOPS).*

Photo: *Daniel Burgui, 2013*

PLANNING FOR FORMATIVE RESEARCH

HOW LONG DOES IT TAKE TO CARRY OUT FORMATIVE RESEARCH?

The time required depends on many factors, including, but not limited to: availability of personnel, funding, logistics, sample size, size of the intervention zone, training needs, the timeframe before implementation of a program, and the scope and depth of the assessment.

Literature reviews can take two to five days, depending on the scope of the research. The community assessment will take longer, as to allow time to talk to members of the community, plan focus groups, and interviews. Data collection for the BA, for each behavior can be carried out in 1-2 days depending on the number of interviewers, and the access to the study area. Items that should not be forgotten in the timeline include training, travel, planning, analysis, and the dissemination of results. Below is an example of a schedule, with an approximate number of days needed. If you chose the TIPs approach, you need to plan several weeks minimum, to develop solutions, test them, and collect feedback.

Task	*Approximate number of working days**
Literature review	2 -5 days depending on the number of reports available
Training for interviewers and supervisors	3-5 days
Community assessment	5-10 days depending on team organization, diversity of the area and number of behaviors to be studied
BA data collection	1 day per behavior (for a team of 12-15 interviewers, depending on the distance)
BA coding, data entry, and analysis	½ day per behavior (all teams of interviewers are needed for the coding)
Complementary research	3 days for FGDs and interviews or 2-3 weeks for TIPs
Reporting	3-5 days
Presentation of results	1 day (2 hours for presentation and 2-3 hours for preparation)

* *This example does not include traveling time.*

HOW MUCH DOES IT COST?

The complete formative research laid out in this guidance document does not have an exact budget that can be followed. It will depend on the costs in the country, and if one uses in-house human resources, or if you need to hire extra people for data collection and a consultant to conduct the research. The BA itself does not require a large financial investment. As a reference, it generally costs less than a KAP survey.

Items to consider in the budget:

- Training needs: training materials, training rooms, per diem/food and accommodation for participants
- Copies of questionnaires, interview/FGD guide
- Consultant fees, flight and accommodation if external resources
- Transportation to the survey site
- Security and communication tools (handset/phone and credit)
- Salaries of interviewers and supervisors
- Dissemination costs: workshop and presentations

AUTHORIZATION AND ETHICS

Before beginning any type of research or assessment you may need authorization from government officials and any other important community level officials.

Before conducting interviews or FGDs, it is important to get consent. Informed consent is used to ensure that those involved in the study understand what it means to participate, which allows potential participants to make a knowledgeable decision on whether or not they should be a part of the study. Part of this is ensuring participants understand that their personal information will be kept secure and private, as well as knowing that participation is voluntary. Interviewers should do their best to ensure that respondents are comfortable and that a level of privacy is maintained at all time.

For more information about good practices on data collection and surveys, refer to the Action Against Hunger Multi-Sector Monitoring and Evaluation Guidelines and toolkits:
https://www.actionagainsthunger.org/publication/2016/08/multi-sectoral-monitoring-evaluation

ANNEXES

ANNEX 1 *Terms of Reference (ToR) for formative research*

MAIN OBJECTIVE

To improve understanding of the area of intervention and inform the design of a behavior change strategy.

- Describe relevant characteristics of the people involved in the behavior of interest: socio-demographic characteristics; way of life and daily routine; current practices, knowledge and attitude regarding the behavior; traditions or cultural beliefs linked to those practices; gender roles and dynamics.
- Identify main factors inhibiting and facilitating behavior adoption.
- Provide concrete recommendations to guide behavior change activities.

SECONDARY OBJECTIVES

- To conduct a literature review and community assessment, including at least the following parameters:
    - Identify main stakeholders in the community involved in the behavior of interest (e.g. hygiene practices, infant feeding or farming practices).
    - Clarify how community organization and mechanisms, family and gender dynamics influence the behaviors of interest.
    - Describe socio-demo characteristics and way of living of the individuals and groups involved in the behavior of interest.
    - Describe current perceptions, knowledge, practices and attitudes specifically related to the behaviors of interest.
    - Identify positive existing practices the project should encourage to promote the behavior of interest.
    - Identify formal and informal channels of communication, preferred tools, events and platforms for sharing information.
    - Determine how specific practices, beliefs, and attitudes that prevent the adoption of the behavior of interest.
    - Identify specific practices, beliefs, and attitudes that support or facilitate the adoption of the behavior of interest.
- To conduct a barrier analysis:
    - Select the most critical behaviors to be investigated in the barrier analysis; based on project data and potential positive impact on outcomes.
    - Identify the most important determinants that influence the behavior of interest (e.g. exclusive breastfeeding, health-seeking practices, handwashing with soap).
    - Make concrete and realistic recommendations to address barriers and enhance enablers.
    - Train Action Against Hunger teams and key partners in barrier analysis methodology.
    - Develop a strategy of behavior change, including clear guidance for implementation and tools for field workers.
    - Train field workers on the strategy developed, content, methodology, and tools.

PRODUCTS TO BE DELIVERED

Final report, executive summary, data collection tools, behavior change strategy, a guidance document for project implementation, and training tools.

ANNEX 2 *Participatory activities with field staff and key actors to describe the priority group – 2 hours*

SET OF QUESTIONS TO WORK WITH BARRIER ANALYSIS WHILE TRAINING PARTICIPANTS, IN GROUP WORK

Collecting information from your field team on the group of people who should be practicing the target behavior (priority group)

This information will be used to describe the priority group when designing the behavior change strategy. Divide the participants into 3 groups and distribute the questions, flip chart, and markers. Give them 20 min to work in groups and then 10 min for each group to present.

GROUP 1 Describe the priority group

Socio-demographic characteristics

- What is the sex and age range of the priority group?
- What is their source of income and/or livelihood?
- What is their level of income?
- What is their living status (rural, urban)?
- What language is spoken by the priority group?
- What is the education/literacy level of the group?
- What are the religious beliefs of the group?
- What are the ethnicities of the group?

Daily routine of the target group

- What does the group do during the day?
- What are specific activities they do during the week?
- What are specific activities they engage in throughout different seasons?
- When do they participate in social gathering activities? What kind?
- How do they get news/information (media available, formal and informal channels of communication)?

GROUP 2 Describe the priority group

Current practices regarding the behavior of interest (behavior to be promoted in the project)

- Describe what you know about the current practices.
- Are there existing harmful/inadequate practices? Which ones? Why do they do them?
- Are there positive practices? Which ones? Why do they do them?
- What does the group know about the behavior we want to promote?
- How do they feel about the behavior we want to promote?
- How many people already practice the targeted behavior?
- What are the main barriers that prevent the priority group from practicing the behavior we want to promote (barriers we already identified before conducting the BA)?

Gender roles and dynamics

- How do gender roles (roles of women and men) influence the practices?

GROUP 3 Draw a map of the area

On a flipchart draw a map of the area of intervention.

- Indicate the boundaries and the main administrative divisions or health catchment areas
- Indicate main roads, rivers, moutains, villages
- Indicate the water points, markets, schools, health structures
- Indicate the repartition of language, ethnic groups, religious groups
- Indicate anything that may affect geographical access
- Indicate any zone of insecurity

In plenary, each group presents its work. After each presentation, other groups can ask questions, add, or correct information. The information from this session will help complete the description of the target group in designing the behavior change framework. This exercise also helps to triangulate information gathered by other methods.

ANNEX 3 *Participatory exercise with field staff and key actors – 1 to 1.5 hours*
Evaluating the stage of change

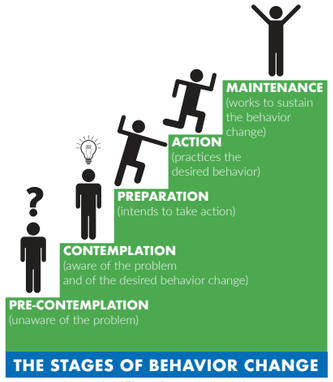
1 INTRODUCTION – INDIVIDUAL TASK

Ask each participant to individually assess his/her own stage of change related to a behavior. Use another example of behavior with the stage of change assessment tool.
Give 5-10 minutes for the participants to read and complete the stage of change assessment tool. Ask the participants to identify their own stage of change.

2 PLENARY

On a flipchart with the stage of change drawings, ask participants to situate themselves on the flipchart (using a Post-it or making a cross with a marker).
Ask the participants to analyze the answer as a whole and to identify at what stage of change the group is. Ask participants what each stage means to them. Then, ask what they know about each stage. Summarize and complete by explaining:

- **Pre-contemplation** ("not ready to change"): the stage in which people are not intending to take action to change the target behavior in the next few months.
- **Contemplation** ("deciding to change"): the stage in which people are considering the possibility of changing in the future, and they are beginning to think about the "pros" and "cons" of change.
- **Preparation** ("ready to change"): the stage in which people are clearly intending to take action in the immediate future (days or weeks), and have begun active preparations for the behavior change.
- **Action**: the stage in which people have actively taken explicit, overt, actions in the past weeks or months to modify their behavior.
- **Maintenance**: the stage in which people try to maintain and stabilize change, preventing relapses.



Sources: *Grimley (1997) and Prochaska (1992)*

3 GROUP WORK

Divide the participants into 2 or 3 groups and distribute the questions, flip chart, and markers. Give them 15 minutes to discuss what they know about the priority group, and at what stage they are.
Give each group a flipchart with questions and ask the participant to situate the priority group:

- Are they interested in trying to _____? (**Pre-contemplation**)
- Do they see _____ as a problem _____? (**Pre-contemplation**)
- Are they thinking about _____? (**Contemplation**)
- Are they thinking about the pros and cons of _____? (**Contemplation**)
- Are they ready to plan how to do _____? (**Preparation**)
- Are they in the process of trying to do _____? (**Action**)
- Are they trying to keep doing _____? (**Maintenance**)

4 GROUP WORK PRESENTATION IN PLENARY

Ask each group to present its estimation and the reasons or data that support this estimation. At the end, discuss the last question: Stages of Change: pre-awareness, awareness, preparation, action, and maintenance.

5 PLENARY – INTERACTIVE DISCUSSION

Ask the participants:

- At which stage of change do we think most of the group finds itself?
- Look at the map of the district (area of intervention), from your experience, do you think all the villages are at the same level of change?
- Are there some villages that are more advanced? More reluctant? Why?

6 CLOSURE

Summarize what has been said in the discussion and what is the main conclusion of the exercise. Thank the participants. Record the results and complete the DBC framework.

ANNEX 3 *How to conduct semi-structured interviews:*

1. Train interviewers on how to properly present the survey, ask for consent, interview, translate, take notes, and listen actively during the interview.

2. Identify general topics you would like to discuss during the interview and define the objectives.

3. Develop an interview guide (list of questions or theme to be discussed).

4. Test the interview guide and make sure the interview does not last more than 40-60 minutes.

5. Select "key informants" or specific people who are relevant for your data collection; this includes: men, women, mothers, fathers, community leaders, shop vendors, etc.

6. Ensure that your selection of key informants covers the diversity of the population in terms of sex, age, ethnic group, religion, life style, etc.

7. Ensure that there is an appropriate venue available, and privacy if needed.

8. To carry out an interview, it is important to do the following:
    - Create a "safe" space and comfortable environment as well as conveying your neutrality to make sure participants feel that they can speak freely.
    - Present the goals, reason, and general information for why you are carrying out the interview.
    - Explain that there will be no incentive, no obligation to participate, give the approximate duration of the interview and ask permission to conduct the interview (verbal consent). If the person refuses, thank him/her and look for someone else.
    - Ask the participant if she/he is willing to participate.
    - Follow the interview guide (the interviewer can skip a question if already answered).
    - Probe and ask clarification questions to get more details or understand the meaning of the answers.
    - It is possible to change the order of the questions of the interview guide, to allow a natural flow of conservation.
    - Listen actively to the interviewees and let them answer the questions completely.
    - Respect the duration of the interview.
    - You may provide answers to the questions, but only once the interview has been completed.
    - Thank the interviewee for his/her time and ask if there are any questions.

ANNEX 4 *Example of an interview guide for community assessment*

INTERVIEW OF A TRADITIONAL HEALER AND BIRTH ATTENDANT HEALTH SEEKING BEHAVIOR AND UNDERNUTRITION

1. What kind of medicine do you practice? What else?
2. Could you tell me how you became traditional healer/traditional birth attendant?
3. What are the main reasons why people come to see you?
4. What is the most common illness in young children?
5. Do people bring you children with those signs (show pictures of marasmus and kwashiorkor), and if yes, what is your diagnosis?
6. What are the causes of those illnesses?
7. How do you handle those cases?
8. How much does the treatment cost?
9. What do you do if the treatment does not work?
10. Do you refer patients to them, or they to you? In what scenarios?
11. Do you think it could be possible that when you receive a child with those signs (show photos again) that at the end of the consultation, you also advise the parents to bring the child to health facility?
12. Is there any preventative care that you provide for those children? What do you do?
13. How is the collaboration between health center workers and traditional healers in general?
14. What could be done to improve collaboration?
15. Among the following actions, which ones do you think you could do?
    - Measure the children under 5 years of age and refer them to the health center
    - Counsel on nutrition
    - Explain how to use ORS in case of diarrhea
    - Refer pregnant women to ANC (list of behavior to be adapted according to the project)

ANNEX 5 *How to carry out a focus group discussion*

1. Train facilitators on how to properly present the activity, invite participants, ask for consent, facilitate the discussion, take notes, and actively listen.
2. Identify general topics to discuss, define the objectives.
3. Develop a focus discussion guide (list of questions or themes to be discussed).
4. Organize the team in pairs to conduct FGDs: 1 facilitator for the discussion and 1 note taker.
5. Define the profiles needed and invite participants to take part in the focus group.
6. It is important to have each focus group made up of similar types/backgrounds of people. This will allow participants to feel more comfortable during the group discussion. For example: in most cultures, single gender group is recommended, if women are to speak about sensitive topics, for them to feel allowed to speak more freely. This is also the same for many social issues with respect to creating groups of the same age, religion, or ethnic groups.
7. Set ground rules with which everyone in the group can agree. For example, "each person's ideas/opinions are valid", "there may be some agreement and disagreement among the group", "open exchange is being sought".
8. Introduce the first topic with an open-ended question to the participants and let all participants speak; this will increase discussion.
9. Facilitate the discussion and ask a follow-up questions.
10. Recognize and document all contributions.
11. The interviewer should stay neutral: don't be judgmental or give personal opinions.
12. Close the focus group with a general summary of topics discussed with participants.
13. Ask if there is anything else the participants would like to add and thank them for coming and taking their time to be a part of the focus group.

For more detailed information, refer to the Action Against Hunger Multi-Sector Monitoring and Evaluation (M&E) Guidelines and toolkits:
https://www.actionagainsthunger.org/publication/2016/08/multi-sectoral-monitoring-evaluation

ANNEX 6 *Example of focus group discussion guide: breastfeeding in the first days of life*

Sub county _____ Village Name _____ Cluster N° _____ Team N° _____ Date: ___ / ___ / 2017

Profile of the participants: _____ Number of participants: M ____ F ____ Total: ___

Kindly use these questions as a guideline in a focus group discussion, probe the participants for more information:
a) Include 6-12 people with a similar profile (only mothers, only fathers, or only traditional healers, only health staff, etc.)
b) Don't ask questions from only one person

Present yourself and explain the format of the day. Ask for consent.
Give thanks to all for joining this activity. *"We will be together for an hour and a half, participation is voluntary (no payment). We will take notes but we will not put names on who said what, it is anonymous. It is up to you to participate or not, there is no obligation. If you don't want to participate you can go now."*

Begin the FGD
"Thanks for participating. Now, let's begin. I will ask some questions, but there is no right or wrong answer. I would like to get your sincere opinions. We will discuss a topic together. Feel free to give your point of view, and please respect the opinion of other people."

Objective of the question	*Ask only the questions in BOLD letters, probe several times to get more information*
Describe current practices and identify what follows or deviates from the recommendations. **Aspects:** **1** Immediate skin contact baby/ mother **2** Begin breastfeeding within 1 hour after birth **3** Give colostrum **4** Give only breast milk (no tea, no water, or other liquid) **5** Breastfeed on demand (empty 1 breast completely before offering the 2nd) **6** Breastfeed during the night too	**1. Could you tell me, here in your village, just after delivery, what happens to the baby in the first day of life? What is given to the baby to eat and drink?** Write down all answers. Probe with: "***What else?***", "***Could you tell me more about this?***", "***Ok, and according to you, what is the reason for this?***" or ask for explanations if needed. From what has been said from the respondents, circle 1 or 2 aspects from the left column, that need to be investigated in question 4, 5, 6 for aspect 1, and question 7 and 8 for aspect 2.
Identify actors involved in delivery/ after delivery	**2. In the first hours of life, who are the people involved in caring for the baby? What do they do?** Write down each actor and his/her role. Probe several times with "***Who else?***" and "***What is his/her role?***"
Identify influencers	**3. Among those people, who decides what the child is eating in the first hours of life?** Write down all answers.
Identify perception of social norm and beliefs associated with aspect 1 (focus on an aspect identified in question 1). If you don't have strong knowledge on IYCF, ask: *According to your opinion, what should a good mother do regarding the first yellow milk (first milk)?*	**4. According to your opinion, what should a good mother do regarding _____?** (name aspect 1) Write down the answers. Probe with "***Could you tell me more about this***" or "***What is the reason why you are doing this?***" and "***What will happen if they don't do that?***"
Identify what people think are the common practices (social expectation). If you don't have strong knowledge on IYCF, ask: *What do most of the mothers do with the yellow milk (first milk)?*	**5. I would like you to think about what people really do in your community. From your observation, what do most of the mothers do regarding _____?** (aspect 1) Write down the answers.
Identify barrier to practices. If you don't have strong knowledge on IYCF, ask: *Is there a reason that prevents the mother from giving the first milk (first milk)?*	**6. What are the reasons that prevent mothers (or what are the difficulties) from doing _____?** (aspect 1) Write down the answers.
Solutions to create an enabling environment/support needed	*Review the list of people identified in question 3 (influencers)*
From question 1, identify a current practice that deviates from the recommendations.	**7. What are the things that _____** (names the influencers) **could do to support a mother to breastfeed/to overcome the difficulties** (names difficulties identified)**?** ***Who?*** | ***Action***
Prioritize solutions	**8. Among these actions** (summarize what was said)**, which ones are the most helpful?**

If you see participants are willing to go because they are busy, ask them how much time they have, agree on how long the discussion will last, and close the FGD on time.

"Thanks for your participation. Thanks for your time. Do you have a question for me, about Action Against Hunger, or our programs?"

ANNEX 7 *Example of a stage of change questionnaire*

STAGE OF CHANGE ASSESSMENT TOOL – VITAMIN A THROUGH FRUITS AND VEGETABLES

Individual questionnaire

ASSESSMENT

Explain to the respondent what vitamin A sources are, by naming them and showing photos. Read the statements one by one and then tick the one(s) that the respondent chooses.

Explain to the respondent: "*I am going to share with you several statements about giving vitamin A through fruit and vegetable sources to children every day, and then I will ask you which ones best reflect your own thinking.*"

___ I need some help to access the fruits and vegetables.
___ I want to give vitamin A through fruits and vegetables, and need my family to support me.
___ I'd be able to give vitamin A through vegetables and fruits if I had it at home.
___ I am not giving vitamin A through fruits and vegetables every day because I don't feel it is needed.
___ I do give vitamin A through fruits and vegetables to my child every day.
___ I'd be able to give vitamin A through vegetables and fruits if my husband were to buy them.
___ I'd be able to give vitamin A through vegetables and fruits if I were able to afford it.
___ I have been giving vitamin A through fruits and vegetables to my child every day for few months.
___ I am not giving vitamin A through fruits and vegetables, and my child is healthy.
___ I think it is OK not to give vitamin A through fruits and vegetables to my child.
___ I know I should give vitamin A through fruits and vegetables to my child, but the other mothers are not doing it either.
___ I'd be able to give vitamin A through vegetables and fruits if my family approved.
___ I was giving vitamin A through fruits and vegetables to my child, but I don't do it currently.

Repeat the statements again if the respondent is not sure. Give the respondent time to think about the statements and respond. For literate people, you can use this tool as a self-evaluation questionnaire.

ANALYSIS

Match the respondent answer with the stage of change

___ I am not giving vitamin A fruits and vegetables every day because I don't feel it is needed. ___ I am not giving vitamin A fruits and vegetables and my child is healthy. ___ I think it is OK not to give vitamin A fruits and vegetables to my child.	*Pre-contemplation*
___ I know I should give vitamin A fruits and vegetables to the child but the other mothers are not doing it either. ___ I'd be able to give vitamin A fruits and vegetables if my family approved. ___ I'd be able to give vitamin A fruits and vegetables if I had it at home. ___ I'd be able to give vitamin A fruits and vegetables if my husband were to buy it. ___ I'd be able to give vitamin A fruits and vegetables if I could afford it.	*Contemplation*
___ I need some help to access the fruits and vegetables. ___ I want to give vitamin A fruits and vegetables and need my family to support me.	*Preparation*
___ I do give vitamin A fruits and vegetables to my child every day. ___ I try to give vitamin A fruits and vegetables to my child every day.	*Action*
___ I was giving vitamin A fruits and vegetables to my child but I don't do it currently.	*Relapse*
___ I have been giving vitamin A fruits and vegetables to my child every day for a few months.	*Maintenance*

ANNEX 8 *How to organize data collection*

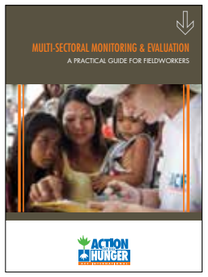
TIPS FOR THE COMMUNITY ASSESSMENT SUPERVISOR

- Depending on the topic and the profile of interviewees, select appropriate interviewers considering: sex, local language, ethnic group interaction.
- The interviews should last no longer than 40-60 minutes, and FGDs no longer than 2 hours.
- Participants should not be paid.
- Train interviewers and translators on qualitative methods and in using the interview/FGD guide.
- Train interviewers and translators on confidentiality, consent.
- For FGDs, have someone who can take good notes who is not also facilitating (1 facilitator + 1 note taker).
- Good questions are open, simple, and conversational.

TIPS FOR INTERVIEWERS AND FACILITATORS

- Explain clearly the formats of the interview/FGDs: no obligation, consent, confidentiality, duration, no payment, or incentive, etc.
- It is possible to record interviews and FGDs only if participants are aware of it and agreed to be recorded.
- Write participants/interviewees' answers –literally– with their own words.
- Probe multiple times and ask for details if the information is not clear.
- Be respectful of opinions and ideas.
- Listen actively and be patient.
- Make sure you compile the notes as soon as possible after the interview.

For more detail information, refer to the Action Against Hunger Multi-Sector Monitoring and Evaluation (M&E) Guidelines and toolkits:
https://www.actionagainsthunger.org/publication/2016/08/multi-sectoral-monitoring-evaluation



Group: ❑ Doer ❑ Non-Doer

Barrier Analysis Questionnaire:
Quantity of food per day
for use with Pregnant Women

Behavior Statement
Pregnant women eat 4 meals per day.

Interviewer's Name: _____Questionnaire No.: _____Date: ___/___/___

Location: _____

Scripted Introduction:
Hi, my name is_____; and I am part of a study team looking into things pregnant women do to stay healthy. The study includes a discussion of this issue and will take about 15 – 20 minutes. I would like to hear your views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. Likewise, if you chose to be interviewed you will not receive any gifts, special services or remuneration. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A - Doer/Non-doer Screening Questions

1. Are you pregnant?
   - ❑ a. Yes
   - ❑ b. No → *End interview and look for another respondent*
   - ❑ c. Do not know / no response → *End interview and look for another respondent*

2. Since you noticed you were pregnant; did you increase the quantity of food you take every day?
   - ❑ a. Yes
   - ❑ b. No
   - ❑ c. Do not know / no response → *End interview and look for another respondent*

3. I would like you to think about how many times you ate yesterday. How many meals did you have?.....Did you have additional snacks? How many times did you have a snack yesterday?.....
   - ❑ a. 4 meals (or 3 meals + at least 1 snack)
   - ❑ b. 3 meals only or less than 3 meals→ Mark as Non-doer
   - ❑ c. Do not know / no response → *End interview and look for another respondent*

DOER /NON-DOER CLASSIFICATION TABLE

DOER (all of the following)	Non-Doer (any ONE of the following)	Do Not Interview (any ONE of the following)
Question 1 = A		Question 1 = B or C
Question 2 = A		Question 2 = C
Question 3 = A	Question 3 = B	Question 3 = C

Group: ❑ Doer ❑ Non-doer

Section B – Research Questions

Behavior Explanation (as needed)
In the following questions, I am going to be talking about eating 4 meals per day. When I say 4 meals, it means you eat 4 times a day, it can be the usual 3 meals and 1 extra meal or 1 extra snack.

(Perceived self-efficacy)

1a. ***Doers***: What makes it ***easier*** for you to take 4 meals (or 3 meals and a snack) every day?
1b. ***Non-doers***: What would make it ***easier*** for you to take 4 meals (or 3 meals and a snack) every day?
(Write all responses below. Probe with "What else?" and ask "why does it make it easier? ")

(Perceived Self-efficacy)

2a. ***Doers***: What makes it ***difficult*** for you to take 4 meals (or 3 meals and a snack) every day?
2b. ***Non-doers***: What would make it ***difficult*** for you to take 4 meals (or 3 meals and a snack) every day?
(Write all responses below. Probe with "What else?" and "why does it make it difficult? ")

(Perceived Positive Consequences)

3a. ***Doers:*** What are the ***advantages*** of taking 4 meals (or 3 meals and a snack) every day?
3b. ***Non-doers:*** What would be the ***advantages*** of taking 4 meals (or 3 meals and a snack) every day?
(Write all responses below. Probe with "What else?" and ask "why is it an advantage? ")

(Perceived Negative Consequences)

4a. ***Doers:*** What are the ***disadvantages*** of taking 4 meals (or 3 meals and a snack) every day?

4b. ***Non-doers:*** What would be the ***disadvantages*** of taking 4 meals (or 3 meals and a snack) every day?
(Write all responses below. Probe with "What else?" and ask "why is it a disadvantage? ")

(Perceived Social Norms)

5a. ***Doers:*** Who are the people that ***approve*** of you taking 4 meals (or 3 meals and a snack) every day?
5b. ***Non-doers:*** Who are the people that ***approve*** of you taking 4 meals (or 3 meals and a snack) every day?
(Write all responses below. Probe with "Who else?" "who in particular?)
(Perceived Social Norms)

6a. ***Doers:*** Who are the people that ***disapprove*** of you taking 4 meals (or 3 meals and a snack) every day?
6b. ***Non-doers:*** Who are the people that ***would disapprove*** of you taking 4 meals (or 3 meals and a snack) every day?
(Write all responses below. Probe with "Who else?" Who in particular")

(Perceived Cues for Action / Reminders)

7a. ***Doers:*** How difficult is it to remember to take 4 meals per day? Very difficult, somewhat difficult, or not difficult at all?

7b. ***Non-doers:*** How difficult do you think it would be to remember to take 4 meals per day? Very difficult, somewhat difficult, or not difficult at all?

- ❑ a. Very difficult
- ❑ b. Somewhat difficult
- ❑ c. Not difficult at all

(Perceived Susceptibility / Perceived Risk)

8. ***Doers and Non-doers:*** How likely is it that you will become anemic in the coming year? Very likely, somewhat likely or not likely at all? (If anemia is not a well-known condition, then say have tired blood or become overly tired)

- ❑ a. Very likely
- ❑ b. Somewhat likely
- ❑ c. Not likely at all

(Action Efficacy)

9. Doers and Non-Doers How likely is it that your child will be healthy if you take 4 meals every day? Very likely, somewhat likely or not likely at all?

- ❑ a. Very likely
- ❑ b. Somewhat likely
- ❑ c. Not likely at all

(Culture)

10. **Doers and Non-doers:** Are there any traditions or taboos that prevent pregnant women to take 4 meals every day? Which one? What would be the consequence for the pregnant woman if she goes against this tradition/taboo?

Now I am going to ask you a question totally unrelated to the topic we've been discussing.
(Universal Motivators)

11. **Doers and Non-doers:** What is the one thing you desire most in life?

THANK THE RESPONDENT FOR HER TIME!

ANNEX 10 *How to plan field data collection for barrier analysis?*[39]

1. In which communities/villages will we conduct the survey?
2. If there is more than one behavior to study, which will we study, and in which communities/villages?
3. In what order should we study the behaviors (e.g. on day one, day two, day three)? Does the order matter?
4. How far are the communities (driving time) from the departure place?
5. What time do you need to depart? From where will we depart?
6. Who will be on which teams? What variables need to be taken into consideration when dividing interviewers into teams?
7. Will interviews be done individually or in pairs? If in pairs, who will work with who?
8. Do we need written permission from any authorities?
9. Do we have the cell phone number of the village chief/authority?
10. Do the teams need something to drink? Something to eat? Where will this come from? How much will it cost? Who will get the drinks/food?
11. How many vehicles do we need given the number of interviewers and supervisors?
12. How many printed copies of questionnaires does each team need?
13. What is the timeframe for the survey (number of days, number of hours per day)?
14. Who are the supervisors? What are their responsibilities?
15. Are there any security issues we need to take into consideration?
16. How will the supervisors make sure that we have a sufficient number of doers and non-doers to interview, and that enough are interviewed all together?
17. How will the supervisors keep track of the number of questionnaires each interviewer has completed?

39 Adapted from Lesson 11 Handout 1: Barrier Analysis Field Work Logistical Issues to Address. Kittle, Bonnie. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International.

ANNEX 11 *Barrier Analysis Supervisor Checklist*[40]

Before departure

- ☐ Make sure you have handset/air time on your cell phone and contacts of interviewers.
- ☐ Collect extra supplies of water, snacks, pencils, erasers, sharpeners, rain gear, etc.
- ☐ Know where (which village/community) you are expected visit for the BA.
- ☐ Know how many BA questionnaires you should have to take to the field.
- ☐ Check that enough BA questionnaires have been printed (at least 100/behavior).
- ☐ Coordinate departure arrangements (time, place) with the driver and survey coordinator.
- ☐ Ensure that your team departs on time.
- ☐ Check the security of the route and destination.

Upon arrival at the field site

- ☐ Meet the field-based contact person.
- ☐ If necessary, greet any officials and explain the purpose of the study.
- ☐ If the priority group is already gathered, greet them and thank them for coming. Explain that each person will be interviewed in turn if they fit the profile of the priority group.
- ☐ Identify places where each interviewer can conduct the interviews.
- ☐ Distribute questionnaires to each interviewer and indicate how many people each interviewer should interview.
- ☐ Identify one respondent (priority group member) for each interviewer and guide them to the interviewers.
- ☐ While the first interviews are underway, circulate among the priority group members and check to see if they fit the profile. If not, thank them for coming and dismiss them.
- ☐ As interviews are completed, guide other priority group members to each interviewer.
- ☐ Collect completed questionnaires and review them. Make sure:
    - The name of the interviewer is clearly written on the questionnaire
    - The classification of the respondent is correct
    - All questions have been answered
    - Open-ended questions have several responses
    - The writing is easily read
    - Responses to questions "make sense"
- ☐ Track the number of doers and non-doers against the number expected for the site.
- ☐ If necessary, inform data collectors which type of respondent (doers or non-doers) they should seek out in particular.
- ☐ Maintain communication with other data collection teams to track the total numbers of doers and non-doers.
- ☐ Ensure that respondents who have been interviewed do not talk with respondents who are waiting.

Before returning from the field

- ☐ Count the questionnaires, tally the numbers of doers and non-doers, and secure the questionnaires in a water-proof place.
- ☐ Ensure that you have the required number of doers and non-doers.
- ☐ Thank the local authorities for their cooperation.
- ☐ Liaise with the home office regarding estimating the time of arrival (so lunch can be made ready).

40 *Lesson 11 Handout 2: Barrier Analysis Supervisor Checklist. Kittle, Bonnie. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International.*

ANNEX 12 *Conducting the coding session*

- Organize the table and chairs in a U shape.
- Ask all the interviewers and supervisors to sit outside of the U shape table, by the team, and to place the completed questionnaires and some pencils on the table.
- Make sure that the supervisor already checked section A and verified the classification for each questionnaire.
- Ask each supervisor to gather his/her questionnaires, count them, and state how many doers and non-doers are in the pile.
- Enter the numbers of questionnaires, and numbers of doers and non-doers, for each team, and check the totals.
- Separate the doer and non-doer questionnaires.
- Re-distribute the non-doer questionnaires and the interviewers (keep the doer questionnaires aside, make sure they don't get mixed with non-doers). Each interviewer should interpret his/her own questionnaires (unless they are too many, in this case, they can be reviewed by someone else to distribute the workload).
- Ask interviewers to display the questionnaires in front of them, in a way they can see all the responses for the same question at a time
- Ask the other interviewers if they also have a similar answer. If they do, then agree with the team on a code –a few words taken from the answer that will represent all the similar answers– and note it on a flipchart or directly in the Excel tabulation sheet.
- List all the answers that are on the completed questionnaires.
- After finishing the list of codes for the first question, ask the interviewers how many respondents had this answer.
- Make sure each interviewer is focused, checks his/her questionnaires, and gives you accurate numbers of respondents. Have an assistant who can help by checking that each interviewer is following and answering for each code.
- Then, continue with the next question of section B.
- After finishing the non-doers, collect all the questionnaires, count them, pack them and put them aside.
- Take the doer questionnaires and distribute them to the interviewers. Same as before, each interviewer interprets his/her own questionnaires unless there are too many.
- Then, display all the doer questionnaires in a way that the 1st answer of section B is visible.
- Take the list of codes that was made for the non-doers, and for each code, ask how many doers gave this answer.
- Enter the result in the Excel tabulation sheet directly or take note on a flipchart. After going through the list answers, ask the interviewers if there are answers that are in the doer questionnaires that are different from the list of codes already coded.
- Proceed to code those answers and count how many respondents have similar answers.
- The data entry can be done at the same time of the coding, or at the end.
- Make sure that the total answers and number of doers and non-doers is correct before inputting the data into the sheet.

Closed question ("*How difficult is it?*" A. Very; B. Somewhat; C. Not at all): Count the results for each option of the question and check the total.

Open questions (e.g. "*What makes it easy?*"): Ask the interviewers who have more non-doer questionnaires, and then to look at the first open answer they have in question B. Ask them then if they can see some similarity between the questionnaires.

ANNEX 13 *How to fill in the Excel tabulation and how to interpret results of BA*

HOW TO FILL IN THE TABULATION SHEET- WHAT GOES WHERE

In these boxes make sure you fill out how many doers and non-doers were interviewed (*sample size*)

The **estimated prevalence of the behavior** should be entered if it is known. If it is unknown then leave the 10%

All cells that are highlighted green are cells that you need to fill in for the tabulation sheet to give you results

Barrier Analysis Tabulation Sheet (05/02/2016)
[Complete behavior description here]

Total Doers	45	<--Be sure to complete these two cells!
Total Non-doers	45	
Estimated Prevalence of Behavior	10%	*(If unknown, leave as 10%)*

Determinants	Doers Giving Response	Non-Doers Giving Response	Doers NOT Giving Response	Non-Doers NOT Giving Response	Doers %	Non-Doers %	Diff.	Odds Ratio	Confidence Interval		Estim. Relative Risk	p-value	Doers	Non-doers
									Lower Limit	Upper Limit				
1. Self-Efficacy : Can you do the behavior?														
Yes	30	15	15	30	67%	33%	33%	4.00	1.66	9.61	3.45	*0.001*	Doers are 3.5 times more likely to give this response than Non-doers.	
Possibly	10	15	35	30	22%	33%	-11%	0.57	0.22	1.46	0.60	0.173		
No	5	15	40	30	11%	33%	-22%	0.25	0.08	0.76	0.28	*0.010*		Non-doers are 3.6 more likely to give this response than Doers.
2. Self - Efficacy : What makes it easier?			45	45	0%	0%	0%					1.000		
My husband buys soap	4	1	41	44	9%	2%	7%	4.29	0.46	40.01	3.28	0.180		
I make my own soap	8	2	37	43	18%	4%	13%	4.65	0.93	23.27	3.53	*0.045*	Doers are 3.5 times more likely to give this response than Non-doers.	
education of children	6	4	39	41	13%	9%	4%	1.58	0.41	6.02	1.49	0.370		
3. Self - Efficacy: Makes it Difficult:					0%	0%	0%							
I don't have money	4	12	41	33	9%	27%	-18%	0.27	0.08	0.91	0.29	*0.026*		Non-doers are 3.4 more likely to give this response than Doers.
no time	5	4	40	41	11%	9%	2%	1.28	0.32	5.12	1.25	0.500		
children are sick	2	1	43	44	4%	2%	2%	2.05	0.18	23.41	1.86	0.500		

Green rows where the codes from the coding session are listed

Enter the number of doers and non-doers who gave a response corresponding to this code in these 2 columns

White cells don't need to be filled, they contain pre set formulas and will automatically display results

HOW TO INTERPRET THE DATA

The **Relative Risk** estimates how many times more likely it is that doers mention a reason to do or not to do a behavior as compared to a non-doer (or the converse). The further away from "1" this number is, the more important the determinant.

The P-Value <0.05 means the difference between doers and non-doers is not due to chance (blue font). This tells you the difference is "real".

Barrier Analysis Tabulation Sheet (05/02/2016)
[Complete behavior description here]

Total Doers	45	<--Be sure to complete these two cells!
Total Non-doers	45	
Estimated Prevalence of Behavior	10%	*(If unknown, leave as 10%)*

Determinants	Doers Giving Response	Non-Doers Giving Response	Doers NOT Giving Response	Non-Doers NOT Giving Response	Doers %	Non-Doers %	Diff.	Odds Ratio	Confidence Interval		Estim. Relative Risk	p-value	Doers	Non-doers
									Lower Limit	Upper Limit				
1. Self-Efficacy : Can you do the behavior?														
Yes	30	15	15	30	67%	33%	33%	4.00	1.66	9.61	3.45	*0.001*	Doers are 3.5 times more likely to give this response than Non-doers.	
Possibly	10	15	35	30	22%	33%	-11%	0.57	0.22	1.46	0.60	0.173		
No	5	15	40	30	11%	33%	-22%	0.25	0.08	0.76	0.28	*0.010*		Non-doers are 3.6 more likely to give this response than Doers.
2. Self - Efficacy : What makes it easier?			45	45	0%	0%	0%					1.000		
My husband buys soap	4	1	41	44	9%	2%	7%	4.29	0.46	40.01	3.28	0.180		
I make my own soap	8	2	37	43	18%	4%	13%	4.65	0.93	23.27	3.53	*0.045*	Doers are 3.5 times more likely to give this response than Non-doers.	
education of children	6	4	39	41	13%	9%	4%	1.58	0.41	6.02	1.49	0.370		
3. Self - Efficacy: Makes it Difficult:					0%	0%	0%							
I don't have money	4	12	41	33	9%	27%	-18%	0.27	0.08	0.91	0.29	*0.026*		Non-doers are 3.4 more likely to give this response than Doers.
no time	5	4	40	41	11%	9%	2%	1.28	0.32	5.12	1.25	0.500		
children are sick	2	1	43	44	4%	2%	2%	2.05	0.18	23.41	1.86	0.500		

The P-Value >0.05 means the difference between doers and non-doers is not significant (black font). This tells you the difference is not important.

These two columns give the textual interpretation of significant difference: how many times doers are more likely to give this answer.

FOR FOOD.
FOR WATER.
FOR HEALTH.
FOR KNOWLEDGE.
FOR CHILDREN.
FOR COMMUNITIES.
FOR EVERYONE.
FOR GOOD.
FOR ACTION.
AGAINST HUNGER.