Barrier Analysis: unlocking barriers to behavior change

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What is Barrier Analysis?

- Barrier Analysis is: “...a rapid assessment tool that can help community organizations identify why recommended healthy behaviors are reluctantly adopted or not adopted at all.”
- Used to develop more effective behavior change communication messages / activities.
- Compare Doers and NonDoers.
- Designed using two main theories from the scientific literature; Health Belief Model and the Theory of Reasoned Action/Theory of Planned Behavior. Modified based on AED’s BEHAVE Framework and Doer/NonDoer Analysis.
- Supported by funding from CORE www.coregroup.org
What is Barrier Analysis?

- Compares those that are *doing* the behavior and those that are *not doing* the behavior (doer/non-doer analysis)
  - Doers’ responses may include ideas for strategies on how to make the behavior *easier or more appealing*, and could provide clues for messages to Non-Doers. Examine these carefully.
  - Sometimes more Doers list a particular disadvantage of the behavior than do Non-Doers.
  - Looking at differences between Doers and Non-Doers as to who approves or disapproves of the behavior may provide important information on who to target for your intervention.
- A series of survey questions about *determinants* of a given behavior, to identify the obstacles to change.
What are behavioral determinants?

- *Reasons why someone does or does not do a behavior.*
What are behavioral determinants?

- Cues for Action: *Can I easily remember how to prevent the disease?*
- Perceived Severity: *Do I think the consequences are very severe?*
- Perceived Susceptibility: *Am I even at risk of this disease?*
- Perceived Action Efficacy: *Is preventing the disease easy to do?*
- Perception of Divine Will: *Does God (or the gods) approve of preventing this disease?*
What are behavioral determinants?

- Perceived Social Acceptability: *Do my friends and family support me in preventing the disease?*
- Perceived Self-efficacy: *Do I know how to prevent the disease?*
- Positive & Negative Attributes: *What are the good/bad attributes associated with the prevention action?*
Why is the benefit of BA?

- Gives you underlying reasons why some behaviors don’t or aren’t changing
- It provides a set of *locally* derived results of a single, specific behavior (Note: *is not* representational, like a KPC but can provide SS results)
- Results can be shared with other implementers *addressing the same behavior in similar settings*
- Valid results for 5 years or so under most circumstances
When is it used?

- At the **beginning** of programs when new programs, new interventions are being developed
- In the **middle** of programs when specific behaviors are still not changing
What are the steps?

• Decide what the behavior is that you want to change
• Decide what the definition is of a ‘doer’ and a ‘non-doer’
• Create a questionnaire based on samples provided
• Interview 60 doers and 60 non-doers
  ▫ Per behavior
  ▫ Per significant group (gender, age, urban/rural, social group)
What are the steps?

• Analyze the data with excel spreadsheet
• Identify the statistically significant behavioral determinants
• Develop messages/interventions to overcome barriers to change
• *Use a KPC (baseline/endline) to determine changes at the population level*
Deciding on the behavior: how do you identify the ‘doer’?

- To be a doer, the behavior needs to be easily determined!
- Must be specific!
  - Frequency?
  - Right timing?
  - Start and end time?
  - Right steps?
  - By the right people?
Determining the behavior

- The problem: Youth are having sex and spreading HIV
- The solution: A program to promote abstinence and delay of sexual debut
Determining the ‘doer’ for a program emphasizing sexual abstinence:

- What is a ‘doer’? What does it mean to be *sexually abstinent*?
  - Someone who self-identifies as abstinent?
  - Someone who has not had sex in the last 6 months?
  - Someone who has not had sex in the last 12 months?
  - Someone who has never had any form of sex!
What do results look like?

<table>
<thead>
<tr>
<th>Location</th>
<th>Perceived Susceptibility</th>
<th>Perceived Action Efficacy</th>
<th>Perceived Self Efficacy</th>
<th>Perceived Social Acceptability</th>
<th>Perceived Divine Will</th>
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= = differences ≥20%; ☺ = 10-20%
What messages were developed?

- Perceived action efficacy?
  - Avoiding sex helps you avoid HIV!
- Perceived self efficacy?
  - You can be abstinent! You can do it!
- Perceived social acceptability?
  - Your friends, family and others support your choice to be abstinent!
What do you do with the results?

• Emphasize them in your curricula
• Tweak your programming to ensure that the determinants are emphasized?
  ▫ *Example: if action-efficacy, or belief that you can do the behavior is a determinant, try skill-building exercises!*
• Use the messages on billboards and IEC materials
• Print them on T-shirts for your volunteers
Results from a KPC: Ethiopia and Nigerian Youth (aged 10-24)

• Significant determinants from the BA study changed (ss) on a KPC:
  ▫ Action efficacy (avoiding sex helps to avoid AIDS)
  ▫ Perceived susceptibility (avoiding sex will help me avoid AIDS)
  ▫ Action efficacy (condoms work to prevent AIDS)- Nigeria only
  ▫ Self-efficacy (can avoid AIDS over next 12 m)
  ▫ Social acceptability (friends and family approve)
  ▫ Divine will (God approves)
  ▫ Perceived severity- Ethiopia only
Ethiopian Youth (10-24) Behavioral Determinants from a KPC survey

All data matched by gender, age, and geographic area

* denotes statistical significance (p<0.05)
Nigerian Youth (10-24) Behavioral Determinants from a KPC survey

- Action efficacy (avoiding sex): Baseline 81.0%, Final 93.8%
- Perceived susceptibility (get AIDS if not using a condom): Baseline 79.5%, Final 93.5%
- Action efficacy (using a condom helps reduce chance of AIDS): Baseline 62.1%, Final 74.2%
- Self efficacy (can avoid sex over next 12 months): Baseline 70.0%, Final 84.0%
- Social norms: Baseline 85.0%, Final 88.9%
- Divine will: Baseline 90.0%, Final 95.6%
- Perceived severity: Baseline 70.0%, Final 87.3%
So what?

- Even if the barriers changed, did the behaviors themselves change?
  - Answer: in the 12 months after the endline evaluation,
    - Between 86% and 90% of youth pledged
    - Of those pledgers, 83% to 92% did not have sex in the last 12 months!!
Behavior, pledging and following up: KPC results for Ethiopian and Nigerian youth aged 10-24

C1: sex in last 12 m (baseline)  |  C1: sex in last 12 m (final)  | Cohort 1 pledge  | C1 Follow up: Did not have sex during last 12 m

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<tbody>
<tr>
<td>C1: sex in last 12 m (baseline)</td>
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<td>C1: sex in last 12 m (final)</td>
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<tr>
<td>Cohort 1 pledge</td>
<td>90.0%</td>
<td>86.1%</td>
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<tr>
<td>C1 Follow up: Did not have sex during last 12 m</td>
<td>92.0%</td>
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8-10 months of intervention period

12 months after intervention
Conclusions

• By identifying barriers to behavior change through BA, and by targeting populations with BA messages, even very difficult behaviors can change!
More information

- Barrier Analysis training and manual:
  - http://barrieranalysis.fhi.net
  - Complete downloadable manual
  - Step-by-step online course

- Note: FH no longer recommends the use of focus groups, which are still included in the training above.
Thanks!

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