



**ACF-INTERNATIONAL  
MANUAL**

# **ABC - ASSISTING BEHAVIOUR CHANGE**

**THEORIES AND MODELS**

To better understand behaviour change and the process of change



**PART 1**





# **ABC**

# **ASSISTING BEHAVIOUR CHANGE**

Designing and implementing programmes in ACF  
using an ABC approach

## **PART 1**

## **THEORIES AND MODELS**

To better understand behaviour change and  
the process of change

December 2013  
*Scientific and Technical Department*

Action contre la Faim-France



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Authors: Luca Pezzullo, Francesca Corna, Cécile Bizouerne, Alexandra David.

Design Graphic: Céline Beuvin

Cover photography: © S. Hauenstein Swan - ACF UK - Tchad

Printed in december 2013

Recycled paper Cyclus print

First published: December 2013

© Action contre la Faim 2012, 4 rue Niepce 75662 Paris cedex 14  
[www.actioncontrelafaim.org](http://www.actioncontrelafaim.org)

# ACKNOWLEDGEMENTS

Thanks:

To Helène Deret, Ioana Kornett, Maureen Gallagher, Sophie Aubrespin, Elisabetta Dozio, Sandra Bernhardt, John Adams, Julien Eyrard, Martha Falk for their attentive review and precious suggestions.

To Suzanne Ferron for her final and accurate review.

To Armelle Sacher for her brilliant drawings.

Contact details:

Cécile Bizouerne, MHCP senior advisor:  
cbizouerne@actioncontrelafaim.org

Francesca Corna, MHCP advisor:  
fcorna@actioncontrelafaim.org



## ABBREVIATIONS AND ACRONYMS

<b>ABC</b>	Assisting Behaviour Change
<b>ACF</b>	Action contre la Faim
<b>BC</b>	Behaviour Change
<b>BCC</b>	Behaviour Change Communication
<b>CSC</b>	Communication for Social Change
<b>CLTS</b>	Community Led - Total Sanitation
<b>FSL</b>	Food Security and Livelihood
<b>HBM</b>	Health Belief Model
<b>HoD</b>	Head of Department
<b>HQ</b>	Headquarters
<b>KAP</b>	Knowledge-Attitudes-Practice
<b>LoC</b>	Locus of Control
<b>MHCP</b>	Mental Health and Care Practices
<b>PCP</b>	Personal Construct Psychology
<b>PD</b>	Positive Deviance
<b>PLA</b>	Participatory Learning and Action
<b>PMT</b>	Protection Motivation Theory
<b>PRA</b>	Participatory Rural Appraisal
<b>SEM</b>	Social Ecology Models
<b>TPB</b>	Theory of Planned Behaviour
<b>TRA</b>	Theory of Reasoned Action
<b>TTM</b>	Transtheoretical Model
<b>WaSH</b>	Water, Sanitation and Hygiene
<b>WHO</b>	World Health Organization

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# SUMMARY ABC HANDBOOK - PART 1

*«All changes, not into nothing, but into something which exists not yet»  
Epictetus*

Behaviour change initiatives are fundamental to achieving project objectives through the reinforcement of positive practices, the identification of new or alternative practices and the promotion of structural changes of specific psychosocial variables such as knowledge, attitudes, behaviours and social norms. The behaviour change process can be divided into two aspects: initiating behaviour change and maintaining behaviour change.

Within the first part of this manual you will find an overview of some of the main concepts relevant to behaviour change such as the determinants of behaviour and how change comes about, as well as an explanation of the key BC models developed by psychological and social sciences research.

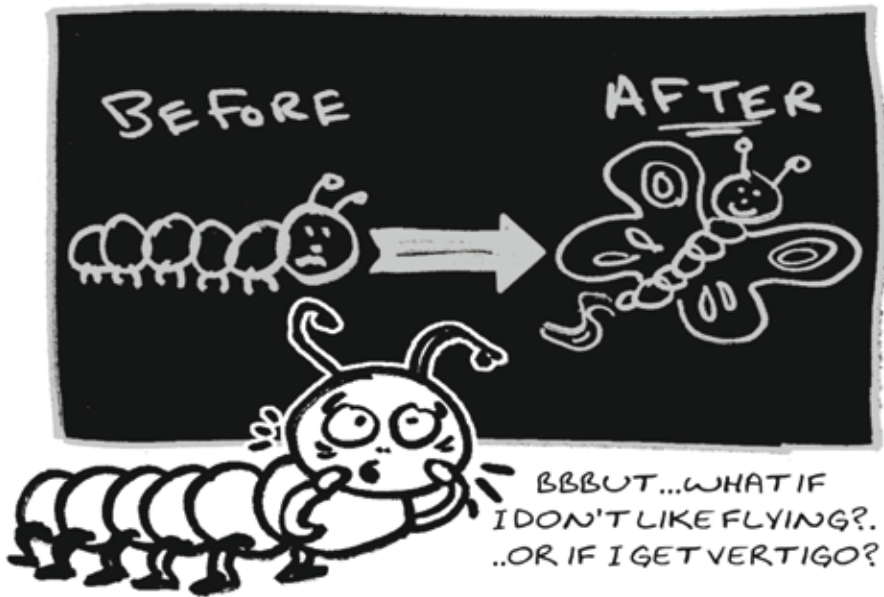


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# I. INTRODUCTION





How can we increase the rates of exclusive breastfeeding in areas where bottle-feeding and infant formula carry significant risks for a child?

How can we work with a community to improve hygiene practices at household and community level and reduce the risk of diarrhoea?

How can we help a family to include a variety of foods in their diet to reduce the risk of under nutrition?

How can we support people to adapt their daily practices to a new context (such as an IDP camp) and strengthen their psychosocial resilience in a humanitarian crisis?

## **1. WHY IS THE PROMOTION OF BEHAVIOUR AND SOCIAL CHANGE NECESSARY IN ACF PROGRAMMES?**

In recent years there has been much talk about “Behaviour Change” in the field of humanitarian aid. Behaviour change (BC) interventions and processes are at the core of many humanitarian aid initiatives, in the most diverse operational areas: health, nutrition, water, sanitation and hygiene (WaSH), shelter, child-care and food security.

Behaviour change initiatives are fundamental to achieving project objectives in these areas, through the reinforcing of positive practices, the identification of new or alternative practices and the promotion of structural changes of specific psychosocial variables such as knowledge, attitudes, behaviours and social norms.

Behavioural factors and psychosocial variables will influence the effectiveness of humanitarian interventions and a well-planned behaviour change initiative can act as a powerful “magnifier” of the impact of nutrition, food security and livelihoods, child care or WASH programmes.

It is important to recognise that behaviour change is NOT a separate or autonomous activity that has to be “added” onto other projects. It is a *functional approach to humanitarian interventions*, a technical “style” of work that accentuates impact and needs to be mainstreamed within all interventions to enhance the programme’s effectiveness.

A behaviour change intervention should be a structured yet flexible component that is adapted to the specific needs of the local context, aid programme and objectives and this component is applicable to a wide variety of projects.

ACF’s experience to date illustrates many weaknesses in the ‘awareness raising’ and educational approaches currently employed. A more informed approach is necessary to improve our capacity to develop participatory, sustainable and effective interventions.

## 2. WHAT IS CHANGE?

Social scientists - in particular psychologists have studied behaviour in great detail in recent decades and a large amount of scientific research on the structure and management of behavioural processes, at the individual and social levels, has been produced.

Indeed, the most challenging question from a psychological perspective is, '*what does change mean exactly*'? This has enormous practical consequences for all of our technical initiatives.



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We cannot simply focus on the mechanical "how to change something", but we must first understand "what", "with whom" and "why" we are trying to stimulate and support a specific change. We also need to know about social dynamics and about the individual, family, social and cultural influences on change.

Our theoretical and methodological focus should not only aim to achieve change, but also to clarify the conditions required to make a difference in *the quality of life* of people with whom we work. It is often assumed that these two concepts, ('changing something' and 'making a difference') is almost the same thing but they can be different, and this requires the adoption of different attitudes when working with behaviour change processes. To learn more about the "change" concept, refer to Appendix 6.2.

## 3. WHO IS THIS HANDBOOK FOR?

This handbook aims to provide ACF humanitarian programme staff with a solid understanding of the main theoretical concepts related to behaviour change as well as practical suggestions and tools for planning and carrying out programmes with a behaviour change component.

ACF's position on behaviour change initiatives is clearly explained and it also aims to support field staff by formulating new and pertinent operational questions, analysing local contexts and carefully adapting ACF practices to the needs and constraints in the field.

## 4. STRUCTURE OF THE HANDBOOK

This manual synthesizes some of the main theoretical and methodological issues involved in BC initiatives and focuses on how to apply the theory to practical field situations.

The handbook is in two parts:

- **PART 1** - Theoretical models and concepts. (you are currently reading this part!)
- **PART 2** - Practical methods.



Those who are interested in the more practical aspects of how to intervene can go straight to PART 2 for more operational guidance. However, PART 1 is important if you want to understand the rationale for the use of specific techniques. It will also be useful if you are required to carry out technical training sessions.

### **PART 1:**

- A short glossary introducing some of the main terms and concepts related to behaviour change
- An overview of some of the main concepts relevant to behaviour change such as the determinants of behaviour and how change comes about, as well as an explanation of the key BC models developed by psychological and social sciences research. This part is suggested reading for everyone as it provides an overview of the general concepts used in all contexts. It forms the theoretical basis of ACF's approach to behaviour change.
- ACF's position on behaviour change and the 10 steps Model with a summary of ACF's position on behaviour change interventions
- Appendices containing additional explanation on the concepts and models

### **PART 2:**

Part 2 of the handbook is focused on practical methods and techniques for implementation and it is structured as follows:

- Introduction and summary of key theoretical concepts associated to ABC (and described extensively in part 1 of the handbook)
- Practical tools both for assessment, implementation and evaluation of programs with a ABC perspective
- Future trends and final thoughts on ABC and on the process of encouraging and supporting a ABC dynamics

**PART 2** aims to provide support for both those working in the field and at headquarters, to design and implement a behaviour change intervention. Methods, techniques, tools and exercises that can be used with groups or with individuals are presented with their specific objectives and guidance on how to implement them in the field.



Tables, diagrams, examples and summaries have been provided throughout the handbook to help the reader focus on the key concepts and understand how the theory applies to practice.

References are provided as footnotes and at the end of the handbook for those who want to know more about specific concepts, models or methodologies.



## II. BEHAVIOUR CHANGE MYTHS



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Let's start by challenging some of the myths about behaviour change.  
The table below reminds us what is and what is not:



BEHAVIOUR CHANGE IS...	BEHAVIOUR CHANGE IS NOT...
An approach	A specific technique
A pragmatic and structured effort to change what it is possible to change, and to improve what it is possible to improve.	A silver bullet to magically solve every intractable problem.
An integrated approach, focused on individual and social, values, emotions, meanings and perspectives.	A process of information transfer or a didactic provision of education or awareness raising.
A participatory effort, focused on empowering people and communities to sustain and actively maintain change.	A top-down approach, “we-are-the-experts-we know what is best for you” style.
A comprehensive effort, both to sustain good practices, as well as to build a “supportive environment” to enhance and modify critical practices.	A mechanical process that only focuses on one part of the ‘problem’.
The coherent application of precise scientific research outcomes, integrated into a well-designed and structured intervention.	The casual addition of generic psychological concepts without adequate assessment or understanding.
A systematic yet flexible process, that is carefully adapted and customized to local contexts.	A rigid, standardized, “one-size fits all” procedure that is applied to every context.
A broad “style of work”, applicable to many different types of operations, issues and interventions.	A separate, autonomous activity that is added onto an existing programme.







## ATTITUDE

An attitude is a hypothetical construct that represents an individual's degree of “like” or “dislike” for something. Attitudes are generally **positive** or **negative** views that people hold of a person, place, thing, or event (Zimbardo, 1999).

A **positive attitude** towards breastfeeding means that the person is in favour of breastfeeding practice.

A **negative attitude** towards food diversification means that the person is not in favour of diversifying their diet.

Social psychologists describe attitude as an overall evaluation about a social object that is composed of three interrelated variables: knowledge or cognitive elements (*belief*), affective elements (*feelings*) and behavioural ones (tendencies to implement a behaviour).

In psychology, this is called the “*tripartite model of attitudes*”.

### For example

*A person's attitude towards breastfeeding combines cognitive elements (knowledge, information and beliefs about breastfeeding, its benefits, etc.), affective elements (the emotional and relational experiences related to the experience of breastfeeding) and behavioural ones (the willingness to breastfeed).*

Attitudes can be measured by what people say in interviews, using questionnaires or how they rate themselves using scales (reported answers).

## BEHAVIOUR

Behaviours are actions and mannerisms carried out by organisms or systems (e.g. people, communities, social groups) in relation to their environment. It is the response of the system or organism to various stimuli or inputs, and it can be **observed externally**. Humans evaluate the acceptability of behaviour using social norms and regulate behaviour by means of social control. Most recent approaches in psychology tend to conceptualize behaviour in a less mechanistic way, representing it as “a person's pattern of actions finalized to reach an aim”.

The behaviour for hand washing is the actual performance that can be observed.

Different behaviours can have different functions, from adapting to the environment to expressing social and individual identity.

Behaviour patterns can be measured only by observations.

## PRACTICES

Practices are acts/behaviours linked to habit, daily life, and experiences; they are structured by actions that follow a certain order or logic. They are often culturally transmitted.

A “traditional practice” represents and reflects social rules, traditional knowledge and personal roles. It is often the case that respecting the practice is essential for the recognition of one’s own identity and social role inside a community, and tradition strongly influences individual behaviours and the “way to do things”.

*An example is the practice of child feeding that includes: how we feed the child according to his or her age, what kind of food is used, how often etc.*

The table below presents the above concepts, showing the differences in terms of psychological (cognitive, emotional, behavioural) aspects and the focus of the intervention.

	THIS IS ABOUT	WORK FOCUSED ON IT WILL BE CENTRED ON...
Knowledge	What I Know	Cognition Information Learning
Attitude	What I Feel	Emotions Personal experiences Socio-cultural values
Behaviour Practice	What I Do What I Do Usually	Expertise Competence Self-Efficacy

## CHANGE

As stated in the introduction, the idea of “change” is particularly complex. Change can be considered in its quantitative aspects (“an event that occurs when something passes from one state or phase to another”) and qualitative aspects (“*becoming different in essence; losing one’s original nature*”<sup>2</sup>). This latter definition highlights the positive/negative dichotomy that sometimes characterizes “change”: “becoming different” means also losing its own “original nature”, and its related positive elements.

Change, in itself, isn’t “good”, “desirable” or “necessary” of its own accord; in some cases the original nature of something is “functionally better” and enables one to adapt and cope with the context in which the behaviour developed. The usefulness of change or the opportunity for promoting “change” is thus a very relative concept, and it is related to the “systemic fit” between the “new behaviour and the old context”.

1 - <http://www.thefreedictionary.com>

2 - <http://www.thefreedictionary.com>



## COMMUNICATION

One definition of communication is: “*The conveying or sharing of ideas and feelings*”.

In social interaction, “communication” (from the Latin “to bring something together”) is composed both of “content” and “relation”, and it is characterized also by “sharing” of socio-cultural “contextual” elements. This definition reflects the complexity of communication, compared to the more common definition of communication that highlights a simple transfer of data between a “sender” and “receiver”, focusing on the content transmitted, not on the relation and context.

Every communication is a psychological exchange, and thus has to be understood also through psychological methods and modelling.

## SELF-EFFICACY

Self-efficacy has been defined as “the belief in one’s ability to succeed in specific situations”<sup>3</sup>, or the individual’s perception of their own skills and capabilities to accomplish a given task.

The concept, developed by psychologist Albert Bandura in the 70s, is important because the individual sense of self-efficacy seems to have a major role in one’s management of tasks and challenges related to behavioural performance or behavioural change issues. A low self-efficacy may be due to lack of knowledge or lack of practice; but it can also be a consequence (and/or a cause) of other related psychological processes, such as low self-esteem, depression, lack of social support, stress etc.

### *For example*

*A family that has experienced traumatic incidents (such as different types of violence), and that is living in very deprived conditions, may find it difficult to change their hygiene habits (e.g. cleaning the home environment in order to avoid being exposed to illness). Indeed, the effect of their past and present difficulties, in terms of self-esteem and self-perception of capacity may hinder their ability to change their practices. In such a situation, some interventions may be insufficient or unrealistic for this family (for example, only providing information on hygiene practices). Other interventions aimed at providing support to increase their self-esteem and self-efficacy, may be more successful, e.g. regular home-based counselling, individual support or peer support groups.*

For more details about this concept see Appendix VI.4 and VI.5.

## SOCIAL NORMS AND SOCIAL PRESSURE

Social norms are “the customary rules that govern behaviour in groups and societies”, and they serve, often implicitly, as “a kind of grammar of social interactions. Like grammar, a system of

3 - Bandura, A., (1977). Self-efficacy: Toward a Unifying Theory of Behavioral Change. Psychological Review, 84, 2, p. 191-215.

norms specifies what is acceptable and what is not in a society or group”. The respect of social norms is indirectly “enforced and reinforced” by family, peer or social pressure; not respecting well-established social norms is very stressful for individuals, and can lead to strong social criticism and marginalization.

“Norms vary between social groups, and what is deemed to be acceptable in one subgroup may not be accepted in another. Essentially, social norms are rules that define the behaviour that is expected, required, or acceptable in particular circumstances. They are learned through social interaction”.<sup>4</sup>

In some societies, women after delivery are considered impure for a certain period. The social norm prescribes that they are isolated and have no access to their household. The norm is accepted and followed even if this can reduce the social support necessary for the mother and the new-born.

## **BELIEF**

Psychology and related disciplines have traditionally treated belief as if it were the simplest form of mental representation and therefore one of the building blocks of conscious thought. The relationship between belief and knowledge is that a belief is knowledge if the believer has a justification (a reasonable assertion or evidence) for believing it is true.

The socio-cultural environment strongly influences an individual’s beliefs.

## **PERCEPTION OF CONTROL**

Perception of control refers to a person’s feeling of being or not being responsible for his own life and actions. People who view the world as the primary influence shaping their lives and believe that forces outside of themselves are responsible for their misfortune or success have a low perception of control. Those who view their life and destiny as a result of their own doing, have a high perception of control.

The concept is related to self-efficacy since a person with a high perception of control also has a high sense of self-efficacy.

### ***For example***

*In some cultures where people believe that sickness is due to the influence of the spirits of their ancestors, it is difficult to expect change to occur by trying to “convince” them to adopt a more “western” view of the transmission of disease. In order to support the development of a higher perception of control, it might be more useful to start by discussing local beliefs, trying to identify what culturally approved and acceptable actions could be initiated within this framework of beliefs.*

4 - From [http://en.wikipedia.org/wiki/Norm\\_%28social%29](http://en.wikipedia.org/wiki/Norm_%28social%29).



## AWARENESS

Awareness refers to the level of knowledge or the ability to perceive, to feel, or to be conscious of events, objects, and attitudes. For instance, we often spread messages with the aim of increasing knowledge in the target group.

### For example

*If mothers do not know that breast milk contains important antibodies that can protect a child; we can increase their awareness by providing them with this information.*

## EDUCATION

Education is often aimed at changing knowledge and attitudes. It is a form of learning in which the knowledge, skills and habits of a group of people are transferred from one generation to the next through teaching, training, research etc.

### For example

*A mother who is against breastfeeding (negative attitude) can change her point of view or attitude about breastfeeding if she listens to the positive experience of other lactating mothers or if we show her examples of healthy children who are exclusively breastfed but this does not mean that she will ultimately breastfeed her own child.*

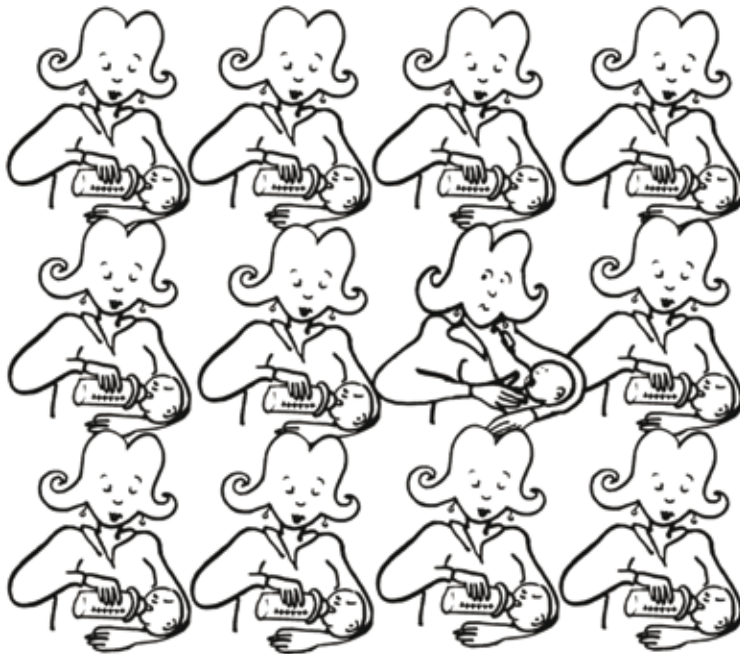
## ASSISTING PRACTICE OR BEHAVIOUR CHANGE

Assisting practice or behaviour change is aimed at the behavioural level. For instance, we work with individuals, families, groups to reinforce positive behaviours and practices, to integrate new behaviours and to experiment with changes in behaviour that may then be integrated into daily life.

For further reading on this chapter's entries, see also: World Health Organization (1998). Health Promotion Glossary; [http://www.who.int/hpr/NPH/docs/hp\\_glossary\\_en.pdf](http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf)



## IV. KEY THEORETICAL MODELS



In this section, we will learn about the most important psychological concepts and determinants of behaviour. We will learn about the key theoretical models used in health and social psychology to represent and explain the factors influencing behaviour and how change comes about.

We will also explore some of the main scientific debates relating to behaviour change.

**This section is USEFUL to gain an understanding about the theoretical basis behind the BC approach and to know about BC concepts and challenges.**

# I. THE DETERMINANTS OF BEHAVIOUR AND DESCRIPTIVE MODELS OF BEHAVIOUR CHANGE

## 1. DETERMINANTS OF BEHAVIOUR: SECTION OVERVIEW

- The science of psychology studies the determinants of behaviour, categorizing them as “personal” (individual knowledge, cognitive competence, social skills, attitudes, self-efficacy, self-esteem, etc.) and “situational” (economic resources, geographical limitations, contextual factors, social norms, cultural values, traditional practices, etc.). The complex interaction of these determinants influences and shapes individual and social behaviours.
- Social attitudes and cognitive beliefs are considered important determinants of behaviour, but scientific research gives mixed results about whether there is a direct causal relationship with behaviour.
- There is a long-standing debate on the relationship between Knowledge, Attitudes and Behaviour; different descriptive models of this relationship have been proposed.
- The behaviour change process can be divided into two aspects: initiating behaviour change and maintaining behaviour change. These two aspects are influenced by different psychological determinants.

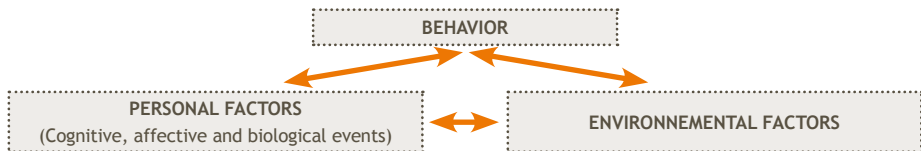
Behaviour is a very complex process, which is correlated with various other psychological and psychosocial processes. Understanding the “causes” of behaviour, by identifying the factors contributing to maintaining or changing human behaviour (the determinants of behaviour), represents a core question in the field of psychological research, and has produced a wide range of models and hypotheses<sup>5</sup>.



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Some models, such as the bio psychosocial model, focus on a detailed description and analysis of the factors involved in behaviour change. Recently the bio psychosocial model has been widely used, as it shows the simultaneous interaction of biological, psychological and social variables in the determination of behaviours<sup>6</sup>.

The diagram below represents one of the bio psychosocial models:



Source: Pajares (2002)<sup>7</sup>

5 - For a quick historical overview of the scientific study of behaviour, see appendix 7.1

6 - Engel GL. (1980), The clinical application of the bio psychosocial model. Am J Psychiatry, 137, 535-544; Smith, R.C. (2002). The Biopsychosocial Revolution: Interviewing and Provider-patient Relationships Becoming Key Issues for Primary Care. J Gen Intern Med. 17(4), 309-310.

7 - Overview of social cognitive theory and of self-efficacy (<http://www.emory.edu/EDUCATION/mfp/eff.html>, retrieved 01/12/2011)



The personal factors refer to the person's level of knowledge, cognitive competence, social skills, attitudes, personal competencies, self-efficacy, self-esteem, etc. The environmental factors describe both environmental and physical aspects, such as economic resources, geographical characteristics and limitations in the individuals' environment and psychosocial factors (e.g. social norms, values, traditional practices, and social organization systems). In this model, the interaction between these two types of factors defines individual and social behaviour<sup>8</sup>. Using a similar bio psychosocial paradigm, some authors propose more complex models to describe the factors influencing human behaviour (see Bronfenbrenner's model in Appendix 6.2).

These types of models are interesting as they show the complexity of human behaviour and some of the key variables influencing these behaviours. They also underline the need to analyze these variables and to make reference to them when designing programmes.

These models, however, are limited in that they are predominantly "descriptive" and they describe possible correlations between different variables. They do not propose an in-depth understanding of the direct causal relationships between knowledge, attitudes and practices and actual behaviour change; neither do they explain the relationship between behaviour change and its long-term maintenance; nor between this change and its impact on public health.

Indeed, despite many years of scientific research, a clear evidence based understanding of these causal relationships is still lacking.<sup>9</sup>

### **THE MAIN THEORETICAL PROBLEMS WITH THE DESCRIPTIVE MODELS ARE THE FOLLOWING:**

- 1. The uncertain relationship between Knowledge - Attitudes - Practices (KAP) and actual behaviour.** For example: a mother can be well informed about breastfeeding and know the advantages of it for her child and herself (positive knowledge), she can say that she is in favour of breastfeeding (positive attitude) BUT she may decide not to breastfeed her child (negative behaviour) because it takes too long and she does not have enough time.
- 2. The relationship between initiating behaviour change and its long-term maintenance/stabilization** (e.g. many people start a diet, or stop smoking; but after a short time, they return to their previous unhealthy habits and initiating behaviour change is not the same thing as maintaining it in the long term). Psychological research shows that it is easy to obtain a superficial short-term change, but long-term maintenance is more difficult, and seems to require different psychological processes.<sup>9</sup>
- 3. The relationship between behaviour change on one hand, and effective, measurable public health benefits** (reduction in diarrhoea rates or improvements in nutritional status) on the other hand. For instance, if a local community starts using latrines, how long does it take to generate public health outcomes?

8 - It was noted that people from different cultural backgrounds could have different attitudes towards the relevance of personal vs. situational variables in the determination of individual behaviours. Many western cultures tend to focus on personal and self-efficacy variables, many eastern and traditional cultures tend to focus on situational and social ones (cf. Choi, I., Nisbett, R., Norenzayan, A. (1999) Causal Attribution Across Cultures: Variation and Universality, Psychological Bulletin, 125, 1, 47-63).

9 - Wing, R. (2000), Crosscutting Themes in Maintenance of Behavior Change. Health Psychology, 19 (Suppl. 1), 84-88.



## 2. THE RELATIONSHIP BETWEEN KNOWLEDGE, ATTITUDES AND PRACTICE

The question of “how to facilitate social behaviour change ” is one of the great classical themes of social psychology, which has been developing its own social change models based on socio-psychological research for many decades. This research owes much to the work of Kurt Lewin, who introduced some key issues in psychological research, such as the dynamics of small groups and the effect of social influence on behaviour.

Compared to the previous models presented, social psychology models propose a deeper exploration of the relationship between knowledge, attitudes and practice, and acknowledge the important influence of the social context in behaviour change.

A usual dictionary definition for “attitude” is: “*A settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behaviour*”.<sup>10</sup>

This definition highlights the (presumed) link between attitudes and behaviour, which reinforces many behaviour change initiatives. Such initiatives are focused on the transfer of information, which it is assumed, will lead to a change in attitude that will cause a change in behaviour. However, the real relationship between attitude change and behaviour change is much weaker and more complex.

Is it enough to provide a mother with information on the benefits of breastfeeding to encourage her to exclusively breastfeed her child?

In a meta-analysis of available research, Wicker (1969)<sup>11</sup>, highlighted the very weak correlation between attitudes and related behaviours. More recently this link has been explored in greater detail and whilst there is quite a good correlation between attitudes related to a specific behaviour, and the adoption of that behaviour, this relationship is not very strong, direct or linear, and therefore it is important to have a better understanding of the interplay between these different intervening variables.

Research on the relationship between knowledge, attitudes and behaviours has taken an innovative direction in recent years. The traditional “logical ” assumption that “*first you acquire knowledge, then you develop a positive attitude, and then change the behaviour*” (Knowledge > Attitude > Behaviour/Practice) has been criticized for being too linear and simplistic, and in many cases misleading. There are indeed situations where behaviour change precedes the acquisition of precise information, or where a “required” or “imposed” change of behaviour preceded the development of a positive attitude towards the behaviour itself. Psychological research has studied the actual relationship between knowledge, attitudes and behaviour in behaviour change programmes and researchers have proposed six potential models for change. In different settings and in relation to different behaviour or practices, it is possible that they could all be valid “*paths to change*”.<sup>12</sup>

10 - <http://www.encyclopedia.com/topic/attitude.aspx>

11 - Wicker, A. W. (1969). Attitudes versus actions: the relationship of verbal and overt behavioral responses to attitude objects. *J. Soc. Issues* 25, 41-78.

12 - Valente T., Paredes P., Poppe P. (1998). Matching the Message to the Process. The relative ordering of Knowledge, Attitudes and Practices in Behavior Change Research. *Human Communication Research*, 24, 3, 366-385.

The following table summarizes these different “paths”:

CHANGE MODELS (CHANGE DERIVES FROM...)	LOGICAL STRUCTURE (WHAT CAUSES WHAT)	SHORT DESCRIPTION
Learning	K>A>P - Knowledge leads to Attitude change, that leads to Practice change.	Cognitive progression through the stages: first, I learn about something, then I like what I learn, and then I do what I learned and liked.
Affinity	A>K>P - Attitude change leads to Knowledge, that leads to Practice change.	Liking something leads to learning and gaining knowledge about it, then to starting its practice.
Rational	K>P>A - Knowledge leads to Practice change, that leads to Attitude change.	Knowledge of potential benefits of a practice leads to implement it, regardless of personal attitude (that is developed after practice began).
Grudging Acceptance	P>K>A - Practice change leads to Knowledge, that leads to Attitude change.	A practice is initiated, and then learning comes through experience; attitudes shift later, as a consequence.
Dissonance	P>A>K - Practice change leads to Attitude change, that leads to Knowledge.	Practicing something leads to the development of a positive attitude towards it, and then knowledge is gained through experience.
Emotional	A>P>K - Attitude change leads to Practice change, that leads to Knowledge.	Liking a behaviour leads to its adoption, and then knowledge about it is gradually gained.

Source: Adapted from Valente T., Paredes P., Poppe P., (cited).

As you will see in Part 2 of this handbook (Practical tools), different behaviour change methods often emphasize one dimension more than another (e.g. knowledge or attitude or practice). Therefore, it is important to clarify, during the initial action planning stage of programme design, which type of “change model” intended to be used (which will depend on the situation, the contextual variables, the target population and the target behaviours), and not to automatically be bound to the classic ‘Learning’ model as described in the first row of the table above.

**Keep in mind that knowledge is essential but it is not automatically linked to attitude change or behaviour and practice change.**

The scientific literature has not yet provided enough evidence to support the choice of one model over another although the ‘learning’ and ‘dissonance’ models appear to be the most promising



so far. Depending on the specific factors in each context, different models may be more or less suitable for different subgroups, or for different behaviours.

The latest psychological research confirms that the “rational personal intentionality” to act in a certain way, a variable previously considered as essential, is actually less relevant than expected (Webb and Sheeran, 2006):

*“In situations where people control the conditions that may allow a behaviour change (e.g. economic, family etc.), where the behaviour is based on strong habits (e.g. traditional practices “embedded” in everyday life), and where there is a strong influence of social expectations/social pressure, the effect of rational personal intentionality strongly decreases.”<sup>13</sup>*

Unlike the most common behaviour change programmes, which are focused on “information transfer” and rationalist “individual willingness” to change, psychological research shows the importance of not only knowledge and personal intention to act, but also of local, context dependent and socio cultural variables, as well as the availability of social support.

Behaviour change should not be a “passive pedagogy”, or a mere “teach-them-the-right-thing-to-do” affair; it is about promoting personal and social skills, involving people, activating participatory and peer-based dynamics, allowing a better use of available resources, reducing contextual constraints that hinder better practices and hence empowering local communities. This is a lot more complex, but a much more rewarding endeavour.

For further reading on this chapter’s topics, see also: Bohner, G, Wanke, M. (2002). *Attitudes and Attitude Change*. Psychology Press.

13 - Webb, T., Sheeran, P. (2006). Does Changing Behavioral Intentions Engender Behavior Change? A Meta-Analysis of the Experimental Evidence. *Psychological Bulletin*, 132, 2, 249-268.

## II. RESEARCH ON HEALTH-RELATED ATTITUDES, BEHAVIOURS, SOCIAL DYNAMICS AND THE “MEANINGS” GIVEN TO BEHAVIOUR

### HEALTH PSYCHOLOGY MODELS: SECTION OVERVIEW

- There are several different “health behaviour” models that explain the process of change.
- *The Health Behaviour Model* focuses on the barriers and benefits of behaviour change; a behaviour change intervention needs to focus on both, and to work on people’s subjective perceptions, not only on objective data about different risks (the implementers’ perception).
- *The Protection Motivation Theory* focuses on the equilibrium between “threat appraisal” and “coping appraisal”; it is necessary to stimulate a “coping” attitude, enhancing the perception of efficacy (in relation to both the proposed solutions as well as personal efficacy), increasing a person’s perceived control over threats.
- *The Theory of Reasoned Action or The Planned Behaviour Model* analyzes, from a rationalist point-of-view, the different variables that influence the personal “intention” to behave in a certain manner. It is important to understand what the behaviour means to the individual, as well as the effect that social norms and the perception of the ability to perform an action have on the actual intention to act.
- *The Transtheoretical Model* introduces the concept of different “stages”, or phases, of behaviour change, and the importance of adapting the interventions (timing and typologies) to the specific stage in which an individual or a community is situated.
- These models and theories are useful in terms of programme implementation. Understanding these different factors can help to facilitate behaviour change, thus increasing a programme’s positive impact.

Whilst the previous section focused more generally on the mental processes and determinants involved in human behaviour, the following sections illustrate models and research that are focused more on health, the influence and role of social dynamics and the meaning given to behaviour.

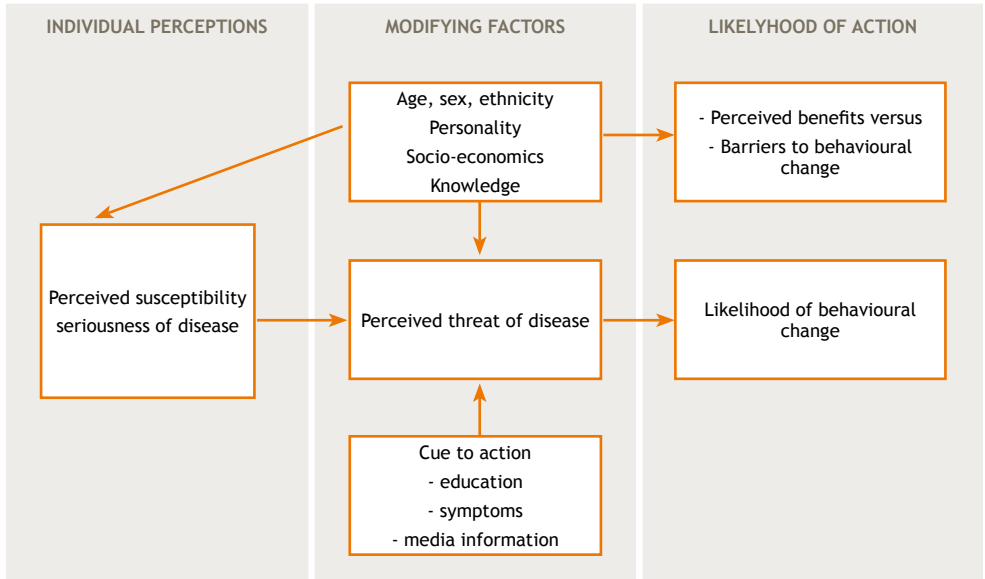
Compared to the previous theories presented, health psychology bases its research on a specific and concrete field of application i.e. health. Researchers in the field of health psychology have developed a series of detailed theoretical models to help illustrate the factors and psychological variables that influence most health-related behaviours. These models have had a significant impact on the way we work on behaviour change, particularly in health care settings and in environmental and community programmes such as those focused on WASH or maternal and child care practices.

The models cover the different factors and stages involved in deciding whether to act to promote one’s health, the role of the perception of fear and a person’s coping capacity in behaviour change.

## 1. HEALTH BELIEF MODEL (HBM)

The HBM was the first health-behaviour model; it was developed by the National Institute of Health in the US in the '50s. The model tried to explain why people act in an apparently unhealthy way, even if they “know” that their behaviours are dangerous for their health.

Model structure:



Source: Glanz et al, 2002<sup>14</sup>

The HBM defines different variables involved in the decision-making process that leads to acting in a specific health-promoting way. These variables are:

1. Perceived Susceptibility (the subjective perception of being vulnerable to a problem).
2. Perceived Severity (the subjective perception of the severity of the problem, if it happens).
3. Perceived Benefits (the subjective perception of the possible positive effect of the behaviour change).
4. Perceived Barriers (the subjective perception of the constraints at the individual and social level that hinder the transition to the new behaviour e.g. a lack of resources or information, social norms, peer pressure, etc.).

In the HBM framework, behaviour change is possible if:

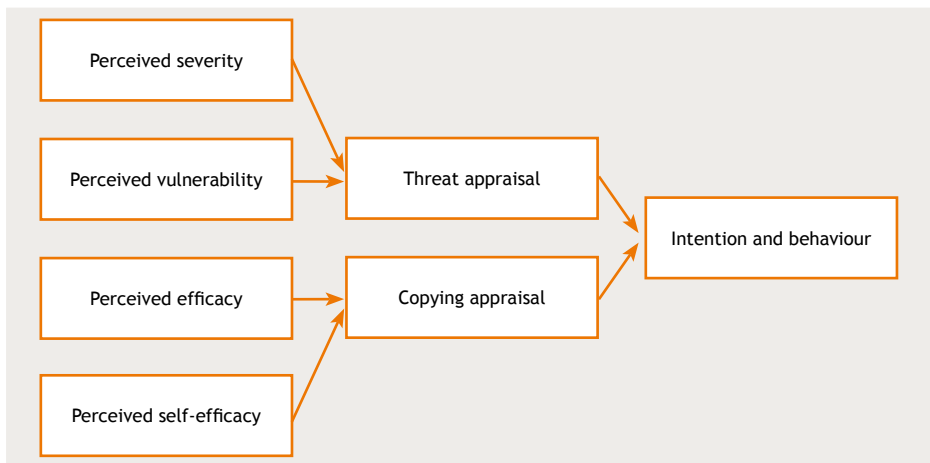
1. A person clearly perceives that they are both vulnerable to the problem and that a severe outcome is likely (Susceptibility and Severity); e.g. *a person may know that limited hygiene practices can lead to a higher risk of serious infections and diseases.*
2. S/he feels that an alternative behaviour can effectively reduce or mitigate this risk (Benefit), e.g. *s/he may know and believe that washing hands can decrease this risk.*
3. There are no barriers to the implementation of the alternative behaviour, e.g. *s/he knows how and when to wash hands effectively, s/he is determined, s/he has water and soap at home and her family members are supportive etc.*

More recent versions of the HBM consider that well framed “cues to action” (reminders to perform the behaviour such as information, mass media campaigns, social support etc.), and high levels of perceived self-efficacy toward the implementation of the new behaviour, can also greatly facilitate behaviour change. Personal and social factors can act as mediating variables at various levels.

## 2. PROTECTION MOTIVATION THEORY (PMT)

Protection Motivation Theory (PMT) was developed by Rogers (1975)<sup>15</sup> to explain the relationship between fear and attitude change and the processes related to the personal motivation to adopt “health protective” behaviour. This model has many similarities with the HBM.

Model structure:



Source: Rogers (1975, 1983, 1985)

15 - Rogers, R. W. (1975). A protection motivation theory of fear appeals and attitude change: *Journal of Psychology*, 91, 93-114; Rogers, R.W. (1983). Cognitive and physiological processes in fear appeals and attitude change: A revised theory of protection motivation. In: Cacioppo, J., Petty, R. (eds.), *Social Psychophysiology*. Guilford Press, New York.



### 3. OPERATIONAL IMPLICATIONS OF THE HBM AND PMT MODELS:

1. It is essential to understand that the PMT model (and almost every psychological behaviour change model) focuses on “individual perceptions” and beliefs as the main variables to be considered in behaviour change analysis. “Perceptions” are always more important than real or actual factors and elements. For example, it is the psychological perception that I have of the risks related to open defecation that is the actual factor directly influencing my hygiene behaviour not the objective, epidemiological risk as defined by health experts.
2. The PMT model emphasizes the importance of clarification (conveying information, sharing experiences) and, whenever possible, the direct experience of the real benefits of the new behaviour or practice.
3. The HBM model also highlights that any behaviour change programme needs to focus both on “barriers” (analyzing them, helping to activate problem-solving strategies and processes, etc.) and “benefits” (information about the benefits and advantages of the new proposed practices compared to the old practice).
4. If the new behaviour is perceived as a highly effective and simple (i.e. easy to implement) solution to a “severe” and “likely” problem, the new behaviour will be more easily applied according to the PMT model.
5. An important implication of the PMT model is that, if the “threat” appears stronger than the ability to “cope”, this psychologically threatening situation may cause a “defensive behaviour”, leading to a disengagement and refusal or rejection of the proposed solution<sup>16</sup>.

### 4. THEORY OF REASONED ACTION (TRA) OR THE THEORY OF PLANNED BEHAVIOUR (TPB)

Fishbein and Ajzen developed the Theory of Reasoned Action (TRA, 1975)<sup>17</sup>, and later the Theory of Planned Behaviour (TPB, 1985)<sup>18</sup>, to explain the variables influencing the relationship between attitudes and behaviour. Their approach was focused on “intentional behaviour”, informed by a “rational planning” logic. Ajzen extended the original TRA model in the ‘80s to better integrate the issue of perceived behavioural control into the theoretical framework.

The TRA/TPB considers three different types of determinant in relation to healthy behaviour. The interaction between them determines the adoption of the behaviour itself. The main causative

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16 - This can activate psychological problems such as fatalism, loss of empowerment, an external locus of control, and lead to other related anxious/depressive and sometime hostile reactions.

17 - Fishbein, M. & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley. Ajzen, I. & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.

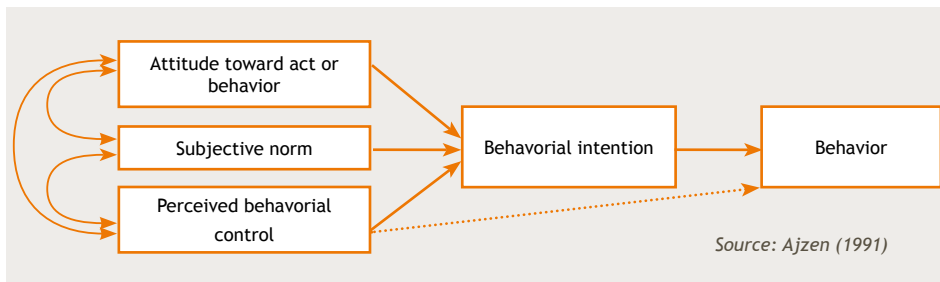
18 - Ajzen, I. (1985). *From intentions to actions: A theory of planned behavior*. In J. Kuhl & J. Beckmann (Eds.), *Action control: From cognition to behavior*. Berlin, Heidelberg, New York: Springer-Verlag.



factor is the intention to act. This intention is determined by the interaction of:

- a) Attitudes toward the behaviour itself (what are the individual's cognitive and affective perceptions - what does he think and feel towards the proposed behaviour);
- b) Social norms, e.g. Do community, peer and/or family members approve or disapprove of the new behaviour?
- c) Perception of behavioural control (perceived ability or self-efficacy and competence to carry out the behaviour).

Model structure:



More positive attitudes towards the behaviour, greater perception of behavioural control, and the perception of coherence and acceptability of the new behaviour with respect to existing social norms, are factors that facilitate the intention to implement the behaviour.

## 5. OPERATIONAL IMPLICATIONS OF TRA /TPB MODELS

From an operational point of view, TRA/TPB highlights the necessity, in any behaviour change intervention, to:

1. Assess and support people to perceive a greater sense of control over the new proposed behaviour (providing clear “how-to” information, support with experimenting and simulating new practices and promoting self-efficacy);
2. Assess people's personal attitudes and perceptions about the new behaviour and, carefully and respectfully tailor behaviour change interventions to suit the context and existing social norms;
3. Whenever possible, involve relatives, friends, and family members in supporting the desired change, since perceived social disapproval from community or family members can seriously hinder the individual process of change.

## 6. STAGES OF CHANGE MODEL (TRANSTHEORETICAL MODEL)

The Stages-of-Change Model, also known as the “Transtheoretical Model” (TTM), was developed by Prochaska and colleagues, from 1977 onwards.<sup>19</sup> It is one of the best-known behaviour change models in public health interventions and its “stage” structure and “stages of change-process and of change coupling logic” was widely adopted in public health programmes in different countries.

The Stages of Change or TTM model considers that behaviour change is a complex multistage process. Each stage corresponds to a different psychological process. Therefore, it is necessary to adapt behaviour change interventions to the specific stage in which the individual or group are situated.

Model structure:



Sources: Grimley (1997) and Prochaska (1992)

The model proposes 5 main phases or stages:

1. Precontemplation (“not ready to change”): the stage in which people are not intending to take action to change the target behaviour in the next few months
2. Contemplation (“getting ready 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 behaviour change.

19 - Prochaska, J., DiClemente, C., (2005). The transtheoretical approach. In: Norcross, J., Goldfried, M. (eds.) Handbook of psychotherapy integration. 2nd ed. Oxford University Press, New York.

4. **Action:** the stage in which people have actively taken explicit, overt, actions in the past weeks or months to modify their behaviour.
5. **Maintenance:** the stage in which people try to maintain and stabilize change, preventing relapses.<sup>20, 21</sup>

Individuals and groups can progress upwards through these different stages, or relapse backwards for various reasons.

## **7. OPERATIONAL IMPLICATIONS OF THE TTM MODEL**

The main operational implication of the TTM model is the importance of linking the proposed interventions to the specific stage in which an individual is situated. For example, educational activities that have been developed to facilitate the maintenance of behaviour, or to facilitate the transition from a preparation to an action stage, can be less useful, or even inappropriate, in facilitating the transition from a precontemplation to a contemplation stage.

Each stage corresponds to different psychological processes and motivations; while the first stages of behaviour change (contemplation/preparation stages) are related to positive expectations about the proposed behaviour, its maintenance is more related to the perception of usefulness or satisfaction with the change that has taken place.<sup>22</sup>

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

21 - A so-called "Termination" stage was also proposed, in which the involved people show a 100% intention and motivation to maintain indefinitely the new behavior, without any risk of relapse. This is more of an "ideal goal" than an actual stage.

22 - Rothman, A. (2000). Toward a Theory-Based Analysis of Behavioral Maintenance. *Health Psychology*, 19, 1 (Suppl.), 64-69.



### III. SOCIAL PSYCHOLOGY MODELS: THE SOCIAL DYNAMICS AND FACTORS INFLUENCING THE PROCESS OF CHANGE

#### SOCIAL PSYCHOLOGY MODELS: SECTION OVERVIEW

- Social psychology studies a variety of social influences and how they interact. Understanding this interaction can inform different strategies for behaviour change.
- Social influence can lead to different types of acceptance, from genuine internalization of the change to a strong refusal of it or even a superficial compliance.
- It is important that behaviour change interventions consider both the influence of social pressure or social norms (what is seen to be desirable behaviour) and the tendency for individuals to believe that others show the most appropriate behaviour in a given situation.
- Social psychologists underline the existence of the influence of the majority (based on the individual's need to perceive themselves as well-liked and socially accepted) and the influence of the minority (where the innovative practice of the minority group is used to convert the majority). In different situations, it is useful to use either one or both.
- Different sources of social influence can exert different effects: an authoritative source (experts, local leaders, parents, etc.), a credible source (trusted and credible persons with a perceived technical expertise), or an attractive source (perceived as very close and similar to the target audience such as peer groups, etc.). It is important to be aware of these different influences and to develop a strategy that is coherent with people's perception of the source of information.
- Self-efficacy is a powerful psychological process in the preparation and action stages of behaviour change and it is influenced by various factors. The perception of competence and self-esteem, particularly, must be taken into account when facilitating and maintaining change. The concept of "Locus of Control" also influences behaviour change attitudes, and needs to be assessed. Interpersonal and group empowerment methods can help to improve self-efficacy.

Social psychology is interested in the psychological thought processes related to the social world, social influence and group interactions and dynamics and is therefore of relevance to all humanitarian and development interventions. Unlike health psychology models, these models are not specific to hygiene, nutrition or health behaviours, but they are scientific attempts to understand social dynamics in terms of individual thought processes, and - at the same time - the effects of these social dynamics on the way the individual thinks and behaves. This section explores the impact of the different levels and types of social influence and the variety of sources conveying information. The concepts of self-efficacy and locus of control are also described in more detail.

## 1. LEVELS OF SOCIAL INFLUENCE

An effective social influence process may activate three levels of behaviour change:

- Compliance (the most superficial type of social influence, in which the individual changes his behaviour only temporarily, to satisfy the source or authority proposing the change).
- Identification (a temporary modification of the behaviour, in order to identify with the positively perceived source or authority proposing the change).
- Incorporation or internalization (a stable behaviour change, in which the proposed modifications are recognized as intrinsically positive and coherent with the individual's own system of meanings, and are therefore “incorporated” into this system)<sup>23</sup>.

A message that proposes a new behaviour but that is incoherent and assumes incorrect social or personal norms or values, leads to “psychological reactance” and people often disregard the message, lose their trust in the proposing source, and can behave contrary to what is proposed.

## 2. TYPES OF SOCIAL INFLUENCE

Conformity is the process of matching attitudes, beliefs, and behaviours to what individuals perceive is “normal” in their social group; it has a “*normative*” and an “*informative*” dimension.

- **Informative social influence** is based on the tendency of people to assume that the actions of others reflect the most correct behaviour for a given situation. This effect is prominent in ambiguous social situations, where people are unable to determine the appropriate mode of behaviour, and is driven by the assumption that surrounding people possess more knowledge about the situation<sup>24</sup>. This is known as a “cognitive” conformity.
- **Normative social influence** is based on the tendency of people to adhere and identify with the social norms, values and traditions of their own social group, to be liked and accepted by the group. This is known as an “emotional” conformity.

**The failure of many behaviour change programmes is linked to the fact that implementers are convinced that changing a behaviour or practice can be brought about by information and “cognitive” conformity alone.**

Instead, social psychology shows that information is necessary, but it is **insufficient** to change the normative processes operating in a group or community. The intervention must also attempt to address change at the “normative” level (social norms, peer and family pressure, etc.).

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23 - Kelman, H. (1958). Compliance, identification, and internalization: Three processes of attitude change. *Journal of Conflict Resolution*, 1, 51-60.

24 - From [http://en.wikipedia.org/wiki/Social\\_influence](http://en.wikipedia.org/wiki/Social_influence)



Therefore, in order to modify normative influences, it is necessary to use sources that are not only credible but that are also perceived as similar. In a behaviour change intervention, it is not useful to rely on information transfer by external experts alone. It is also important to use participatory, group and community activities to address the “normative dimension” of social influence.

### FIELD EXAMPLE

*In a small, rural town, a group information session on managing children’s behaviour is organized for selected parents with young children. During the session, the facilitator explains that using harsh corporal punishments has a negative impact on children’s development. He provides many examples and reasons why this is the case and he demonstrates that this type of discipline mostly teaches children about fear. A better way is to ensure the child understands the reason for the punishment. The facilitator emphasizes the importance and relevance of talking to children about their behaviour, what the boundaries and rules are etc.*

*The participants appear to agree with the facilitator’s ideas. Later, it appears that some parents who tried to implement these behaviour management techniques were laughed at by their neighbours, as they were labelled as “weak parents”. The small town elders also said that children ‘ just can’t behave appropriately without being physically punished’. A few months later, only a few parents were still trying the new approach at home, where they could not be seen by the neighbours.*

Social psychology also makes a distinction between two main types of social influence: “**group majority**” and “**group minority**”.

- **Majority influence** involves “normative influences”, and it is based on an individual’s need to perceive of themselves as “well-liked” and socially accepted. If a given behaviour or practice is considered “positive” by the vast majority of people in a community, the individual will tend to join the group’s behaviour (compliance)<sup>25</sup>.

Majority influence leans towards “convergent thinking” (i.e., people simplify and homogenize their ideas and behaviours; different interpretations are discouraged and reduced).

- **Minority influence** is the influence of a small (minority) group who propose a different perspective, or an alternative view of a specific social practice. At the beginning, the minority view (and its supporters) is subject to intense scrutiny, criticism, and social pressure to adapt to the majority view; but if the practice persists, it may influence others,

25 - Three factors seem to be important to assert majority influence: Strength (the “pressure relevance” that group has for the individual; more relevant relationships mean more influence); Proximity (the temporal or physical proximity of the group to the individual; the more proximal the group, the more powerful the influence); Numerosity (the quantity of people in the group; the more numerous, the more influence).

activating critical thinking and a process of change. Minority influence, if consistent, coherent and correctly implemented, can be a very powerful “informative social influence”; it is based on the credibility and social similarity of the proposing minority members.

Minority influence leans towards “divergent thinking” (i.e., people develop their ideas and behaviours; different ideas and interpretations are stimulated).

### 3. TYPE OF SOURCES

A source of social influence is more effective if it is “authoritative”, “credible” or “similar or attractive” to the target audience:

An “*authoritative*” source is a socially powerful and relevant source (experts, local authorities, local leaders, parents). An authoritative source alone tends to activate a “*superficial compliance*” influence. - A “*credible*” source is a source that obtains the “*trust*” of the target audience, and that has a perceived technical expertise and strong social credibility. Its major influence relates to the “*informational*” dimension, less to the “*normative*” one. - The “*socially similar*” (or “*attractive*”) source is a source that is perceived as socially and emotionally “close” and very “similar” to the target audience.<sup>26</sup> This source of social influence explains the success of peer-based interventions, because peers are perceived as more “similar” from a social and relational point of view than external implementers. This type of source works at both the normative as well as the informative level.

The table below tries to summarize these concepts:

	PROCESSES	BEST SOURCES	TYPE OF GROUP INFLUENCE
Informative goals	Cognitive Knowledge	Credible Similar	Minority Influence
Normative goals	Socio-emotional Identity-related	Authoritative Similar	Majority Influence

For further reading on this chapter’s concepts, see also: Aronson, E., Wilson, T., Akert, R. (2010). *Social Psychology*. Prentice Hall.

26 - Activating “in-group” processes; cf. Tajfel, H. (1974). Social Identity and Intergroup Behavior, *Social Science Information*, 13, 65.



## IV. THE CONTEXTUAL, SOCIAL AND SUBJECTIVE REPRESENTATIONS OF MEANING INVOLVED IN BEHAVIOUR CHANGE

### SOCIAL REPRESENTATION AND CONSTRUCTIONIST APPROACHES: SECTION OVERVIEW

- In parallel to the research on the social factors and dynamics influencing change processes, some psychologists have developed psychological theories focused on how people give meaning to individual and collective interpretations of health, and of behaviour change (known as sensemaking<sup>27</sup>).
- These different theories share some common principles:
  - An analysis of “sensemaking” processes and the design of interventions according to the meaning given to individual behaviours, social dynamics and cultural practices.
  - Going beyond the “right or wrong” dichotomy and understanding the subjective representations of reality.
  - Strong attention to the contextual variables that influence and provide interpretations of individual and social behaviour.
  - Use of hierarchical and networking models to illustrate and analyse perception, meanings, structures and dynamics (i.e. central and peripheral processes, etc.).
  - A strong preference for qualitative and participatory methodologies, so called “thick description” approaches<sup>28</sup>, and more flexible and emic-oriented<sup>29</sup> research methods.
- ACF values behaviour change initiatives that explicitly focus on and take account of local social perceptions and contextual meanings and that recognize and consider local values, dynamics, culture and social norms. Such initiatives appear to be more powerful, coherent, easier to adapt and longer lasting. They are also more respectful of local culture.

27 - Sensemaking (to make sense) is the psychological process by which people and groups give “meaning” to their own experiences, creating an understanding so that they can act in a structured and informed manner. Sensemaking is initiated when an individual or organization recognizes the inadequacy of their current understanding of events; it is an active two-way process of fitting data into a frame (mental model), and fitting a frame around the data (from en.wikipedia).

28 - In anthropology and other fields, a thick description of a human behavior is one that explains not just the behavior, but its context as well, such that the behavior becomes meaningful to an outsider.

29 - The etic and emic-orientated styles are two different styles that anthropologists use in fieldwork. The etic approach uses concepts and categories from the anthropologists' own culture to describe another culture. The emic-orientated approach uses the concepts and categories that are relevant and meaningful to the culture under analysis (see [http://en.wikipedia.org/wiki/Emic\\_and\\_etic](http://en.wikipedia.org/wiki/Emic_and_etic)).



## 1. SOCIAL REPRESENTATIONS<sup>30</sup>

Social representation theory proposes an analysis of the “structural network” of belief about a specific “social object” (an idea, a concept; e.g. how do people understand the concept of “malnutrition” in a given community, what are its components, the related beliefs, the values that are involved, etc.). This complex representation is composed of two functional components: “core” elements and “peripheral” elements.

While the peripheral part is prone to change and adapts its elements to “real world” experiences and interactions, the “core structure” is more stable, and is much more resistant to change (it expresses the prototypical elements of the mental representation). A change in this “core structure” implies a change in the whole concept, while a change in the peripheral part (secondary elements) does not change the main structure of the concept.

There are specific techniques available to analyse people’s social representations of different types of social issues or behaviours that can help to shape more effective interventions.

**At the basis of almost every behaviour related to nutrition, child-care or hygiene, etc., there are specific social representations; an understanding of them increases our knowledge of the social and psychological foundations and implications of these behaviours and enables us to make programming more effective.**

### *For example*

*Child-care practices are related to the social representation of the “child” in a given local culture. In one culture, a child can be perceived as the first priority for resource allocation and care practices, associated with an extremely high emotional investment whereas in another culture, a child may be seen as an additional mouth to feed and may take second place to the main breadwinner in the family. Similarly, different social representations of gender roles in the family can lead to very different social practices. The meanings attached to gender roles are often informed by core elements and as such may be more resistant to behaviour change initiatives.*

## 2. PERSONAL CONSTRUCT PSYCHOLOGY OR SOCIO-CONSTRUCTIVIST APPROACHES<sup>31</sup>

Personal construct psychology (PCP) based models were initiated by the American psychologist George Kelly (1955), and define and formalize a “meaning-centred psychology”. Whilst the basic unit of analysis in behaviourist approaches is the behaviour itself, and the unit of analysis in the

30 - For an introduction: Seca, J.M. (2003), Les représentations sociales, Paris, Armand Colin, Moscovici, S. (1988). “Notes towards a description of social representations”. Journal of European Social Psychology 18 (3): 211-250. See also the detailed website PSR: <http://www.psych.lse.ac.uk/psr/>

31 - For an introduction: Fransella, F. (ed) (2003), An International Handbook of Personal Construct Psychology, John Wiley & Sons.



cognitivist approaches is the social representation, PCP and social constructionist approaches develop their theoretical and methodological applications based on individual or personal meaning. Meaning is seen as the cornerstone of all cognitive processes and as the key factor for initiating, maintaining and changing behaviours.

Therefore, according to the PCP model, if we first consider the existing subjective meanings of the individual or social group and support them to explore and develop these meanings, it is possible to facilitate behaviour change in a more effective and coherent way.

To go further on social and contextual meanings, refer to Appendix 6.6 and 6.7



## V. CONCLUSION & ACF POSITION ON ASSISTING BEHAVIOUR CHANGE



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In conclusion, we first present a summary table including the different theories discussed, highlighting the main theories as well as the main operational implications. The idea is to draw out some concrete aspects that need to be considered for all behaviour change interventions.

Second, we outline ACF's position on supporting the behaviour change process and present the 10-step model for analyzing, designing and implementing programs with a behaviour change objective.



## OPERATIONAL IMPLICATIONS OF USING BEHAVIOUR CHANGE MODELS

We need to underline here that what most interests us from an operational point-of-view is how, these theoretical models and related theoretical debates can help us to identify pragmatic operational guidance that will enable us to achieve practical and verifiable objectives.

The logic of intervention and the use of these theoretical models must be very rigorous, but they should be used in a pragmatic way. Health-behaviour change models, and the suggested techniques, are '*operational tools*' and not '*goals in themselves*'.

### 1. OVERVIEW OF BEHAVIOUR CHANGE MODELS

In summary these different models highlight the following:

- The complexity of behaviour and behaviour change processes.
- The influence of various personal, group and socio-cultural variables that must be assessed and used to inform programme design.
- Interventions that only disseminate information are not sufficient to bring about behaviour change.
- It is important to focus on peer groups and other family and community members.
- Direct experience of the new behaviour or practice can help to facilitate change.
- Improving self-efficacy and self-esteem are important factors in promoting behaviour change.
- Interventions that emphasize threat may bring only a superficial change of attitude or can even bring about resistance to change.

THEORETICAL MODEL	MAIN POINTS	MAIN OPERATIONAL IMPLICATIONS & LEARNING
DESCRIPTIVE MODELS OF BEHAVIOUR	Behaviour is defined by the complex interplay of two main factors: personal and environmental, which are each composed of different elements.	<ul style="list-style-type: none"> <li>• Important to analyze both personal and environmental factors.</li> <li>• Change is difficult to obtain if only one of these factors is considered by the project.</li> </ul>
ATTITUDES-BEHAVIOUR MODELS (SOCIAL PSYCHOLOGY)	The relationship between three key components of behaviour change - knowledge, attitude and practice, is neither automatic nor linear. Different change models exist and may be more effective than the typical KAP approach, depending on the context and the needs of the target population.	<ul style="list-style-type: none"> <li>• Each intervention should identify the most suitable change model, depending on the context and the type of behaviour targeted.</li> <li>• Interventions should not only be focused on information dissemination.</li> <li>• Other aspects of behaviour such as the personal intention to act, social norms and the availability of resources etc. should also be considered.</li> </ul>
<b>HEALTH AND SOCIAL PSYCHOLOGY MODELS</b>		
HEALTH BELIEF MODEL	<p>The variables involved in deciding to act in a specific health promoting way are:</p> <ul style="list-style-type: none"> <li>• Perceived susceptibility to the health problem,</li> <li>• Perceived severity of the problem, benefits of the new behaviour,</li> <li>• Barriers to change.</li> </ul>	<ul style="list-style-type: none"> <li>• Analyze the target audiences' perception and social interpretation of the problem.</li> <li>• Increase awareness among the target population of the implications of an inappropriate behaviour by referring to their own systems of representation.</li> <li>• Identify with the target audience the new behaviour's benefits.</li> <li>• Analyze the potential barriers to change, so as to plan action accordingly.</li> </ul>
PROTECTION MOTIVATION THEORY	The interaction between a perceived threat and perceived coping capacity leads to an intention to change. This intention to change is a crucial element for the adoption of the new behaviour.	<p>Promote self-efficacy and self-esteem:</p> <ul style="list-style-type: none"> <li>• Assess the individual perceptions of a situation (i.e. representations and beliefs).</li> <li>• Provide information AND direct experience of the benefits of the new practice.</li> <li>• The perceived ability to cope with a problem should be stronger than the perceived threat of the problem (in order to avoid resistance and rejection).</li> </ul>
THEORY OF PLANNED BEHAVIOUR	<p>The intention to act is essential in a change process. This intention depends on the interaction of the following factors:</p> <ul style="list-style-type: none"> <li>• Personal attitude towards behaviour,</li> <li>• Social norms and influence of community and family members,</li> <li>• Perception of behavioural control.</li> </ul>	<ul style="list-style-type: none"> <li>• Important to provide clear "how to" information, to propose role-play or direct experience of the new behaviour.</li> <li>• Important to involve relatives, friends, etc. to support change.</li> <li>• The new proposed behaviour should be adapted to the local social norms; working with groups can help to slowly modify social norms.</li> </ul>
STAGES OF CHANGE MODEL	Behaviour change is a complex process divided into 5 main stages. In a behaviour change process, individuals or communities progress through these stages, with possible relapses.	<ul style="list-style-type: none"> <li>• Important to adjust the type and timing of the intervention to the stage of change of the individual or community.</li> </ul>
ROLE OF SOCIAL DYNAMICS	<p>Human mental processes and behaviour are influenced by social dynamics. Their influence may lead to different levels of behaviour change (from compliance to internalization). Information or messages that appear incoherent according to the existing social norms and values may be strongly rejected (psychological reactance).</p> <p>Various social influences and sources of information can influence the change process in different ways</p>	<ul style="list-style-type: none"> <li>• Important to carefully analyze the social context and dynamics during the action-planning phase of the programme.</li> <li>• Interventions focused only on information dissemination are insufficient; it is necessary to also intervene on the "normative level" (e.g. social norms, peer and family pressure, etc.).</li> <li>• Include actions that aim at enhancing self-efficacy (e.g. direct experience of new behaviour, sharing experiences with peers, role play, etc.).</li> <li>• Include activities that aim at reinforcing self-esteem and perception of competence.</li> <li>• Assess internal and external locus of control.</li> </ul>
MODELS FOCUSED ON MEANING / SENSE MAKING ISSUES	<p>Health-related behaviour depends on the meaning that individuals and groups give to health and behaviour. This "meaning" is seen as the main factor to initiate and maintain behaviour change.</p> <p>Social representations are composed of "core" elements (more stable and resistant to change) and "peripheral" elements (able to adapt to experiences and interactions).</p>	<ul style="list-style-type: none"> <li>• Analyze the social representations of the targeted social issues and behaviours.</li> <li>• Consider the subjective meanings associated with the targeted behaviours and support people in exploring and developing the meanings of new behaviours.</li> </ul>

## 2. THE 10-STEP MODEL<sup>32</sup> OF ACF FOR PROGRAMS INTEGRATING AN ASSISTING BEHAVIOUR CHANGE - ABC - PERSPECTIVE

ACF has developed a 10-step model, to present and explain its approach to assisting the BC process. This model is the result of ACF's theoretical and practical analysis of behaviour change in its programmes and draws on other existing models. It is intended to serve as a guide for implementing programmes with a behaviour change objective.

The 10 steps are crucial elements that must be taken into account when designing and implementing BC programs. Each step gives us important information for triggering, facilitating and maintaining a BC process. Each step is necessary for promoting BC, but is not sufficient on its own.

ACF 10- STEP MODEL FOR ABC		
1.	<b>Analysis of way of life and current practices.</b> Understanding the context and the reference points of the population: what are their practices, and the meaning and the consequences of these practices on the community and on individuals' lives?	ANALYSIS
2.	<b>Analysis of community perception of the problem.</b> What is their perception of what we consider "the problem" from outside? Is it perceived as a problem or just as a new event? Is it perceived as a temporary or a lasting event?	
3.	<b>Analysis of causal attribution.</b> What is the cause attributed to the problem? Is it an internal or an external cause?	
4.	<b>Analysis of change phase.</b> Is the population already in a process of change? If yes, at which stage are they and who or what are the resources for facilitating the process.	
5.	<b>Analysis of behaviour and its determinants.</b> We refer to the model developed by Fishbein and Ajzen, 1975 (see par. 5.2.1.4), because it reflects well the complexity of the performed behaviour.	
6.	<b>Analysis of barriers, benefits and resources for BC process.</b> What are the barriers (practical, social, cultural, psychological etc.) identified by people that are an obstacle for the process of change? What are the benefits already perceived? Who the groups or what are the facts that can facilitate the process. What is known about the benefits and barriers?	
7.	<b>Design the programme</b> (approach and activities) taking into consideration the data collected in the analysis phase.	DESIGN
8.	<b>Support the process of change - change the intervention according to the stage of change.</b> For example if people are in the 'resistance stage' then you have to address the reasons for their resistance first. Refer to the Change Curve, adapted from the Kubler Ross 'stages of grief' model (see appendix 6.8).	MONITORING & EVALUATION
9.	<b>Sustaining behaviour change - ritualization.</b> New behaviours or practices need to fit in with cultural and traditional values and a phase of transition and ritualization is necessary to maintain BC. A (self) monitoring system should be planned and in place.	
10.	<b>Evaluation of the BC process.</b> Evaluating the process and the changed behaviour, with suitable measures and indicators.	

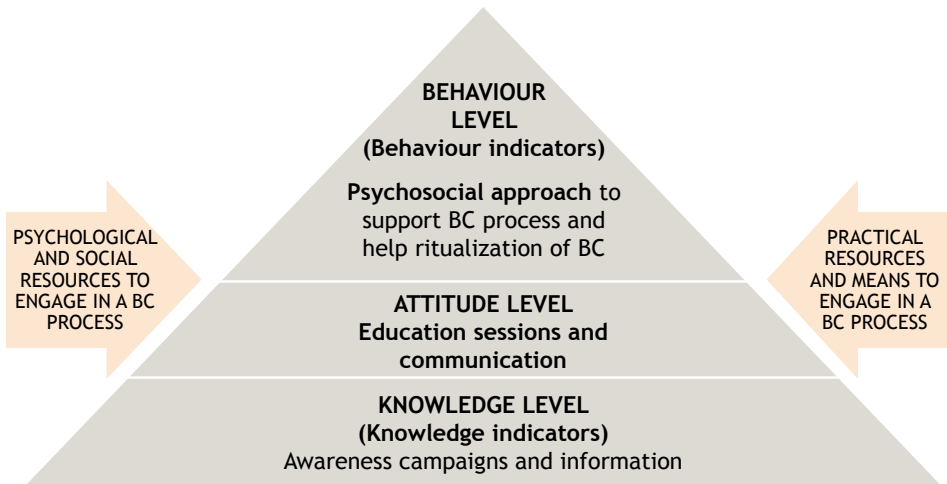
32 - Please, refer also to the ACF-In Position Paper on assisting BC- 2013

### 3. FIELD IMPLEMENTATION

ACF's approach to BC includes several components and *levels of intervention* (see the pyramid of intervention below) and aims to work on the multiple variables involved in behaviour change. All of these levels of intervention are necessary to encourage and support the process and the intervention cannot be classed as a behaviour change initiative without them.

- Assessment related to behaviours, knowledge, barriers and resources for the BC initiative.
- Awareness and educational activities to disseminate information and increase knowledge (such as health sessions, mass media campaigns, etc). However it is important to realise that these activities cannot be conceived as the only activity in the BC process.
- Group work to promote knowledge and sharing of experiences with the aim of working on social norms, beliefs and social pressure (group discussion and peer to peer group.).
- Experiential activities (individual or group) with the aim of working on individual or group self-efficacy and intentionality (role playing, experimental exercises, family development approach, counselling sessions, coaching sessions, etc.).
- It is also important to enable change by ensuring access to facilities where necessary. A family cannot improve its hygiene practices if no water is available in the household or in the village. Therefore a BC program should be integrated with hardware interventions when needed.
- Monitoring activities with the aim of verifying BC maintenance and helping ritualization (observations, journal, self-monitoring, etc.).

### 4. THE PYRAMID OF INTERVENTION



*The pyramid of intervention - Steps to be followed to achieve BC and assisting the whole BC process*



## 5. EXPERTISE AND RESOURCES

As we have seen, behaviour change is a complex process and assisting behaviour or practice change requires expertise and experience. ACF personnel who implement this kind of intervention need to be able to assess properly people's practices, the context, socio-cultural variables and to analyse how these factors interact to influence behaviour. Therefore expertise in the psychosocial sector is required and regular supervision by a specialist experienced in the practical application of the psychosocial sciences is necessary.

However, the initial assessment and awareness and education campaigns could be provided by generalists, if properly trained and supervised.

ACF requires that every BC initiative implemented in the field should be technically supported by a psychosocial specialist, in order to ensure an in depth analysis, and the incorporation of psychosocial aspects related to the BC process (social dynamics, individual self-efficacy, family daily practices, social roles, and empowerment dynamics etc.).

### Two possible operational scenarios:

1. If the BC is a small component of a larger programme that aims to support improved use of new infrastructure, technologies or inputs (for example, the use of different types of food in a garden project, latrine use, etc.) or we are only able to fund awareness campaigns and education sessions, occasional technical support in methodology and tools development will be provided by the MHCP HQ advisors or by the MHCP HoDs in the field (if any) and the programme will be implemented by the sectorial team (WASH, FSL, nutrition & health).
2. If the BC is a programme or initiative in itself with the aim of improving, reinforcing or changing practices (related to care, health, nutrition, risk reduction...), the programme should be implemented by the MHCP teams, that have the appropriate, required expertise in behaviour change and are trained and supervised by BC specialists (with a psychosocial background).

## 6. TIMING OF THE BC PROCESS

As we have seen, behaviours or practices touch a complex world of psychological and social variables: beliefs, norms, previous practices, self-efficacy, and traditional habits. A sustainable and effective intervention in behaviour change needs to work on all of these variables to allow individuals, families and groups to integrate new practices into their way of life (cultural, social, traditional, normative, subjective...) that will necessarily change. The intervention needs to assist this process carefully to avoid negative consequences. This process follows several steps and phases that need to be supported: awareness of the problem (does the population see that there is a problem and perceive a need to change?), the willingness to change (*arousal phase*: a gap is identified between the planned and current situation and the change is conceived), a phase of exploration (*transition phase*: new practices are explored and an evaluation of the integration with previous practices is done), a phase of maintaining of the practices (*ritualization phase*) in the



daily life and an adjustment of the daily life's system with the novelty. However, the process does not need to take a long time if we work on specific variables and if the target group is interested and engaged by the behaviour change initiative. An interesting example is the change provoked by the arrival of mobile phones. No BC programs have been put in places by governments, institutions. But people have easily identified the utility of this new technology; they have started to buy mobile phones and they have learnt to use them. (Daily) communication practices and habits have changed easily and quickly with no specific external pressure.

## **7. MEASUREMENT AND MONITORING**

Measuring behaviour change and identifying BC indicators faces many challenges.

First of all we need to remember that not all the variables involved in the performance of a behaviour can be easily measured and they need specific measuring tools:

- **Knowledge** can be tested by questions (an example indicator: improvement in knowledge - source: pre and post - test of knowledge).
- **Attitudes** can be measured through scales and/or questionnaires (an example indicator: change in attitude - source: pre and post scale of appreciation).
- **Behaviour and practices** can only be measured by observation (an example indicator: change in behaviours - source: observation grids and data). Behaviour change requires specific qualitative and quantitative tools for monitoring (observations, grids, transects, qualitative analysis of the field worker supporting the process of BC, etc.) and data needs to be triangulated.

BC can also be measured by proxy indicators that show the impact of the change on variables external to the BC process. Example: the improvement of child wellbeing in a certain group/population can be considered the proxy indicator showing the positive change in child care practices if all other underlying factors affecting child wellbeing (as health conditions, family wellbeing, maternal mental health, economic, social and political stability...) have been controlled and/or remain stable.

It is also important that the project monitors specific health and psychosocial indicators although such indicators cannot be used to infer a direct causal relationship with the behaviour change intervention. For example if there is an improvement of child wellbeing following your care practices intervention, this could be affected by many different variables such as the reduction of a certain external stress factor, better health condition of the child...and may not be specifically due to your intervention. Therefore care needs to be taken when using and interpreting such variables.



## VI. APPENDICES



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# 1. A QUICK HISTORICAL OVERVIEW OF THE SCIENTIFIC STUDY OF BEHAVIOUR

Whilst people have always been interested in the nature of behaviour, the scientific study of behaviour change - the science of psychology was developed relatively recently to research the dynamics of behaviour, its causes and implications. For over a hundred years psychology has wrestled with the problem of how to conceptualize, define, and modify behaviour (at the individual, group and social levels).

## 1. BEHAVIOURISM

One of the first schools in scientific psychology is known as “*Behaviourism*”, which is a research tradition developed in the 1910s-1930s in the USA, which spread widely in Europe. Behaviourism was based on the assumption that the basic unit of analysis in psychology has to be “observable, overt, behaviour”. Behaviourists assert that behaviours and their associative patterns can be described in a very detailed and scientific way, and do not need to make reference to concepts such as “mind”, “emotion” or “internal representation”.

Behaviourists conceived the mind as a sort of black box. They believed that it was not necessary to open or analyze the box and they were more interested in the causal relationships between the black box’s observable inputs (stimuli, reinforcements, associations)<sup>33</sup> and its observable outputs (overt behaviours).

In the ‘50s, the behaviourist approach was criticized because of this very strict exclusion of every “inside the black-box” process and new theories were developed that took into account the other factors involved in human behaviour.

In the ‘50s, cognitive psychology suggested analysing human behaviour by focusing on cognition. Cognition refers to thought processes, for example, memory, reasoning, logic, language etc. Subsequently, research focused more on the cognitive determinants of behaviour (e.g. understanding what kind of mental processes influence people’s behaviour). Reasoning and rationality have a particularly important place in this approach. Many aspects of modern social psychology have roots in the research done within the field of cognitive psychology.

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33 - A stimulus is everything that reaches the subject, influencing its behaviour. Reinforcement is the process of increasing or decreasing the rate or probability of a behaviour, in the form of a “response” by the delivery of positive or negative stimuli (“punishments” or “awards”) immediately after performing the behaviour; associations are links between stimuli or behaviours, derived from personal experiences.



## 2. SECOND-WAVE COGNITIVISM

A more recent approach, called “second-wave cognitivism”, has been developed since the ‘90s. This approach reduced the strong, almost exclusive, attention on the more cognitive and rationalistic-oriented aspects, and focused on social, relational and emotional aspects of health-related behaviours. This evolution led to a more comprehensive understanding of these issues.

*Behaviourist and cognitivist approaches are only a part (yet an important one) of the wider overall theoretical and methodological body of work of scientific psychology. There are many other “schools of thought” and “traditions of research” in psychology.<sup>34</sup> We decided to focus here on behaviourist and cognitivist approaches due to their particular importance and relevance in the development of some of the most common health and social psychology models of behaviour change.<sup>35</sup>*

## 2. A CHANGE TYPOLOGY

Every time we want to change something, we need to understand what type of change is involved, and how useful or necessary it is in any given situation.

A classical view of change considers it as the simple movement, within a given range of a variable X (i.e. child’s health status), from “A state” (less desirable - e.g. malnutrition) to “B state” (more desirable - e.g. normal nutritional status). A quantitative change of the same variable, within a defined range, is the simplest type of change. This is most often the target of social change programmes and it is known as “Alpha change”.<sup>36</sup>

However, there are two other types of change. The first one still considers a given variable X, but produces a modification in the “range” of the variable, such as allowing you to get from A to C rather than just to B. It is a change always within the same set of variables. This is known as “Beta change” (e.g. a person can pass from a status of high stress to a status of less stress).

Alpha and Beta changes are considered as “first-order” changes, or tactical changes: the behaviours are changed, but their contextual framework isn’t.

Finally, there is a third type of change. This is the most ambitious and complex to measure and it usually represents a very significant change. It is called “Gamma change”. It changes the structure of the system, producing a radical change in the operational context. Gamma change (“second-order change”, or strategic change<sup>37</sup>) is the most difficult to attain, but is the deepest and most powerful change.<sup>38</sup>

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34 - E.g., Psychodynamic (psychoanalytical), systemic, gestalt-based, humanistic approaches, etc.

35 - For further reading on this chapter’s topics, see also: History of Psychology Resources; <http://psych.athabascau.ca/html/aupr/history.html>

36 - Golembiewski, Billingsley, & Yeager, 1976

37 - Cf. Watzlawick, P., Weakland, J.H., Fisch, R. (1974). Change. Norton, New York.

38 - In more technical terms: it changes the positioning and the relevance of the same variable X with respect to the context of other variables in the whole relevant system/framework.

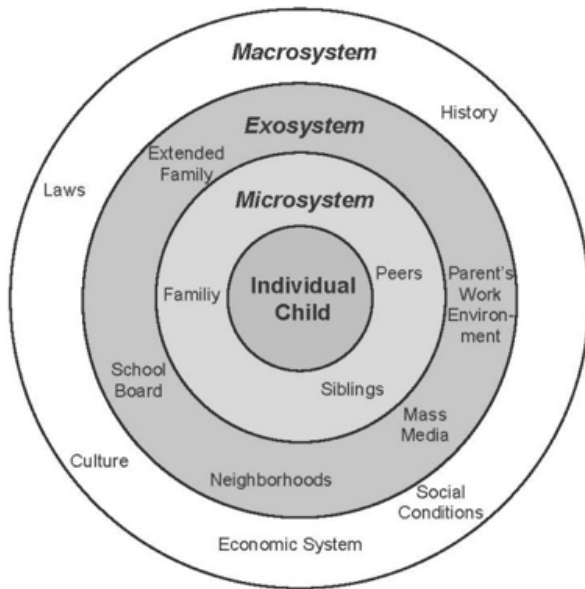
**For example**

Obtaining a slight increase in the quantity of complementary food that a child receives, in a family in which the working men are, for cultural reasons, the first beneficiaries of nutritional resources, is a first-order change (tactical change). Gradually modifying the cultural assumptions themselves, to ensure that the child is seen as having priority over nutritional due to their vulnerability, is a second-order change (strategic change).

Various attempts have been proposed to correlate these types of change with attitudes and cognitive processes (by measuring the depth of cognitive processing etc.).<sup>39</sup>

Although interesting, this information on typology of change remains theoretical. Once the expected type of change has been identified, the specificity and complexity of the local cultural context needs to be carefully analyzed so as to design appropriate and effective interventions. The following issues should be taken into account.

### 3. BRONFENBRENNER'S MODEL



*Ecological Model. Bronfenbrenner's Ecological Model describing the environmental influences on a child, Niederer et al. BMC Public Health 2009 9:94*

39 - Thompson, R., Hunt, J. (1996). Inside the Black Box of Alpha, Beta and Gamma Change: using a Cognitive-Processing Model to assess Attitude Structure. *Academy of Management Review*, 21, 3, 655-690.



## 4. A NOTE ON THE CONCEPT OF SELF-EFFICACY

As previously stated, self-efficacy is a powerful psychological process, applicable to various settings and types of intervention. Aspects of self-efficacy have been integrated into many health behaviour change models,<sup>40</sup> and it is often particularly important in the preparation and action stages of change. However, self-efficacy alone is only a single element in a more complex set of variables that influence behaviour change. In many situations, social or cultural variables may be more relevant.

Where self-efficacy is important, it is more useful to incorporate, direct experience of the new behaviour e.g. through simulation or role play and, discussions with peers, to support the development of self-esteem rather than to provide ‘training in self-efficacy’.

According to Bandura,<sup>41</sup> self-efficacy may be influenced by different factors:

- **Experience:** personal and progressive experience of success in applying the new behaviour is the main factor for increasing self-efficacy; repeated failures can lead to demotivation and to the failure of the behaviour change effort.
- **Modelling:** seeing or sharing experiences with other people who have been successful in applying the behaviour, can be useful to motivate an individual. Their success stories and examples, are very useful to inspire confidence and to feel that the change required is possible. Where possible direct identification or perceived similarity with the target audience works best - e.g. a support group for young mothers who are having problems breastfeeding where advice is given by other young mothers.
- **Social Influence:** social support, peer support and a positive social attitude towards the individual’s ability to succeed helps to increase the sense of self-efficacy. Realistic but positive expectations by peers and family members are very powerful elements both for self-efficacy as well as for self-esteem.
- **Stress and physiological factors:** highly stressed people, or individuals in distress may have a lower perception of self-efficacy - e.g. mothers during a famine may feel physically and mentally stressed, which makes it hard to feel they are capable of feeding and nourishing well their children.

Self-efficacy perception (connected to the perception of competence and self-esteem) is very relevant in facilitating and maintaining change, and must therefore be considered important in any behaviour change programme.

40 - cf. first part of this document.

41 - Bandura, A. (1997). Self-efficacy: The exercise of control. Freeman, New York.

## 5. A NOTE ON THE CONCEPT OF “LOCUS OF CONTROL”

“Locus of Control” (LoC) is a concept that expresses the inclination of an individual to believe that he can “control” events and situations that affect him or her. LoC is a continuum between the extremes of an “internal locus” (i.e., the individual believes that they can personally control all of the main events and situations affecting them) and an “external locus” (i.e., the individual has a fatalistic attitude and believes that “external” forces beyond their control - such as destiny, God, society, spouse - affects their life,). People will be situated somewhere on the continuum. An individual with a strong internal LoC is more resistant to social pressure and external factors; an individual with a strong external LoC will tend to be fatalistic and will not believe that he can act to change things.

Internal locus of control is an important factor for behaviour change initiatives and has to be taken into account especially where barriers to behaviour change seem related to external factors.

It can be more difficult to involve an individual with an external LoC, in the contemplation/preparation phases of behaviour change because they could more easily believe that the possibility of change is “out” of his control/possibilities, and they perceive that the responsibility for change lies with some third-party actor (family, local leaders, social group).

## 6. SOCIAL CONTEXTS, CULTURAL MEANINGS AND CHANGE

The scientific literature often lacks a structured analysis of the “contextual factors” in which the individual and social behaviour is “embedded”. Indeed, the “context” (psychosocial, cultural, economic, and environmental) is one of the main determining factors of health-related behaviours. The approaches that emerged from recent scientific contributions focus on “*social context*” and “*subjective meaning*” as a way to explain the basis of human behaviour.

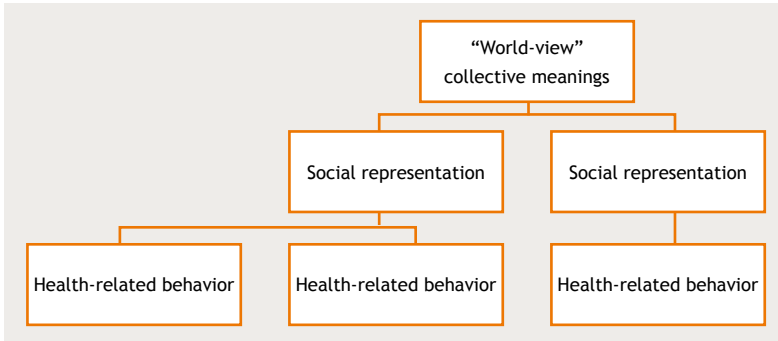
Actions and behaviours, in this sense, are reinterpreted as the “actualization” of meaningful social representations, on which the social identity of the individual is built. The social practices prevalent in the community - especially those related to “basic human actions” such as nutrition, health care, child care practices, family roles and relationships - are expressions of social representations, and express collective cultural values.

### *For example*

*A young mother who is “culturally bound” to seek and follow child-care advice from the older women of her extended family, implicitly expresses, through her behaviour, her “social respect” for power dynamics, social roles, and the superior knowledge of senior community members.*



Community narratives express not only “how the individual has to behave” (social norms), but also “why the individual has to behave in this way” (social sensemaking); these social norms and values represent very powerful constraints for the individual behaviours. Individual behaviours are therefore “derived” and defined by the social representations and cultural meanings shared by the community.



Thus, "changing a specific behaviour" is like trying to change a part of a very complex system of hierarchical and interconnected social meanings nested one inside the other. In a community, every individual needs to respect these social meanings; doing this, he confirms his own social identity (and sometimes a positive social identity is even more essential than many basic needs).<sup>42</sup>

In field interventions, it is therefore necessary to support and facilitate the “least traumatic” changes possible, i.e. changes that are compatible and coherent with general social assumptions and the cultural values of the local context. Such initiatives help to facilitate a type of change that does not risk invalidating the local community’s most essential social meanings and representations. This of course, would otherwise lead to a rejection of the proposed change, because the new behaviour would be structurally inconsistent with or would invalidate the assumptions of its social context.

Psychological approaches, such as Personal Construct Psychology, Social Representations, Social Ecology Theory and Eco-Cultural Studies, aim to explain and understand such a complex network of “social and personal meanings”, correlating them with the physical, institutional, economic and environmental factors that characterize the contexts in which behaviours take place.

42 - Some studies in survival psychology in extreme conditions show that sometimes the need for a positive social identity and a strong coherence with social meanings is perhaps more relevant for the individual than his own physical survival; cf. Frankl. V., “Man’s Search for Meaning”, Random House / Rider, London 2004.



## 7. SOCIAL ECOLOGY

### Integrating material and social dimensions in order to better understand operational contexts

Social Ecology Models (SEM) attempt to incorporate both socio-environmental factors and psychosocial ones, in an integrated analysis of local practices and behaviours.

Classical behaviour change approaches often focus only on EITHER personal OR situational elements. Classical health psychology has often focused only on the individual and given little attention to the environment and cultural determinants of behaviour. For example it might focus on a woman's individual skills and knowledge about the benefits of breastfeeding without considering the context in which she was living (family dynamics, absence of social support, society's attitudes to breastfeeding, etc.). Similarly, "environmental" and technically oriented approaches have focused only on situational factors (e.g. the mere availability of food or sanitation materials), ignoring relevant personal psychosocial factors.

Social ecology highlights the need to bring these variables together, developing behaviour change programmes that recognise the relationship between people and their surroundings (Stokols, 1996)<sup>43</sup>.

#### In social ecology, behaviour change is facilitated when an intervention:

- Considers both individual actions (personal behaviour) that affect one's well-being AND actions that influence others well-being (other directed behaviour).
- Actively involves "*health intermediaries*". These are people with a special social, normative or technical role that can influence the health behaviour of many other people in the community, (i.e., local leaders, health officials, educators, etc.).
- Integrates "*regulatory*" (normative, cultural) interventions with "*non-regulatory*" ones (information, social support, social sharing, individual skills, personal counselling, etc.).

A branch of social ecology, is known as "behavioural ecology" where behaviours or practices only "make sense" when they are considered within the context of their "ecological niche".

*Behavioural ecology* argues that every behaviour or practice was originally developed to maximize the individual and communities' adaptation within the existing environmental constraints and opportunities. Therefore, a behaviour might seem "strange" when considered from outside if it does not take into account its "ecology" within the system in which it developed. However, such a behaviour has significant meaning when contextualized inside a particular social and cultural niche.

Many dysfunctional health behaviours are "behavioural relics". The behaviours originally developed to cope with the problems of a different socio-environmental situation; they are now maintained, even when they became dysfunctional in their new, present day, context.

It is important to understand which psychosocial meanings actively maintain a behaviour, before it is possible to attempt to change it. Many apparently "strange" dysfunctional behaviours are understandable if we consider the cultural and psychosocial values of the original context.

However, modifying these behaviours is very difficult, because they make perfect sense "inside

43 - As Stokols points out: "Everyday human behaviour is organized into recurring patterns of activity that take place within highly structured environmental settings (...) a potentially useful criterion for judging the success of health promotion programs is the ecological depth of intervention outcomes. Ecological depth increases to the extent that positive intervention effects occur over extended periods and at multiple levels of a community" (Stokols, 1996, *passim*).



their context”. A change effort cannot elude this social”sense making” process; instead, it has to use it as leverage, and psychologically reframe the “sense making” system in a more functional way.

### For example

Where nutritional resources are extremely scarce, and the adult male provides the only income for the family then, it becomes easier to understand why the adult male is given priority over food resources and why some children are malnourished. The social norms and cultural traditions would consider it “normal” and “right” that the available food resources are directed at the father, while children are considered only as a longer term potential resource for the family. In the short term they may only be seen as a heavy “cost” in terms of time, necessity of care, and economic resources. In certain contexts, the risk of losing the income of the only adult male of the family, could be considered as worse than wasting the scarce family resources to maintain in good health of one of many children.

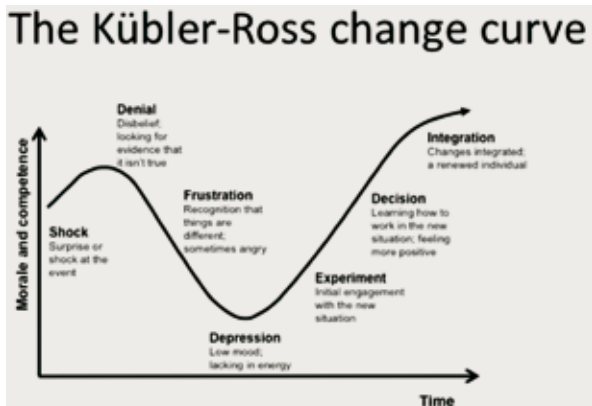
The objective of interventions is thus to maximize the “change” inside its contextual constraints, reinforcing good practices and facilitating the best “possible” change of problematic practices employing a very pragmatic approach.

This does not imply that, strategic or structural changes (gamma change) cannot be considered even where there are problematic and severe socio-cultural constraints. However, the *utility* and *feasibility* of such a radical, difficult and complex change must be clearly assessed and articulated.

For further reading see also: Watzlawick, P., Weakland, J.H., Fisch, R. (1974). *Change*. Norton, New York; Stokols, D. (2000). Translating Social Ecological Theory into Guidelines for Community Health Promotion. *American Journal of Health Promotion*, 10, 4, 282-298.

## 8. THE CHANGE CURVE

The change curve is based on a model originally developed by Elisabeth Kubler Ross in the 1960s to describe and explain the grieving process. It is also used widely nowadays to describe people’s reaction to the process of change.





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## ACF-INTERNATIONAL

### CANADA

1150, boulevard St-Joseph est  
Bureau 306, Montréal, QC, H2J 1L5, Canada  
E-mail: [info@actioncontrelafaim.ca](mailto:info@actioncontrelafaim.ca)  
Tel: +514 279-4876  
Fax: +514 279-5136  
Web: [www.actioncontrelafaim.ca](http://www.actioncontrelafaim.ca)

### FRANCE

4 rue Niepce  
75662 Paris, cedex 14, France  
E-mail: [info@actioncontrelafaim.org](mailto:info@actioncontrelafaim.org)  
Tel: +33 (0) 1 43 35 88 88  
Fax: +3 (0) 1 43 35 88 00  
Web: [www.actioncontrelafaim.org](http://www.actioncontrelafaim.org)

### SPAIN

C/ Duque de Sevilla, 3  
28002 Madrid, España  
E-mail: [ach@achesp.org](mailto:ach@achesp.org)  
Tel: +34 91 391 53 00  
Fax: +34 91 391 53 01  
Web: [www.accioncontraelhambre.org](http://www.accioncontraelhambre.org)

### UNITED KINGDOM

First Floor, rear premises,  
161-163 Greenwich High Road  
London, SE10 8JA, UK  
E-mail: [info@aahuk.org](mailto:info@aahuk.org)  
Tel: +44 208 293 6190  
Fax: +44 208 858 8372  
Web: [www.aahuk.org](http://www.aahuk.org)

### UNITED STATES of AMERICA

247 West 37th Street, 10th Floor  
New York, NY 10018, USA  
E-mail: [info@actionagainsthunger.org](mailto:info@actionagainsthunger.org)  
Tel: +1 212 967 7800  
Toll free: +1 877 777 1420  
Fax: +1 212 967 5480  
Web: [www.actionagainsthunger.org](http://www.actionagainsthunger.org)

