Helpdesk Research Report

Methods and approaches to understanding behaviour change

William Robert Avis

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Question

Describe the scope of approaches and methods to understanding behaviour in international development. Describe the scope of the use of research driven processes towards addressing behaviour change in development (with a focus on Health, Education, Social Protection and Livelihood Development). Review the current initiatives to understand and respond to behaviour change in Uganda and Karamoja.

Contents

1. Overview

A behaviour change method is considered to be any process that has the potential to influence individuals and behaviour. There are a large number of theories and approaches towards behavioural change derived from disciplines such as psychology, sociology, communication and political science. These can focus on the enabling **environment level**, the **community level**, the **interpersonal level**, or the **individual level**. This rapid review draws on academic and grey literature to present a broad overview of theories and models of behaviour and behaviour change. It highlights their adaptation and application to the field of international development and how they can further an understanding of behaviour in Karamoja and of mechanisms to affect behaviour change.[1]

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[1] The review draws on Avis (2016) and the impact of protracted crisis on attitudes and aspirations in Karamoja.

Given the range of theories and models that discuss behaviour change, no single behaviour change method is universally applicable, rather, research suggests that behaviour and behaviour change can be best understood when an **open theory approach** is adopted. This entails an appreciation of the diversity of behavioural theory that can enhance the assessment of a range of issues. An open theory also acknowledges that the translation of theoretical methods to specific contexts, populations, and cultures is often challenging. This distinction between theoretical methods and practical applications is crucial for two reasons:

i.   Evidence of the effectiveness of behaviour change methods is generally only available for generic behavioural methods.

ii. Behaviour change methods are only effective if the parameters for effectiveness are met. Intervention descriptions are incomplete when they do not describe both which theoretical methods they use and to which practical applications these were translated.

Key findings of this rapid review include:

- Information alone is insufficient to support behaviour change. Influencing healthy behaviours and creating a supportive social environment in a variety of contexts requires **stimulation of learning and participation through regular dialogue with the affected community**. This type of behaviour change communication and social mobilisation works best when actions, messages and materials are strategically planned, managed, and monitored with the affected communities and supported by the necessary financial and human resources.

- Relationships with **partners, families and the community or society** in which one lives can substantially determine how we behave.

- Behaviour change interventions need to take into account the **specific psychological and social influences that guide decision making and behaviour in a particular setting**. That means that the process of designing and implementing effective interventions needs to become a more iterative process of discovery, learning, and adaptation. What matters is not only which policy to implement, but also how it is implemented.

2. Theories/models of behavioural change

A behaviour change method is considered to be any process that has the potential to influence psychological determinants (Glanz et al., 2005). Psychological determinants are theoretical variables that influence individuals (and communities) behaviours (Glanz et al., 2005). Examples of such determinants include attitude, risk perception, self-efficacy and habit. These determinants are included in theories of behaviour explanation such as the Health Belief Model. Other theories explain how such determinants may be changed, for example Social Cognitive Theory etc.

There are a large number of theories and approaches towards behavioural change derived from disciplines such as psychology, sociology, communication, and political science (CommGAP, 2009). These can focus on the enabling environment level, the community level, the interpersonal level, or the individual level (C-Change, 2010). It is important to note that no single behaviour change method is universally applicable; some methods may be more appropriate choices than others depending on context, target population of intervention and the practical applications that can be used. In many cases theorists have contributed towards multiple approaches and these approaches are not mutually exclusive

of each other. Examples of well-known, and frequently applied, behaviour change methods are fear appeals, persuasive communication, and modelling (Glanz et al., 2002; C-Change, 2010).

CommGAP (2009) identify the main theories of social behaviour as: Social Cognitive Theory, the Theory of Planned Behaviour and the Stages of Change/Transtheoretical model. Rao (2012) notes that while these theories have their value in specific contexts, their often unquestioned use, particularly of the Theory of Planned Behaviour and the Stages of Change/Transtheoretical model, is highly problematic. Instead, Rao (2012) advocates an open theory approach, where an appreciation of the diversity of behavioural theory is incorporated into the assessment of issues. This open theory approach incorporates a range of disciplines that can contribute to the understanding of a behavioural challenge and intervention options selection.

C-Change (2010) present one example of an open theory approach: This initiative developed tools for Social and Behaviour Change Communication based on a wide range of theories and approaches to behaviour change. These approaches are summarised as follows (Rao, 2012):

Enabling environment level

Media theories

Mass media can focus attention on issues, generating public awareness and momentum for change. Research on agenda setting has shown that the amount of media coverage of a given issue correlates strongly with public perception about its importance. Agenda dynamics refer to the relationship between media agenda (what is covered), public agenda (what people think about), and policy agenda (regulatory or legislative actions on issues) (Dearing & Rogers, 1996). Media advocacy is how civic action groups promote social change through various techniques and persuade the media to cover issues considered important refers to civic actions to shape media attention on specific issues (Wallack, 1993).

Framing is how issues are presented in news coverage (Iyengar, 1991). Experimental research shows that news frames influence how people perceive issues and think about possible courses of action. Persuasion is a form of communication that seeks to influence attitudes or behaviours without the use of force or coercion (Perloff, 2003). Perloff (2003) provides a comprehensive introduction to persuasive communication and attitude change, offering a discussion of classic and contemporary theories of persuasion, exploring the structure and functions of attitudes, consistency between attitude and behaviour, and issues in attitude measurement.

Key questions include: How can the media contribute to changes in the enabling environment? How would media coverage affect policy discussion? How can media coverage of a given issue be expanded and changed? How should media decision-makers (e.g. reporters, editors, publishers) be engaged to promote changes?

Social movement theories

Social movements refer to collective citizen actions to promote social changes in policies, laws, social norms, and values (Tilly, 2004). Social movements promote legislative and policy changes to advance their causes and build coalitions with policy makers. They seek to influence the legislative process through mobilisation, financial and voting support for allies. To promote change, social movements resort to a combination of actions:

- **Campaigns**: long-standing activities to demand that authorities make specific changes.
- **Movement repertoire**: combinations of political action such as coalition building, media statements, rallies, demonstrations, online mobilisation, and pamphleteering.
- **Worthiness, Unity, Numbers, and Commitment (WUNC) displays**: participants aim to demonstrate WUNC. For example, newer social movements in Africa, Asia, and Latin America include faith-based communities, neighbourhood and squatter associations, women's and human rights groups, peasant cooperatives, and environmental activists.

Key questions include: How does a social movement change policy/legislation around the issue? Is there a social movement supporting change related to the issue? What have been its achievements? In case of the absence of a movement, how can a movement be developed and sustained? What promotes people's participation around the issue? What collective action strategies have been successful to express demands and advance change?

Social network and social support theory

The web of social relationships that surround and influence individuals characterises this theory (McKee et al., 2000; Glanz et al., 2008). The structural characteristics of networks refer to: the degree of similarity among members; resource exchange; emotional closeness; formal roles; knowledge and interaction among members; and power and influence among members. The functions of social networks refer to social trust, influence, support and criticism, emotional bonds, and aid and assistance. The types of social support can be emotional, informational, instrumental, and self-assessment.

Key questions include: How do social networks influence individuals' knowledge and practice around the issue? How can social networks be influenced? What dimensions (knowledge, attitudes, perceptions) of behaviour/social change can be promoted through social networks?

Social capital

Social capital refers to the institutions, norms, and values of social networks and their impact on social relationships and institutional resources (Putnam, 2000). These links tie people to other people with similar interests as well as provide bridges with other groups. Social capital includes the social resources that people have and can tap into to engage in various activities, economic, social, cultural, and political.

Key questions include: What institutions are adequate platforms to promote changes? How might trust among people promote changes? Where do people gather to discuss common interests? Who do they rely on to develop links and engage in different activities?

Ecological models

Ecological systems theory suggests that individual behaviours are interdependent with the social context, not only (or mainly) influenced by psychological factors. The social context refers to anything beyond individuals such as social norms, interpersonal relations, culture, and laws and regulations (Glanz et al., 2005). Consequently individual-level interventions should always take other influencing factors into consideration. Programmes need to understand how changes at the level of neighbourhood, community, institution, and social/political structure might affect individual changes.

This theory recommends the adoption of a multiple-level approach that tackles various forces affecting the same change. For example, an information campaign promoting bed net use could be supplemented

by efforts to improve access to low-cost bed nets, promote local production and supply chains, or request government subsidies to provide access to the nets.

Key questions include: What elements/components of the social ecology models are more likely to influence individuals? What evidence shows successful changes of various factors and their impact on individual behaviours and decisions? Must change of the social context always have an impact on individual behaviours?

Theories of complexity

Complexity theorists argue that individuals are part of complex systems characterised by multiple interacting agents (Lewin, 2000; Morin, 2008). They conclude that human behaviour is non-linear and unpredictable because of the number and diversity of agents and variables in the system and, therefore, there are no fool proof recipes for change.

Interventions and activities designed from a complexity standpoint include all of the diverse actors that might be involved with a given issue. For example, an infection control intervention in a hospital should include representatives of all the hospital units that can contribute, including housekeeping, nursing, security, and orderlies, not just be limited to infection control staff (Ganz et al, 2002).

Key questions include: What system components affect individual behaviour around the specific issue? What system elements can be influenced? What is the most likely point of entry into the system? How are systems organised and how do they avoid chaos and disorganisation?

Theories of change

A theory of change is a statement of plausible, testable pathways of change that can both guide actions and explain impact (Kubisch et al., 2002; Valters, 2014). A theory of change is often made visible with a logic model, a visual representation that charts a path from the problem to be addressed, to the inputs (available resources) and outputs (activities and participation), and then finally arriving at outcomes (short, medium, and long-term results) that ideally will lead to impact (long-lasting change). A theory of change brings underlying assumptions to the surface so that the reasoning behind an intervention can be assessed and adjusted as necessary.

Theories of change need to be based on an analysis of how change happens. From this perspective, one should identify the most likely change and drivers of change in a given system. Programmers need to assess possible tipping points of change, their likely impact in the overall system and the feasibility that a programme can affect these tipping points. It is also important to identify emergent change (which is already occurring, whether it's planned or unplanned), transformative change (critical points that caused major transformations in a given community), and projectable change (the kind of change that can be planned and implemented (Ganz et al., 2002).

Key questions: What are suitable pathways of actions to promote change? What changes are already occurring in a community regarding specific issues? What likely changes may have positive and negative ripple effects? What secular trends/emergent changes encourage or discourage proposed changes? What changes have already occurred in a given community that offer insights into local processes of change?

Behavioural economics

Rational choice assumes that people are driven to maximise perceived individual benefits. However, the way choices are structured affects people's decisions (Ganz et al., 2005). If people are offered choice in the form of opt-out (e.g. routine HIV testing that patients have to actively say no to), more people may make certain choices of advantage (e.g. for public health). Such choices raise questions about whether individuals make decisions independently from the environment and also suggest that people make certain choices because they are interested in maximising time, costs, or other factors when making a selection. People can be primed (led, stimulated) to make certain choices just by the structure of options. The easier the choice, the more likely it will be chosen.

Choice architecture is the act of designing available choices in such a way that individuals will be steered (or 'nudged') toward more healthy or socially beneficial behaviour. For example, placing vegetables or salad at the beginning of a school lunch display and reducing the availability of competing fattening foods, or displaying condoms in easily accessible places in kiosks and stores (Kahnemann, 2003; Thaler & Sunstein, 2008).

Key questions include: What behaviours can be made easier if certain environmental factors are altered (e.g., laws, regulations, presentation, distribution, offerings)? Are there examples of successful choice architecture in a given community? What lessons can be considered for the design of other choices around desirable changes? Are choices based on rational thought and self-control, or on spur of the moment decisions? Is a policy change needed instead of behavioural appeals? What incentives and regulations can be put in place and/or promoted to make certain behaviours beneficial or mandatory?

Community level

Community organisation

Community organisation emphasises social action processes through which communities gain control and decision-making over their lives (Glanz et al., 2005). Community organisation involves empowerment, self-determination and capacity to perform critical tasks.

Empowerment refers to the process by which individuals and communities gain confidence and skills to make decisions over their lives. Self-determination refers to the capacity of an individual, and of communities, to make decisions without interference or influence from other actors. Capacity to perform critical tasks refers to the ability to execute actions required to improve conditions.

Key questions include: How are communities organised? How is power structured around specific issues? Which organisations can be mobilised towards positive change? Which organisations may be opposed to change? What local beliefs and practices are or might be linked to change? What has been the role of local organisations in local processes of change?

Integrated model of communication for social change

The Integrated Model of Communication for Social Change describes how social change can happen through a process of community dialogue leading to collective action that affects the welfare of communities as a whole as well as their individual members (Reardon, 2003).

The model describes a dynamic, iterative process that starts with a catalyst/stimulus that can be external or internal to the community. This catalyst leads to dialogue within the community that, when effective, leads to collective action and the resolution of a common problem.

Key questions include: Where do people talk about common problems? How can dialogue about specific issues be addressed? Are there past examples of how local dialogue affects attitudes, opinions, collective action, and/or decisions?

Theory of social norms

The theory of social norms is based on the rules that a group uses to discriminate between appropriate and inappropriate values, beliefs, attitudes, and behaviours (Jones, 1994). Social norms may be explicit or implicit, and failure to conform can result in social sanctions and/or social exclusion. Collective norms operate at the level of the social system (social network, community, entire society) and represent a collective code of conduct. Collective norms are not measured by aggregating individual beliefs (Lapinski & Rimal, 2005). Instead, they are reinforced through routine group approval. Perceived norms are the result of individuals interpreting and perceiving values, norms, and attitudes that others around them hold. Perceived norms are further distinguished into injunctive norms (what ought to be done; similar to subjective norms of the Health Belief Model) and descriptive norms (what is actually done by other individuals in the group, what the perceived prevalence is of the behaviour in question) (Lapinski & Rimal, 2005).

Stigmatisation is a method through which groups establish negative norms. Social norms vary and evolve through time and among generations and between social classes and social groups (e.g. acceptable dress, speech, and behaviours).

Key questions include: What alternative norms may be emphasised to promote desired changes (e.g., tobacco cessation can be promoted through appealing to social norms about health, economic savings, and also consideration for the health of relatives)? Are there gaps between collective norms and perceived norms? Are proposed changes stigmatised? If so, what beliefs underlie stigma? What are the bases for positive or negative beliefs about proposed changes (e.g., religion, culture, economic incentive, policy)? Have there been recent social norm changes in a given community? If so, what are the explanations? Has generational change anything to do with it?

Social convention theory

Social conventions are at work when an individual follows a social rule, because of: i) expectations that many others follow the social rule, ii) preference to do the same as others and iii) compliance being in his/her interest. Influencing social conventions requires effort at the community level because even if an individual or small family unit changes its practices, the social convention will still be in place (Mackie & LeJeune, 2008).

For example: In the case of female genital cutting (FGC), families may be reluctant to abandon the practice if they think that, as a result, their daughter will be less likely to marry (Mackie & LeJeune, 2008). For social conventions to change, a critical mass of community members needs to agree to the change, adopt it and make a public commitment. In Senegal, the TOSTAN project has had success with basic human rights education for women which has resulted in community-organised and public declarations of the commitment of the entire community to abandon the practice of FGC (TOSTAN, 2011).

Key questions include: Why do specific conventions persist? What social networks can be mobilised to promote new conventions? What social conventions have recently changed in the community? Why? Why do people follow a particular social convention? What would happen if people changed conventions? What might discourage people from practicing the current convention?

Theory of gender and power

Gender inequality is a social construction that results from long-term processes of socialisation and education (Connell, 1987). For example, the distribution of work according to gender norms as well as unequal pay produces economic inequalities for women. Power inequalities are reflected and perpetuated in conditions that, for example, put women at increased risk for disease (such as HIV/AIDS) because of an inability to negotiate correct and regular use of condoms, and more vulnerability to illness/death in instances where they have no access to transport to health facilities.

Gender approaches aim to meet the different needs of men and women in ways that contribute to power balance and equitable practices. They seek to find ways to empower women through the attainment of skills, information, services, and technologies. Depending on the desired change, gender approaches in programming can be neutral, gender sensitive, transformative, and empowering (Gupta, 2000).

Key questions include: What gender inequalities exist around the specific issues? How are decisions linked to gender power divisions? What factors maintain gender inequalities around specific issues? What factors discourage women from gaining more power? How can gender-equitable decision-making be promoted? What social norms can be tapped to strengthen women's power? Are there other areas in a given community where men and women have more equitable relationships? If so, why?

Culture-centred approach

The culture-centred approach involves designing change interventions and activities that are consistent with individual and community cultural frameworks (Airhihenbuwa, 1999: 7). Local cultural systems are the basis for the development of interpretation and/or meanings about specific social change issues. This approach recognises the value of local expertise and knowledge, and views community members as agents capable of promoting change within their own communities (Dutta-Bergman, 2007). A culture-centred approach involves inquiry into the preferred modes of communication (written, oral, visual, traditional and mediated) within a given community.

A culture-centred approach views local culture as a resource rather than a barrier to change. When ethical challenges arise, local culture and religious/moral norms can be evoked as a shaming technique to appeal emotionally to perpetrators to cease their behaviour (Ttofi & Farrington, 2008).

Key questions include: How do communities think about a given issue in terms of their own culture? How does this affect people's beliefs and practices about the issue? How do people communicate about the specific issue? When and where do they communicate? What local/traditional values might promote good practices and changes?

The positive deviance approach

The positive deviance approach seeks to understand why a minority in a community practices healthy behaviours and to integrate those insights into effective planning (Zeitlan et al., 1990; Pascale & Sternin, 2005). For example, in a community where most children are malnourished, a positive deviance approach

would try to analyse why some children are well nourished and use these reasons to appeal to others. In this instance, reasons could include access to resources, social capital, religious beliefs, past experiences, etc.

A premise of this approach is that communities have the necessary expertise, solutions, and resources to promote change. The basic steps of the positive deviance approach are (4 Ds):

1. **Define** the problem and desired outcome.
2. **Determine** common practices.
3. **Discover** uncommon but successful behaviours and strategies through inquiry and observation.
4. **Design** an initiative based on the inquiry findings.

The results of a positive deviance initiative never yield a general recipe for change since each community has a different challenge, context, and local expertise. Thus, identifying community capacity to promote desirable changes is critical. Capacity refers to agents (who drive change), resources (how), setting (where), and target (who is the subject of change) (McLeroy et al., 2003).

Key questions include: Are there people who do not conform to the negative norm? If yes, why do they act in that way? Is it possible to spread their unique/deviant norms across the community? What will it entail to mainstream positive deviant behaviours? How can community resources be mobilised to promote desirable changes? Who (individuals/groups) may be more inclined or disinclined to promote change? What are the reasons? Will informing about examples of positive deviance persuade people who practice undesirable behaviours?

Theory of organisational change

Understanding how to create change in organisations is a critical aspect of health and development promotion. Organisational theories can provide insight into how to manage the adoption of organisational policies or institutionalisation of a particular intervention within an organisation or help explain how an organisation may actually discourage certain behaviours with its structure of programs and services (Glanz et al., 2002).

It is important to understand what drives an organisation to change, what demands and leads change, and how change is implemented. The interest of organisations in stability, hierarchy, and predictability may discourage change. The need for renewal, survival, and consolidation may encourage change.

Key questions include: What organisations are responsible or exercise influence over specific issues (e.g. quality of health services)? What organisational practices and rules affect a given issue (e.g., service provision quality and hours)? How is change possible in a specific organisation? Is there a previous example of change? If so, how did it happen? What parts of the organisation are more likely to be changed? What may motivate organisation members to support change? Who has power over change?

Diffusion of innovations

Diffusion of innovations is a process through which an innovation is spread in a given population over time (Rogers, 2003). Under the right conditions, innovations (new services, products, best practices) can be successfully introduced, communicated and adapted at the individual, community, and organisational level. For diffusion of innovation to be successful it must have a relative advantage with observable

benefits (be better than the existing process); be compatible with existing values of perceived social acceptability; be easy to implement; and be possible to trial.

People have different attitudes, beliefs, and experiences that affect their disposition to change. When opinion leaders in the community support the innovation, they communicate their approval and thus increase the likelihood and pace of community-wide adoption. Opinion leaders in one area are not necessarily influential around other issues. Individuals often improve, adapt, or re-invent an innovation to fit their needs/context. Innovations are more likely to be incorporated if they fit into pre-existing needs.

Key questions include: What attitudes exist toward specific innovations? Who (individuals, groups) is more likely to adapt the innovation? Why? What are the advantages of the given innovation over current practices/uses? What opinion leaders might be mobilised to provide public support? Do people have easy access to try the innovation? What might be the benefits of adopting the innovation for different groups of people?

Social marketing approach

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the behaviour of target audiences in order to improve their personal welfare and that of their society (Andreasen, 1995; McKenzie-Mohr, 2011).

The product/practice is what is being promoted. Price/cost is the ease of access and barriers to using the product or practice, although perceived cost may not be identical to actual cost. Places/access points refer to where people might have access to the product, and where the product is distributed and made available. Promotion refers to the information/activities platform that informs people about products and their characteristics. Community-based social marketing (CBSM) relies on formative research conducted in the community to ensure that existing and perceived benefits and barriers are understood prior to the design of an intervention/campaign/activity. CBSM involves the promotion of both actions and/or products (Ganz et al., 2007).

Key questions include: What are the benefits of a given product? Why would people try, use and continue to use a new product? What is the cost/price for people to access the product? Where will people access it? How can the product be promoted? What appeals, format, and content attract people's attention and reach them effectively?

Models of patient-centred communication functions

The paternalistic idea of a hierarchical relationship, with professional distance and underpinned by a consumerist approach is still the norm. In comparison, a patient-centred relationship encourages patients (clients) to see themselves as consumers of health care, while providers are trained to expect an assertive patient (Holman & Lorig, 2000; Glanz, et al. 2008).

Health literacy is an individual's capacity to obtain, process, and communicate information about health and is needed for patient self-management. Social distance is the number and importance of dissimilarities between providers and clients. It may be based on perceptions or objective indicators that do not necessarily have to match. The concept of patient preferences speaks to the fact that patients have varying expectations for their own role and that of the provider, often associated with socio-demographic and cultural characteristics.

Key questions include: What difference does it make to call patients clients? What advantage is there for physicians to have more assertive patients? How can physicians encourage patient self-management? What difference would social distance make to the client-provider relationship and also for health outcomes? What decisions should be made by the provider and what decisions can a client make?

Interpersonal level

Social learning theory/Social cognitive theory

These theories describe the dynamic interaction of the person, behaviour, and the environment in which the behaviour is performed. Five key factors can affect the likelihood that a person changes behaviour (Bandura, 2001; 2004; Glanz et al., 2005):

1. Knowledge of risks and benefits

2. Self-efficacy (confidence in one's ability to take action and overcome barriers)

3. Outcome expectations (the cost and benefits of adopting a behaviour)

4. Goals people set (and strategies for realising them)

5. Perceived social and structural facilitators and/or impediments/barriers to the desired change

The concept of reinforcement suggests that responses to a particular behaviour decrease or increase the likelihood of reoccurrence. In addition, the theory suggests that people learn through observing others performing actions and the benefits they gain through those actions, not just from their own experiences. This concept of modelling has been influential in developing entertainment education programmes.

Key questions include: How do people come to know about a given issue? How do people feel about their ability to practice certain actions? Who influences people's knowledge, attitudes, and behaviours? How can specific practices be reinforced/reminded/maintained? Who are credible role models who perform the targeted behaviour?

Theories of dialogue

Dialogue can be understood as a respectful orientation towards others and a way of raising consciousness about social realities (including inequality in power and economic relations). A dialogic approach of raising awareness through interpersonal contact is the opposite of one-way education whereby an expert transmits information to an empty/ignorant receiver/audience (Freire, 1993; Walton, 1998). Dialogue communication aims to achieve a connection that invites reflection and potential action.

Key questions include: What might a dialogic communication strategy look like? What should the role of the expert be in communication for social and behaviour change? What activities and processes can facilitate consciousness-raising and connection?

Individual level

Hierarchy of effects model

This model considers the effects of communication based in the practice of advertising (Chaffee &Roser, 1986). Together, these variables are referred to as KAB (knowledge, attitude, and behaviour). The aim is

for individuals to move up the hierarchy from knowledge through liking, preference and conviction towards behaviour (in the case of advertising, purchasing).

Key questions include: What knowledge and attitudes might lead to desirable behaviours? How do we know that specific behaviours might be changed if specific knowledge and attitudes are changed?

Theory of self-determination

Motivation to change behaviours happens along a continuum from being controlled by others (external motivation) to being able to self-determine (internal motivation). Internal motivation leads not only to more enjoyment of a behaviour change but also to persistence to maintain a new behaviour (Osbaldiston & Sheldon, 2002).

Key questions: Do people feel that they or others control decisions about specific behaviours? Do people believe they can change or promote changes? Have people effectively promoted and achieved positive change? If so, which ones?

Theory of human motivation

Maslow's hierarchy of needs provides some reference to understand the barriers to change for any behaviour. The hierarchy highlights how humans must first meet basic physiological and safety needs (food, water, shelter, etc.) before addressing other needs such as social relations, esteem, or self-actualisation (e.g. a fulfilling career) (Maslow, 1943).

The success of behaviour change interventions may be limited in circumstances/contexts where people are focused on meeting basic needs or have other priorities.

Key questions include: What are people's perceived priority needs? What are their most urgent needs around specific issues (e.g. health, education)? Is it possible to present the promoted change in terms of existing perceived priorities?

Stages of change/ Transtheoretical model

This model focuses on stages of individual motivation and readiness to change behaviours (Glanz et al., 2005; Glanz et al., 2008.):

- Pre-contemplation: individual has no intention of taking action within the next six months.
- Contemplation: individual intends to take action in the next six months.
- Preparation: individual intends to take action within the next 30 days and has taken some behavioural steps in this direction.
- Action: individual has changed behaviour for less than six months.
- Maintenance: individual has changed behaviour for more than six months.

Key questions include: What are the different stages across several groups in a community concerning proposed changes/issues? Are there any obvious explanations to understand such differences across groups? How can stage transition be promoted? What motivates people to act to maintain behaviour change? Can those factors be tapped into to promote changes among peoples in other, previous stages?

Theory of planned behaviour

This theory posits that behavioural intention is the most important determinant of behaviour (Ajzen, 1985). Behaviours are more likely to be influenced when: individuals have positive attitudes about the behaviour; the behaviour is viewed positively by people who influence the individual (subjective norm); and the individual has a sense that he/she can control the behaviour (perceived behavioural control).

Key questions include: How likely are individuals to perform behaviour? Are individuals opposed to the behaviour? Why do some individuals have positive or negative intentions? What might motivate people to have positive attitudes?

Health belief model

This model highlights an individual's perceptions of: i) their vulnerability to a health condition; ii) the severity of the health condition; iii) the benefits of reducing or avoiding risk; iv) the perceived barriers (or costs) associated with the condition; v) the cues that may activate a readiness to change; and vi) confidence in their own ability to take action (Glanz et al.,2005; King, 1999).

For example, in the case of HIV prevention, an individual must: believe they are at risk for HIV/AIDS; believe that HIV/AIDS is serious and deadly; believe that avoiding HIV/AIDS is both worthwhile and possible; and feel and be able to take preventative measures.

Key questions include: What populations are at risk? What is their level of risk? Why do people believe that they are at risk while others do not? How do risk perceptions match objective risk? What perceived barriers and benefits for practicing specific behaviours exist? What actions can be promoted to reduce risk and risk perception? Are there groups who seem ready to change/practice new behaviours? Do people understand how change is possible, if so, what needs to happen?

Open theory models

The behaviour change wheel

The Behaviour Change Wheel (BCW) was developed from 19 frameworks of behaviour change identified in a systematic literature review (Michie et al., 2011). It consists of three layers. The central hub identifies the sources of the behaviour that could prove fruitful targets for intervention. It uses the COM-B ('capability', 'opportunity', 'motivation' and 'behaviour') model, which recognises that behaviour is part of an interrelated system. Interventions need to change one or more of these components in such a way that will minimise the risk of it reverting.

Figure 1: Behaviour Change Wheel
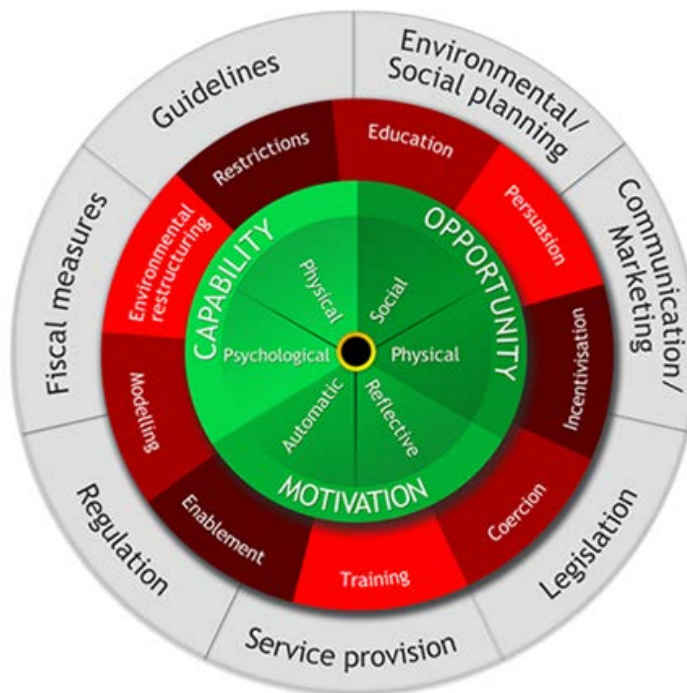
Source: Michie et al., (2011: 7)

The second layer includes nine intervention functions to choose from, based on the particular COM-B analysis undertaken. The outer layer, the rim of the wheel, identifies seven policy categories that can support the delivery of these intervention functions.

Key questions include: How does judgement influence the second layer (intervention functions) and the outer layer (policy categories)? While the framework appears to be comprehensive and can be used to characterise interventions, what difficulties arise during its practical application?

3. Behaviour change in international development

The World Bank (2015) comment that policy making involves assumptions about human behaviour; public policy typically subsidise and publicise certain activities considered worth encouraging, while taxing those which are viewed as requiring discouragement. Underlying this approach is the notion that human behaviour arises from rational choice. Policies arising from this perspective focus on changing the benefits and costs of individual actions and have proven effective in many domains. However, research on decision making and behaviour change has cast doubt on the extent to which people make choices in these ways. Applying recent findings on human decision making and behaviour, the World Bank (2015) have developed a framework for affecting behaviour change that relies on three principles:

Thinking automatically. Much thinking is automatic. Deliberative thinking, in which the value of available choices is weighed up, is less common. Minor changes in the immediate context in which decisions are made can have disproportionate effects on behaviour.

Thinking socially. Human beings are deeply social, institutions and interventions can be designed to support cooperative behaviour. Social networks and social norms can serve as the basis of new kinds of policies and interventions.

Thinking with mental models. When people think, they generally do not invent concepts. Instead, they use mental models drawn from their societies and their shared histories. Societies provide people with multiple and often conflicting mental models; which one is invoked depends on contextual cues. Policies and interventions to activate favourable mental models can make people better off.

The World Bank (2015) concludes that interventions need to take into account the specific psychological and social influences that guide decision making and behaviour in a particular setting. That means that the process of designing and implementing effective interventions needs to become a more iterative process of discovery, learning, and adaptation. What matters is not only which policy to implement, but also how it is implemented.

The translation of theoretical methods to specific contexts, populations, cultures is often challenging. This distinction between theoretical methods and practical applications is crucial for two reasons:

1. Evidence of the effectiveness of behaviour change methods is generally only available for generic behavioural methods.

2. Behaviour change methods are only effective if the parameters for effectiveness are met. Intervention descriptions are incomplete when they do not describe both which theoretical methods they use and to which practical applications these were translated.

Finally, behaviour change and how to achieve it raises ethical question regarding whether it is right or proper to change behaviours and in what instances change is mandated. Society may mandate existing or recommended behaviours itself. Further, if the recommended behaviour is absent, then the more appropriate term to use may be "behaviour development" rather than "behaviour change". Ideally the causes of non-optimal behaviour (for example in relation to health or development) should be understood and addressed (UNICEF, 2005: 7).

UNICEF - Communication for Development (C4D)

UNICEF (2005) notes that good communication strategies use concepts that range from psycho-social learning theories of role modelling communicated via the mass media, to the use of advocacy and social mobilisation. Dialogue with, and active participation of, individuals are considered essential elements in communication for behaviour and social change. Many communication programmes focus attention on the individual as the locus for change, however, UNICEF (2005) suggest that harmful cultural values, societal norms and structural inequalities have to be taken into consideration for behaviours to change on a large scale. Good communication strategies also have to be mindful of the policy and legislative environment and be linked to service delivery. For example, immunisation booths or confidential counselling services for people living with HIV (UNICEF, 2005: 5).

UNICEF (2005) suggests that the discourse of "behaviour change" must be linked to "social change". While behaviour change implies individual level change, social change seeks to create an enabling environment for change:

Behaviour change is a research-based consultative process for addressing knowledge, attitudes and practices. It provides information and motivation through strategies using a mix of media channels and participatory methods. Behaviour change strategies focus on the individual as a locus of change.

Social change focuses on the community as the locus of change. It is a process of transforming the distribution of power within social and political institutions. For behaviours to change, certain harmful cultural practices, societal norms and structural inequalities have to be considered and addressed.

Communication for social change is a process of public and private dialogue through which people define who they are, what they want and how they can get it. Behaviour and social change have often been seen as distinct approaches, requiring different strategies and unique skill sets. UNICEF C4D sees them as complementary techniques used to define and address individual and social influences.

UNICEF (2005) concludes that a sound behaviour development communication strategy (or programme communication) should be linked with overall programme frameworks. These strategies are aimed at changing knowledge, attitudes and practices of participant groups and stimulating and facilitating wider social change at local and national levels. Behavioural change communication therefore involves the use of qualitative and quantitative research data, disseminating information and measuring change in peoples' attitudes and behaviours. Information need not be limited to factual knowledge. It also covers behaviour modelling, self-efficacy and empowerment of the people. Past programmes have demonstrated that behaviour development strategies are more successful when they are tied to social mobilisation and advocacy strategies. Furthermore, such strategies are incomplete unless their impact is measured against the programme objectives.

Behaviour change communication in emergencies: toolkit

UNICEF (2006a) note that many communication efforts launched in emergency responses, such as those following the 2004 tsunami, focus on media advocacy and public information. Such communication efforts cater to policy makers, donors and the general public and are designed for advocacy, fund-raising and public awareness of the general situation. UNICEF (2006a) call for a holistic communication strategy that caters as much to the communication needs of affected families through interactive behaviour change communication and social mobilisation. They view behaviour change communication as a necessity as it ensures that the most vulnerable have access to accurate and instrumental information about proper practices, available services and supplies that provide sustenance, prevent disease, harm, abuse and exploitation.

UNICEF (2006a) concludes that information alone is insufficient to support behaviour change. Influencing healthy behaviours and creating a supportive social environment in an emergency situation requires that stimulation of learning and participation through regular dialogue with the affected community. This type of behaviour change communication and social mobilisation works best when actions, messages and materials are strategically planned, managed, monitored with the affected communities and supported by the necessary financial and human resources.

USAID: C-Change

The C-Change Project was designed to provide support to USAID missions and their partners in designing, planning, implementing and evaluating communication activities. It was also designed to support the development and dissemination of communication innovations, best practices and lessons learned. C-Change[2] employs the following strategic approaches to achieve the outcomes outlined below:

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[2] https://www.c-changeprogram.org/

- Identify and influence the social determinants of behaviours. A key component of the C-Change approach is to bring about positive behaviour change by shifting social norms that may require addressing gender roles and cultural practices.

- Improve the quality of social and behavioural change communications (SBCC) interventions and streamline approaches and tools. C-Change streamlines formative research and pre- and concept-testing methods and creates frontline teaching tools and hands-on, skills-based training.

- Build the capacity of local institutions, including NGOs, CSOs and FBOs. C-Change increases local institutions' ability to plan and implement SBCC approaches by strengthening both their technical and program management skills.

- Conduct research and improve monitoring and evaluation to inform programme development and implementation. C-Change identifies and examines how programmes can utilise social determinants of behaviour, social norms and social networks that influence and reach beyond the individual.

- Engage the media as a partner. C-Change involves journalists and other media professionals as full partners in the process of social change.

- Achieve scale and sustainability. C-Change assists programs to achieve scale by engaging and strengthening existing institutions and social networks and building program coalitions.

C-Change expected programme outcomes:

- **Evidence-based communication programs carried out at scale**. C-Change seeks to achieve large-scale, population-based impact by applying integrated communication approaches at national and regional levels. Major strategies include:
    - Enlisting and strengthening the SBCC skills and programs of NGO networks.
    - Engaging the media to stimulate social action.
    - Strengthening district and community planning for SBCC.
    - Building system-wide coalitions and commitment to SBCC programs.

- **Communication skills and knowledge transferred to developing country institutions**. In countries where the program operates, C-Change seeks to build the capacity of NGOs and networks, using a competency-based approach to training that includes both technical and management skills. Activities include:
    - Developing and strengthening communication courses in academic institutions.
    - Developing local networks of communication excellence among research institutions, advertising and public relations firms and NGOs.
    - Supporting the design of tailored SBCC strategies with measurable benchmarks.

- **Information and research in communication applied to implementation**. Through its research agenda, C-Change is generating lessons learned to improve communication for behaviour and social change. A critical challenge for C-Change is how to best integrate findings from research, implementation, and evaluation activities to facilitate social change. Major cross-cutting research questions include:
    - Understanding how social norms change and developing ways to facilitate this change.
    - Improving interaction and communication among organisations around common goals and building social capital.

- o   Demonstrating the application of innovative social change approaches.
- o   Developing valid, reliable indicators.

FHI360: Social and behaviour change communication

FHI 360 (nd) use a socio-ecological lens to view the complex interplay between individual, interpersonal, community, and societal factors that affect behaviours. They select interactive, participatory strategies to ensure a holistic view of people's desires, needs, and barriers and facilitators to change. They employ the following tools and approaches to inform their projects (FHI 360, nd):

- Theory-based socio-ecological model recognises the relationship between people and their environment. It allows the identification of tipping points for change.

- Small, doable actions (SDAs) are behaviours that, though not ideal, are more likely to be adopted because they are considered feasible by individuals and are effective from a public health perspective when practiced consistently and correctly.

- Full market impact leverages investments from commercial partners to expand the availability and affordability of health products and presents motivations for their uptake.

- Interactive SBCC research techniques ensure a better understanding of people's needs and preferences. Participatory action research and media, ethnographic methods, value systems research, and commercial marketing techniques are some of their tools.

- User-centred design approaches are infused into their work and ensure that the end-user is a part of intervention design, formative research, prototyping, and implementation.

Action Aid: Stepping Stones

Stepping Stones (ActionAid, 2006: 6) is a participatory training package. It was designed in the mid-1990s specifically to address the prevention and spread of HIV and AIDS in sub-Saharan Africa and increase the care of people living with HIV and AIDS (PLWHA) at the community level. It did so through promoting communication and relationship skills within households and communities. Stepping Stones aimed to enable individuals and communities to find their own solutions to the threat of HIV&AIDS, both avoiding it and coping with the reality of AIDS. It focused on filling gaps and addressing the shortcomings of the most prevalent HIV&AIDS messages, which were and continue to be focused on the dangers of AIDS, promoting the ABC (abstinence, be faithful and use condoms) approach to prevention. The theory underlying the training package was based on an understanding of how people learn to change their behaviour and make sustainable changes.

Stepping Stones recognised that sexual relationships lie within a broader context of relationships with sexual partners, to include families and the community or society in which one lives. These influences often substantially determine behaviour. The Stepping Stones workshop series note that individuals often have knowledge that they should make changes to their lives (e.g. using condoms), but are not able to do so because they do not communicate well with partners, fear violence or abandonment, or think their culture or religion does not allow them to.

Stepping Stones is a communication tool developed to initiate and sustain meaningful dialogues around sexual attitudes and needs. It was designed both for use in existing HIV/AIDS projects and in general community development projects which plan to introduce an on-going HIV and sexual and reproductive health (SRH) component. While it was developed specifically in response to growing communication

needs in Uganda, the tool has been tailored to other parts of Africa, Asia and the Caribbean in order to reinforce messages previously designed and supporting behavioural change.

ActionAid (2006) note that findings on behaviour change were strong, with most reviews referring to positive changes in behaviour such as: a greater take up of condoms; more respect for women; less domestic violence; respect for women to refuse sex within marriage; better communication between couples and parents-children; and more co-operation around household chores and income. The caveats to these findings are that, again, they are often rather generalised, based on self-reporting or observation soon after training ends, and the changes are not explored in any detail.

4. Behaviour change in Karamoja, Uganda

As noted by Avis (2016), the Karamoja context has been shaped by a complex range of conflict and security dynamics linked to governance, social, cultural and development issues with the majority of people coping daily with high levels of vulnerability. Decades of cyclical conflict, and marginalisation from central government strategies, have left the Karamoja population at severe disadvantage. Protracted and endemic armed violence, violent conflict, illicit small arms proliferation and insecurity, alongside environmental degradation, have afflicted the region. A by-product of this has been the undermining of traditional lifestyles and livelihoods and an increasing sense of social dislocation and cultural depression (Crawford, 2016).

The protracted crisis in the Karamoja region has had an impact on notions of manhood, particularly the need for status, pride, associated prestige and respect within the community from being able to marry, and of being wealthy with many cattle. The increased inequality within and among communities in the region and the erosion of cattle-based livelihood roles have, for many young men, acted as negative forces on their self-worth and status; these may also be important drivers of violence and crime.

Stites et al. (2016) suggests that livelihoods in Karamoja continue to change as security improves; this includes a revitalisation of pastoral production for some households and a diversification of livelihoods for others. They also note that, broadly, animal ownership has declined substantially over the past ten years as a result of the poor conditions in the protected kraals, which arose during the disarmament process. Rebuilding herds has been difficult, particularly in the context of high rates of animal disease. Some former livestock owners have opted out of pastoral livelihoods by choice or force; some of these households are now participating in cultivation.

This study concludes that whilst pastoralism is rebounding in Karamoja despite decades of insecurity and the encouragement of sedentarisation, challenges to the full recovery of animal-based production systems include: substantial inequity in livestock ownership and holdings; poor animal health and an overall lack of preventive and responsive treatments; inconsistent access to water and pasture; and a dearth of pro-poor and pro-pastoral policies in Karamoja (Stites et al., 2006).

Efforts to affect behavioural change within the Karamoja context have focused on targeting interventions, principally around nutrition, health and hygiene. There are number of programmes that investigate or seek to affect behaviour change:

Trials of improved practices in Karamoja: Investigating behaviours of nutrition and hygiene

Concern's Resiliency through Wealth, Agriculture and Nutrition in Karamoja (RWANU) programme commissioned trials of Improved Practices (TIPs). It is a formative research method designed to test the feasibility and acceptability of practices at the household level that a programme plans to promote:

- **Dietary diversity**. Caregivers give foods that are high in vitamin A, iron, and protein.
- **Hand washing**. Caregivers wash hands at the 5 critical times: 1) Before preparing food, 2) Before eating, 3) Before feeding a child, 4) After defecating, 5) After cleaning a baby's bottom
- **Designated defecation**. Caregivers create a designated space (a fenced area at least 50 metres away from water points) for entire family, and identify a place to defecate just outside of the manyatta at night times if insecurity is a concern.

The TIPs final report (Fernandes, 2013) highlighted that caregivers were willing to increase the diversity of a child's diet if the foods were affordable. It was also easy and time saving for the mothers to incorporate additional foods in a child's daily porridge. Practical demonstrations motivated hand washing practices, and the practice of latrine usage and digging and burying was more acceptable than designating a space for defecation for the entire family. Participants also requested community support for promoted behaviours related to designated defecation.

The outcomes of the TIPs research demonstrate that the RWANU programme should promote the three nutrition and hygiene behaviours of dietary diversity, hand washing, and designated defecation using specific, small doable actions (SDAs) identified in the research process (Fernandes, 2013).

- For dietary diversity: TIPs results show that fortifying porridge with a variety of additional foods was easy and time saving for caregivers, and creating a more diverse diet for a child depended on the affordability and accessibility of food items.

- For hand washing: participants washed their hands at the five critical times in order to eliminate germs and illnesses in the home. Hand washing demonstrations, including tippy-taps, had a positive effect on the motivation of mothers as well as neighbours.

- For designated defecation: most mothers were willing to dig and bury. However there are many constraints such as lack of effort or interest, and a common request for community support, especially from decision makers who have the final say on financial matters in the home and elders or leaders who have the power to approve and disapprove of social norms.

The final report noted that the TIPs process revealed positive responses to and appreciation of the repetitive house visits and counselling sessions, providing the caregivers with moral support and increasing motivation to carry out the new practices (Fernandes, 2013). This highlights the need for counselling and negotiating skills to be emphasised in future training for behaviour change activities.

Northern Karamoja Growth, Health and Governance Program

Studies conducted in the region have shown that the health and nutrition situation requires significant improvement (World Vision, 2013). According the Uganda Demographic and Health Survey (2011) the Karamoja region had the highest chronic malnutrition levels among children 6-59 months (in Uganda) with severe stunting at 23.5% and moderate stunting at 45%.

Most of these indicators are considered to stem from poor health-related behaviours and practices of community members. World Vision (2013) sought to develop appropriate behaviour change strategies so that the priority groups in project communities could adopt better health-promoting behaviours. The programme aimed to analyse existing barriers and enabling framework for prioritised Maternal Child Health and Nutrition/WASH behaviours. A barrier analysis survey methodology was first conducted to inform the process.

Barrier Analysis is a rapid assessment tool used in community health and other community development projects to identify behavioral determinants associated with a particular behavior. These behavioral determinants are identified so that effective behavior change strategies and appropriate supporting activities can be developed. It focuses on twelve perceived determinants: self-efficacy/ skills; positive and negative consequences; social norms; susceptibility; severity; action efficacy; access; cues for action/ reminders; perception of divine will; policy; culture of the behavior. For each behavior, at least 45 people who practice the behaviour (doers) and 45 who do not (non-doers) are studied and compared.

Based on the barrier analysis survey eight behaviours were identified that should be promoted:
- Hand washing with soap or ash at five critical moments among mothers of children <24 months,
- Latrine use for defecation among household heads,
- Frequency of meals given by mothers/caregivers to children ages 6 – 23 months,
- Exclusive breastfeeding for children 0 – 6 months,
- Lactating women eating more each day than they did before pregnancy,
- Facility-based delivery among mothers of children <24 months,
- Antenatal care attendance at least 4 times during pregnancy among mothers of children <12 months,
- Use of family planning method among women 15 - 49 years.

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