



**ACF-INTERNATIONAL  
MANUAL**

# **ABC - ASSISTING BEHAVIOUR CHANGE**

**PRACTICAL IDEAS AND TECHNIQUES**

Designing and implementing programmes in ACF using an ABC approach



**PART 2**





# **ABC**

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using an ABC approach

## **PART 2**

## **PRACTICAL IDEAS AND TECHNIQUES**

December 2013  
*Scientific and Technical Department*

Action contre la Faim-France



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## 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>TBA</b>	Traditional Birth Attendant
<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 2

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

This manual has been created in order to provide ease of access to the concept of behaviour change, and to provide aide in cases in where there is a lack of information or knowledge about an issue, and this has been identified as a main barrier to the adoption of a new behaviour.

Throughout the second part of this manual we will show that complex behaviour change initiatives have to be developed at both the mass communication level, as well as at other levels such as the family and group a using interactive methods (community narratives and events, discussion and support groups, role-playing, etc.) as well as individual counselling.

Different settings and techniques (learning groups, discussion groups, support groups; role-play, simulations, psychodrama, etc.) can be adapted to facilitate the proposed objectives and to support the most diverse practice and behaviour change efforts, at various levels, and mass media campaigns, if well developed, can help to disseminate information and knowledge to large numbers of people, and to give regular "cues to action" to people and communities involved in the behaviour change process.

This is an intervention focused on the individual who encounters problems in changing behaviour because of lack of information or knowledge or low self-efficacy, relationship and communication problems with other members of his family or social group (lack of social support) or mild personal psychological difficulties related to fear, anxiety, stress, depressive symptoms etc.







# I. INTRODUCTION AND KEY THEORETICAL CONCEPTS





How can we increase the rates of exclusive breastfeeding in areas where bottle-feeding and infant formula carries 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.

## 3. WHO IS THIS HANDBOOK FOR?

The 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 with 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.
- **PART 2** - Practical methods. (you are currently reading this part!)



Those who are interested in the more practical aspects of how to intervene should go directly **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.

**PART 1** is also useful if you are required to carry out technical training sessions.

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.

The glossary, ten step model and ACF's position on behaviour change appear in both parts of the handbook and familiarization with the common terms and ACF's position provides the basis for understanding how to use the practical tools in **PART 2** of the handbook.

## 5. HOW THEORY INFORMS PRACTICE FOR ACF

The research and models outlined in PART 1 describe the complexity of human behaviour and the subtle interplay of the different variables that are involved in the development, adoption or rejection of a specific behaviour. Identifying and analysing these variables in their actual context (social, psychosocial, cultural, etc.), both at the individual level and the group or community level, is an essential step for all interventions.

Consequently, it would be simplistic and unacceptable to view behaviour change as an approach that could be duplicated in exactly the same way in different contexts and for different groups of individuals.

**The main conclusions that can be drawn from the theoretical review are:**

- ACF promotes a bottom up approach to behaviour change where individual or groups in the community are actors of change and not just passive targets of BC interventions delivered from the top down. The role of ACF and its teams is to encourage, support and facilitate the process.
- ACF does not favour a specific behaviour change technique (e.g. positive deviance, behaviour change communication etc.), but prefers to adopt a holistic approach to behaviour change that has several key steps and uses a variety of methodologies adapted to the specific context.
- Knowledge, attitude and behaviours are not necessarily linked in a linear fashion and the dissemination of information does not on its own lead to behaviour change
- As the “theory of planned behaviour” illustrates, a variety of psychological and social variables (such as beliefs, norms, perceptions etc.) limit the direct link between knowledge and behaviour.
- The complexity of behaviour and of the process of behaviour change is evident and we must take into consideration the influence of the different variables, related to the local socio-cultural environment and individual psychology.
- Assessment of the local context, including: the perception and understanding of behaviours at the individual and group level, perceived needs, capacities, constraints, social norms etc. This assessment is a crucial step in successfully implementing behaviour change initiatives.
- Awareness and education are part of the BC process but are not sufficient to ensure effectiveness since they focus mainly on knowledge and attitude and not on the behaviour itself. Other factors involved in the BC process should also be addressed in the intervention.
- It is important to include activities that recognise the influence of peer groups and community and family members.



- It is also important to incorporate direct experience of the new behaviour or practice.
- Helping the target population to increase its perceived self-efficacy towards a situation or issue is an important factor in behaviour change.
- Interventions that emphasize a threat (e.g. that encourage fear of sickness) may bring a superficial change of attitude or even resistance to change.

## 6. BEHAVIOUR CHANGE MYTHS

As already outlined in PART 1 it is important to challenge some of the myths about behaviour change. The table below reminds us what BC is and what it 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.

## 7. GLOSSARY

The glossary defines some of the terms and concepts related to behaviour change that are used in the handbook.

Many terms are in common usage but their technical definition, as outlined by the behavioural sciences, is sometimes slightly different.

### 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”<sup>1</sup>) 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

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

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

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”.

## 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 6.4 and 6.5.

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



## 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 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 instance, we might provide information, research data, examples and experiences to change a negative attitude about latrine use.

### 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)





## II. THE ACF 10-STEP MODEL<sup>5</sup> FOR ABC



ACF has developed a 10-step model, to present and explain its approach to assisting the BC process (ABC). 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.

<sup>5</sup> - Please, refer also to the ACF-In Position Paper on assisting BC- 2013



### ACF 10- STEP MODEL FOR ABC

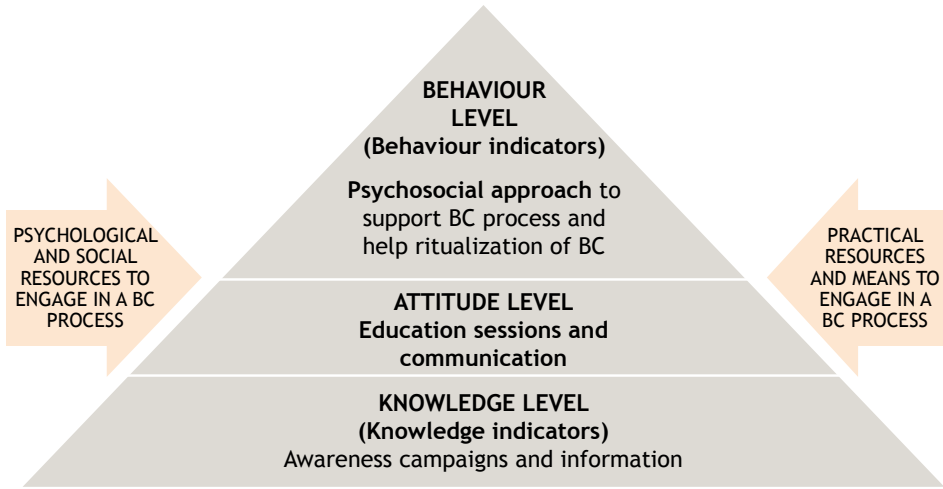
1.	<b>Analysis of way of life and current practices</b> Understanding the context and the reference points of our population: what are their practices, and the meaning and the consequences of these practices on the community and on individuals' lives?	A N A L Y S I S
2.	<b>Analysis of community perception of the problem</b> What is their perception of what we consider "the problem"? 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, because it provides a useful reflection of 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 to the process of change? What are the benefits already perceived? Who are 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	D E S I G N
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 7.8 of Part 1)	M O N I T O R I N G & E V A L U A T I O N
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.	

# 1. FIELD IMPLEMENTATION

ACF's approach to ABC 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; the intervention cannot be classed as a behaviour change initiative without them. The phase of assessment, first step of the process, is crucial and necessary to identify at which level of intervention we should start working. Not always the knowledge level and the awareness sessions step are the first steps of intervention since the population is maybe already well informed and sensitized. So there is no need to provide information sessions but the need is mainly to support the adoption of new behaviours.

- 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) if knowledge is insufficient or incomplete. 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.).

## 2. THE PYRAMID OF INTERVENTION



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



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### 3. 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 are implementing this kind of intervention need to be able to assess people's practices, the way of life and context and other socio-cultural variables and how these 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, generalists could provide the initial assessment, awareness and education campaigns, 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 sectoral team.
2. If the BC is a programme or initiative in itself with the aim of improving or reinforcing or changing practices (related to care, health, nutrition, or hygiene.), the programme should be implemented by the MHCP teams, that have the appropriate, required expertise in behaviour change, and are trained and supervised by the BC specialist (with a psychosocial background).

### 4. 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.

## 5. 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 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.



### III.

# PROCEDURES, TECHNIQUES AND TOOLS FOR ASSESSING, DESIGNING, IMPLEMENTING AND MONITORING ABC PROGRAMS



*«I hope to have the strength, to help change what it is possible to change;  
the patience, to accept the limitations of what I cannot change;  
and above all the intelligence, to discriminate between the two...»*

*Reinhold Niebuhr*



This section will focus on both general approaches and specific methods to assess and facilitate behaviour change.

Some key methodological issues will be analysed, and some techniques for carrying out assessments and interventions will be explained.

Techniques for planning and evaluation will also be explored.

This section is USEFUL to help design and develop interventions with an ABC objective, that focus on work with communities, groups and individuals.

### Let's go back to the ACF 10 Step Model for ABC:

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 our population: what are their practices, and the meaning and the consequences of these practices on the community and on individuals' lives?	A N A L Y S I S	FOR THIS PHASE REFER TO PARAGRAPH 3.2
2.	<b>Analysis of community perception of the problem</b> What is their perception of what we consider "the problem"? 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, because it provides a useful reflection of 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 to the process of change? What are the benefits already perceived? Who are 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.	D E S I G N	FOR THIS PHASE REFER TO PARAGRAPH 3.3

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 7.8 of Part 1).	M O N I T O R I N G & E V A L U A T I O N	FOR THIS PHASE REFER TO PARAGRAPH 3.4
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.		

In the following paragraphs you will find several techniques, exercises, practical methods that may help you to make operational each phase described in the ACF ABC Model. The techniques’ presentation is not exhaustive and you can create, learn, and adopt new techniques according to your objectives and competencies. Be creative, adapt them to your program and context of intervention and use them according to your needs. But be careful: an approach of ABC is not a package of defined techniques, proposed at a certain time and to certain target groups. An approach of ABC needs to be thought according to the context analysis and to the shared objectives. The techniques and the exercises are the means to facilitate the process, attend the objectives and promote behaviour change but they cannot be thought as an approach in itself.

## 1. GENERAL OVERVIEW ON TECHNIQUES AND TOOLS

### 1. GENERAL ISSUES

It is important to take the following issues into account when employing the assessment and implementation techniques on the following pages:

- **Triangulation:** this refers to the coherent implementation of multiple and coordinated methods in order to verify or confirm assessment data and information. Whilst different methods are useful for understanding different issues, there is often an overlap in some of the information obtained that can confirm the findings revealed by other methods. This can help to overcome the bias that is associated with using only one method or having only one assessor. At the same time the use of different methods can draw on synergies to deepen the understanding of a particular issue.



- **Saturation principle:** the collection of qualitative data can be stopped when no new information are collected anymore. After a certain number of interviews, FGDs we can notice that no more useful information emerge. This helps us to understand that our knowledge about the topic is good enough to stop the data collection.
- **Facilitators’ training:** all staff that will be using these techniques must be well trained and supervised so that they are confident in their use and the quality of assessment and implementation is assured.
- **Exploratory vs. standardized approaches:** it is initially recommended that a more open, unstructured and qualitative approach is used, in order to understand the relevant psychosocial processes in greater depth (exploratory phase). In the second phase, it is possible to use more “closed”, standardized, structured approaches that allow for quantitative comparison.
- **Intervention-induced biases:** implementers should be aware that the use of certain techniques, or the even the mere knowledge of being involved in an intervention can lead to people or groups modifying their reported or actual behaviour or reported social variables. In these cases, the self-reported information tends towards a bias for social desirability.<sup>6</sup> The use of qualitative and participatory methodologies alongside quantitative ones, the active involvement of many different stakeholders and social subgroups and the triangulation of methods and can help to reduce and mitigate the risk of bias.

## 2. HOW TO CHOOSE A TECHNIQUE

In the following section we will present several techniques and tools that may be useful to ACF field workers to help them design and implement assessments and programme for promoting and supporting BC.

As we said the list does not claim to be exhaustive; many other techniques could have been chosen but these represent some of the tools that have been useful in ACF programmes. However, you are not limited to these techniques, and you are welcome to use your creativity to identify new tools, on your own or in conjunction with local staff and communities. Help from the MHCP team is also available to help you identify the most appropriate tool to use.

Once again it is important to stress that ACF favours the application of an holistic and comprehensive approach more than the use of a specific technique that is used slavishly. An approach should not be reduced to a technique even if we know that it has a positive impact with the target population. A technique on its own cannot address all of the determinants of behaviour and the process of change. A cocktail of techniques, procedures and tools should be identified according to the context and the needs and adapted to suit the change process .

The table below may be useful to help identify and chose the appropriate techniques according to programme objectives and targets. All the techniques are detailed in the following pages.

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<sup>6</sup> - People may also express and show a “stronger-than-usual” involvement in proposed activities, local leaders tend to show the better side of things and to impose their own “vision” and representations on the situation, etc.

OBJECTIVES	TARGET			
	COMMUNITY	GROUPS	FAMILIES	INDIVIDUALS
ASSESSING the context and target population in an ABC programme	<ul style="list-style-type: none"> <li>• Secondary data</li> <li>• Stakeholders analysis</li> <li>• Community interviews</li> <li>• Observations</li> </ul>	<ul style="list-style-type: none"> <li>• FGDs</li> <li>• Observations</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews</li> <li>• Observations</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews</li> <li>• Observations</li> </ul>
ASSESSING behaviours, barriers and resources for change	<ul style="list-style-type: none"> <li>• Community maps</li> <li>• Timelines</li> <li>• Future trend timeline</li> <li>• Ranking technique</li> <li>• Triple task method</li> <li>• Rich picture</li> </ul>	<ul style="list-style-type: none"> <li>• Problems tree</li> <li>• ABC technique</li> <li>• Venn diagrams</li> </ul>	<ul style="list-style-type: none"> <li>• Problems tree</li> <li>• ABC technique</li> </ul>	<ul style="list-style-type: none"> <li>• Problems tree</li> <li>• ABC technique</li> <li>• Social network charts</li> <li>• Future trends timeline</li> <li>• Life timeline</li> </ul>
IMPROVING knowledge/ attitude	<ul style="list-style-type: none"> <li>• Media communication</li> <li>• Community narratives and story telling</li> </ul>	<ul style="list-style-type: none"> <li>• Child to Child</li> <li>• Peer education and peer-based approach</li> <li>• Learning groups</li> <li>• Discussion groups</li> </ul>		<ul style="list-style-type: none"> <li>• Counselling</li> </ul>
IMPROVING behaviour/ practices	<ul style="list-style-type: none"> <li>• Advocacy and inputs in legislation at local and national level</li> </ul>	<ul style="list-style-type: none"> <li>• Child to Child</li> <li>• Discussion groups</li> <li>• Support groups</li> <li>• Behavioural simulation and rehearsal</li> <li>• Hot seat</li> <li>• Psychodrama</li> </ul>	<ul style="list-style-type: none"> <li>• Family support and home visits</li> <li>• Family development approach</li> </ul>	<ul style="list-style-type: none"> <li>• Support counselling</li> <li>• Motivational interviewing</li> <li>• Personal representation</li> <li>• Hot seat</li> </ul>
MAINTAINING the new behaviour - ritualization process		<ul style="list-style-type: none"> <li>• Behavioural simulation and rehearsal</li> <li>• Practical home exercises between sessions</li> <li>• Notes on agenda/daily diary</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioural simulation and rehearsal</li> <li>• Practical home exercises between sessions</li> <li>• Notes on agenda/daily diary</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioural simulation and rehearsal</li> <li>• Practical home exercises between sessions</li> <li>• Notes on agenda/daily diary</li> </ul>

## 2. ASSESSMENT AND FORMATIVE RESEARCH - STEP 1 TO 6 OF ACF ABC MODEL

Before going into a detailed description of the tools and techniques for assessment, here is a quick reminder of the first 6 steps of the ACF-10 steps Model for BC that relate to analysis of the context.

1.	Analysis of the way of life and practices	A
2.	Analysis of problem perception	N
3.	Analysis of causal attribution	A
4.	Analysis of change phase	L
5.	Analysis of behaviour and its determinants	Y
6.	Analysis of barriers, benefits and resources for the BC process	S

Five main points need to be considered in order to make an assessment for an ABC intervention:

- 1) Context analysis,
- 2) Target behaviour definition and analysis,
- 3) Perception and interpretation of target behaviours,
- 4) Change agents analysis,
- 5) Barriers and resources for change.

The following table lists each of these operational steps, with the corresponding assessment techniques that could be used and that you will find detailed in the next pages.

This kind of in depth assessment and analysis is also called **formative research**. Formative research can be defined as: “Research conducted during the development of a programme to help decide on and describe the target population, understand the factors which influence their behaviour, and determine the best ways to reach them. It looks at the behaviours, attitudes and practices of target groups, involves exploring behavioural determinants and uses a myriad of methods to collect data. Formative research may be used to complement existing epidemiological and behavioural data, to assist in programme planning and design”.

### NOTA BENE

The assessment and data collection phase are already part of the change process. Some data collection techniques can be already used as first steps for involving people in the change process. Timelines exercise could for example help the participant to realize the changes affecting his/her life and the consequences of it. This awareness moment is a crucial (and necessary) step of the global process of change. So some of the techniques that we will now introduce can be also used for implementation purpose or even more for monitoring and evaluation objectives. So do not hesitate to use them for different purposes (but the objective need always to be clear and defined!) and to be creative in using them.

OPERATIONAL STEPS	POSSIBLE METHODS TO USE <sup>7</sup>
An approach	A specific technique
<p><b>1. Context analysis</b></p> <ul style="list-style-type: none"> <li>How is the target community organized? What social structures are in place?</li> <li>What are the relevant socio-cultural variables: main cultural issues, social norms, relevant traditional practices related to maternal and childcare, nutritional care or WASH?</li> <li>How do people perceive or feel the “need” or “opportunity” to change?</li> </ul>	<ol style="list-style-type: none"> <li>Secondary data analysis</li> <li>Community interviews</li> <li>Observation</li> <li>Coherence analysis; ABC technique (not to be confused with ACF ABC approach)</li> </ol>
<p><b>2. “Target behaviour” definition and analysis</b></p> <ul style="list-style-type: none"> <li>What practices need to change?</li> <li>What are the “negative outcomes” of the behaviour to be changed, in terms of public health?</li> <li>How exactly these “negative outcomes” are directly correlated to specific individual behaviours or social practices?</li> <li>Which specific behaviours or practices can be targeted to obtain the highest efficacy (high-leverage behaviours)<sup>8</sup>?</li> </ul>	<ol style="list-style-type: none"> <li>Epidemiological data</li> <li>Public health reports</li> <li>Field observation</li> <li>Interviews with health care personnel</li> <li>Ranking/laddering approaches, resistance-to-change grids</li> </ol>
<p><b>3. Perception of “target behaviour”</b></p> <ul style="list-style-type: none"> <li>What are the community’s social perceptions / social meanings associated with the targeted behaviours or practices?</li> <li>Are these practices perceived as “problems”? Is the direct link with their negative outcomes clear to the people involved?</li> <li>Do these practices appear “culturally coherent” or “necessary” from the point of view of the local cultural assumptions or social norms? How so?</li> </ul>	<ol style="list-style-type: none"> <li>Focus groups</li> <li>Interviews with “key witnesses”/local leaders</li> <li>Community narratives</li> </ol>
<p><b>4. “Change agents” analysis</b></p> <ul style="list-style-type: none"> <li>Who are the “change agents” for the targeted behaviours/practices - women/mothers? Local leaders? Heads of families?</li> <li>Who are the most marginal social stakeholders, and what are the specific barriers to their involvement in the behaviour change initiative ?</li> <li>Do they really have the knowledge, the social influence, or the psychological motivation to implement the proposed change? How can they be supported in this process?</li> </ul>	<ol style="list-style-type: none"> <li>PLA approaches</li> <li>Beneficiaries/stakeholders analysis</li> <li>Focus groups, discussion groups</li> </ol>
<p><b>5. Barriers to change and resources for change</b></p> <ul style="list-style-type: none"> <li>Why do people not perform a certain behaviour? What are the barriers?</li> <li>Is there a lack of economic or material resources? Or a lack of skills or information”?</li> <li>Do cultural meanings, social norms, and emotional and affective issues hinder the adoption of the new behaviour?</li> <li>Why do some people perform the target behaviour (despite being in a similar situation). What is their motivation?</li> <li>What social resources and cultural perceptions could be used to facilitate the change?</li> <li>Is the target group or population motivated to change and /or already in a process of change?</li> </ul>	<ol style="list-style-type: none"> <li>Focus groups, community interviews</li> <li>ABC technique/Rich Picture</li> </ol>

7 - More information on these methods and how to use them will be presented in the next sections.

8 - High-leverage behaviours are behaviours that have a direct link with the public health outcome, that are not too strongly “resistant to change” (implied by essential cultural elements), and that can be usefully generalized to other types of behaviour. Stokols, D. (1992). Establishing and maintaining healthy environments: Toward a social ecology of health promotion. American Psychologist, Vol 47(1), Jan 1992, 6-22.

## 1. GENERAL TOOLS FOR ASSESSMENT AND FORMATIVE RESEARCH<sup>9</sup>

This section provides more detail about specific methods, techniques and tools, derived from different behaviour change approaches.

These tools are useful to assess the context in which behaviour change initiatives take place and to assess behaviours and their potential for change. They are also useful for promoting and facilitating positive change.

Some tools are more suitable for the initial assessment, but they can also be adapted for use during the evaluation phase in order to compare results or to analyse qualitative outcomes.

Please take into consideration that for most of the techniques and tools here presented the staff needs to be properly trained and to have familiarity with social and psychological topics. In most of the presented techniques and exercises, the team will need to deal with sensitive topics and mechanisms ( such as self-efficacy, mutual support, resources identification...) so a proper training and a continuous supervision/technical support should be always planned.

### → A/ SECTION OVERVIEW

- Assessment techniques are very diverse in terms of objectives, methods and application contexts. Some can be used both for the initial assessment and also for ongoing monitoring and/or the final evaluation.
- Specific techniques are very useful for assessing the problems associated with a specific behaviour change and for understanding different stakeholders' perspectives.
- Participatory and representational or visual tools allow a broad analysis of local processes and procedures, in terms of the way situations are perceived, causal relationships and the perceived implications of various issues. They can be used to understand local social structures and dynamics, to study group dynamics and to encourage active discussion that reveals “local knowledge” about an issue.
- The heterogeneity of these techniques and tools can be confusing, but they are very powerful ways of learning about a situation. They need to be very carefully chosen and adapted to specific operational objectives.
- Not always do the change objectives of the population/group/individual correspond to the change objectives of the implementing agency. The phase of assessment and its techniques are also useful to (negotiate and) define together with the target population the objectives of change to be achieved. Acceptance and willingness to change by the population is essential and a basic requirement for the whole change process. This phase of objectives agreement with the individual (if individual work) or community (if community-based work) should be well cared of.

<sup>9</sup> - Formative research is an in depth assessment carried out at the beginning of a programme to help to shape the design of the intervention. It explores all of the different variables that might influence behaviour as well as identifying the key audiences or stakeholders and the best ways to work with them.

## → B/ SECONDARY DATA COLLECTION

### Definition:

The collection of secondary documents such as official documentation, previous field analysis/ reports, geographical, economic, socio-cultural data, epidemiological and public health data and analysis, technical documentation, grey literature.

### Objective:

To allow an initial “framework analysis” of the operational environment, and of the economic, territorial and socio-cultural variables influencing the development and maintaining of the behaviours that can have negative outcomes in terms of public health.

### Target / persons involved:

Programme implementation team.

### Method description:

Aside from the more “concrete” general data on the local environment, particular attention should be given to documents related to:

- The local social organization, data on local culture, beliefs, socio-cultural norms and social representations related to the targeted behaviour,
- The precise description of the target practice / behaviour to be changed, as well as the “history” of this practice,
- The situation, living conditions and social status of the group / community targeted for the intervention (or any other information about this community),
- The possible change agents,
- The level of control that the beneficiaries have over their living conditions and their capacity to make decisions about their lives,
- Field reports. These documents also offer the possibility of having discussions with international staff or local implementers who have previously worked in the same area or country or community.

## → C/ STAKEHOLDER ANALYSIS

### Definition:

The process of identifying those affected by an event and potentially involved in the BC process.

### Objective:

To allow a rapid analysis of the role of these different people or groups in the change process.

### Target / persons involved:

Programme implementation team.

### Method description:

- Draw a matrix that lists each group of stakeholders,
- Record their level of “power or influence” (low, medium, high),

- Record their “interest or involvement” (uninterested, interested, strategically involved) in the situation or targeted practices,
- Record their “disposition towards the change processes” (hostile, neutral, well-disposed),
- These relations and dimensions can also be illustrated graphically on a “social map” that depicts “who is influencing whom”; this can also be useful when defining target groups and activities,
- Note specific situations, or conflicts between stakeholders (e.g. in a food security programme the presence of a potential conflict between farmers and pastoralists; both of them are strongly involved but they have very different objectives in relation to land use).

*Example of a stakeholders’ analysis in the context of a programme for young mothers in an urban community on which behaviour?:*

Stakeholders	Power/Influence	Interest/Involvement	Disposition	Notes
Young mothers	Low	Interested	Well-disposed	
Husbands	Medium	Uninterested	Neutral	
Mothers-in-law	High	Interested	Well-disposed	
Grand-mothers	High	Strategically involved	Neutral	
Community leaders	High	Interested	Well-disposed	
Local nurses	Medium	Uninvolved	Well-disposed	
Traditional doctors	High	Uninterested	Hostile	

## → D/ INTERVIEWS

### Definition:

An exchange of different points of view on one or more subjects or topics; an interview is a conversation, not an interrogation.

### Objective:

To collect people’s interpretations, perceptions, opinions, knowledge and experiences in a one-on-one setting.

### Target / persons involved:

Individuals and community members or key informants<sup>10</sup> who represent other groups in society.



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10 - For example, local leaders, political or religious representatives, relevant local stakeholders, activists and representatives of the opposing stakeholder groups (e.g. the “poorest” and the “richest”, the “most educated” and the “least educated”, representatives of sub-communities, etc.).

### Method description:

There are two main types of interview: semi-structured and structured.

Type of interview	Semi-structured interview	Structured interview
Description	Discussion on general themes or issues.	Each respondent is asked a set of pre-defined questions in the same way.
Positive aspects	Allows you to freely and deeply explore the defined themes.	Allows coherent data collection, and comparing the results or data is easier and more reliable.
Negative aspects	Difficult to compare the answers or data collected.	More rigid and less adaptable approach.

### Implementation steps:

- Define the type of interview based on the objectives.<sup>11</sup>
- Recruit participants: contact “key informants” or specific people interesting for your data collection (mothers, men..) note that it is important not to under-represent or over-represent individuals drawn from social subgroups that are too similar to each other.
- Ensure that an appropriate venue is available; note that usually semi-structured interviews last longer than structured interviews.
- Implementation:
  - Create a comfortable environment and ensure you convey your neutrality. Consider the possibility of recording the interview.
  - Choose open questions in preference to closed ones (avoid, if possible, “yes/no” answers);
  - Ask for the “why’s” and the “how’s”;
  - Ask the interviewees not only to “describe”, but also to “explain”;
  - Ask them not only to describe the “present situation”, but also how they imagine future changes and what has changed compared to the past situation.
  - Analysis: analyse the different answers and compare and compile the results of all the interviewees. How? You should be a bit more explicit here and talk for example about softwares or other analysis.

## → E/ OBSERVATION

### Definition:

The attentive examination of an object, a phenomenon or a process, without intervening to change it, in order to deepen understanding of it.

### Objective:

To collect objective data on overt behaviour.

### Target / persons involved:

Community, group, family, individuals.

### Method description:

There are two main methods: direct (systematic) observation and participant observation. Transect walks are also covered in this section.

11 - For example, what information are we looking for? Do we need a basic, general understanding of the context? (In which case, semi-structured interviews are more useful). If we have a good knowledge of the context, and we need to verify or compare specific issues among different representatives or informants, it is better to use a structured interview.



Type of observation	Direct observation	Participant observation	Transect
Definition	Structured observation, using standardized observation tools/ grids (observing in an “objective” way)	Observation of a community / group by joining this community / group (observation “from the inside”)	Community observation during structured walks in a community setting (“naturalistic” way)
Positive aspects	Very useful for collecting quantitative data on the frequency or distribution of certain behaviours	Deeper understanding of the social context, norms, habits and behaviour dynamics	Helpful to get to know the observed community / group well and for them to get to know and trust you.
Negative aspects	Presence of the observer can influence individual and group behaviour	Partial loss of “objectivity”, through being part of the target group (in regards to data quality), difficult to gather quantitative data	Presence of observer can influence individual and group behaviour

Example of a structured observation tool:

Behaviour	Frequency	Intensity	Observed causal factors	Observed associated events	Observed consequences
Behaviour 1: Breastfeeding	4 to 5 times per day...	...Variable	...When child cries	...Mother seems stressed when child cries	Child is more quiet and relaxed, mother cuddles the child, they look at each other more intensely...
Behaviour 2: Play interaction between mother and child	2 to 3 times per day	High	When mother has finished her work,	Mother-in-law not at home during these play moments	Child smiles more, is more active, softer physical contact and gestures from the mother

## → F/ FOCUS GROUP DISCUSSION (FGD)

### Definition:

A “group interview”, in which about 6-12 people are asked to talk together about their thoughts, interpretations, perceptions and attitudes towards a theme or issue (ideas, behaviours, practices, etc.).

### Objective:

To gather information and analyse the participants’ thoughts, experiences and opinions related to specific themes or issues; to better understand the practical, cultural or psychosocial implications of local behaviours and practices; to listen to the participants’ ideas about the proposed solutions for change.

### Target / persons involved:

Community, group, family, individuals.

### Method description:

The moderator acts as a facilitator, and participants are free to interact with other group members and to express their ideas in their own words. Ideally, there should also be someone who is able to take detailed notes on what is said unless it is possible to record the discussion. A note taker is preferable as any recordings would have to later be transcribed and this will take some time. It is very important that the facilitator: 1) has a clear set of questions, but explores the issues in depth using the questions as an initial guide only and 2) acts as a “facilitator” to draw out discussion with the participants: a focus group is not a “group interrogation”, it is a “group conversation with a theme”.

### Implementation steps:

- Contact the local leaders.
- Define and recruit people to take part: participants have to be as representative as possible of the main social subgroups but each group should be as homogenous as possible so that people feel comfortable talking with each other e.g. rural women of similar ages with young children.
- The maximum number of participants is 12 - any more and people may not feel comfortable to speak openly.
- Prepare the questions and themes to be discussed (the question guide has to be sufficiently broad and open).
- Identify a suitable venue and time. Create a comfortable environment and be sensitive to group dynamics.
- Consider how you will record the focus group (you will need to ask permission from the group if you use a tape recorder).
- If you take notes, explain to the group why you are doing this but that their names will not be recorded.
- Analyse the data<sup>12</sup>.

## → G/ COMMUNITY DISCUSSION

### Definition:

A public meeting that involves as many people as possible within a community to stimulate discussion and debate around key issues.

### Objective:

To gather information from the community on their thoughts on a particular issue, or to reach a consensus on a particular issue.

12 - There are various methodologies derived from “Grounded Theory” approaches that could be very useful for collecting, organizing and analyzing this type of data. CAQDAS (such as Atlas.ti) are extremely useful, and their use is encouraged in order to obtain a better understanding of the processes.



### Target / persons involved:

Community members.

### Method description:

A community interview is similar to a focus group, but it is also very different in the sense that the setting is broader. The number of participants is larger and the group can be drawn from all sections of the community and therefore the group dynamics will be different.

*Limitations:* Local leaders and individuals with relevant social roles may easily impose their points of view, creating bias making the results less representative. People or groups with less social power might not be adequately represented, or they may not be able to express themselves in a community interview. It is thus necessary to be aware of these limitations, and triangulate the results of the community interview with other methods.

### Implementation steps:

- Contact local leaders.
- Define with the local leaders the scope and objectives of the community interview, and involve them in the event.
- Inform community members about the community interview.
- Prepare a large, commonly used public location within the community. Note that the interview is usually about one hour long.
- Prepare questions for the interviews: questions have to be more structured and specific than in a focus group, with more “closed” questions and well-defined objectives.
- Facilitators must pay particular attention to local group dynamics. Consider especially regarding those with less social power and influence, or people with low status social roles. Try to find out about local power struggles before the meeting.
- You can also use the community interview to share information about the project.
- Record and analyse the local social dynamics, cooperative and competitive dynamics among subgroups, emerging unofficial leaders and representatives, general atmosphere, who was and was not represented and the general views of the local leaders, etc.

## 2. SPECIFIC ASSESSMENT TOOLS FOR COLLECTING DATA ON BC AND RESISTANCE TO CHANGE

Diagrammatic and visual techniques are traditionally used by many different participatory approaches, and are one of the main methods used by PRA and PLA. They are very flexible and powerful “knowledge sharing” techniques, that allow easy discussion of group interpretations related to different constructs or issues. They are also useful for use with non-literate groups. They can be easily adapted for assessments related to BC interventions.

## → A/ PROBLEM TREE

### Definition:

This is a small group exercise to conduct a shared analysis of a problem (recognized as such by the participants), though the graphic identification of the different root causes and consequences of the problem.

### Objective:

To facilitate a collective and analytical exploration of the causes and consequences of identified problems and behaviours (e.g. poor sanitation, high malnutrition, high rates of domestic violence). To develop a common knowledge and perspective among the participants.

### Target / persons involved:

6 - 15 individuals from the target community.

### Method description:

On a blackboard, or a sheet of paper, the facilitator draws a representation of the causes and consequences of the “problem”, based on a brainstorming exercise with the participants. There are two types of problem trees (they can be integrated into one “big” complete tree):

Type of problem tree	“Downward” problem tree	“Upward” problem tree
Stages in production of the tree	<p>The identified problem is written at the top of the whiteboard.</p> <p>The group is asked to identify the “roots” of the tree or the immediate causes of the problem and the individual behaviours and social practices that in turn have led to these immediate causes drawing them from the top to the bottom, showing their associative relationships.</p>	<p>The identified problem is written at the bottom of the whiteboard.</p> <p>The group is asked to identify the “branches” of the tree representing the consequences of the problem or behaviour, and their subsequent implications, drawing them from the bottom to the top.</p>

## → B/ ABC TECHNIQUE<sup>13</sup>

### Definition:

This technique compares behaviours with their consequences, in order to analyse an individual’s or group’s readiness to change. It can also help to reinforce the change process.

### Objective:

To analyse the barriers and motivations for changing behaviour. More specifically, to understand if behaviour change is possible from the subject’s perspective (what do they have to gain, what are the negative consequences associated with the change) and to work on a more individual level to address the barriers and resistance to change.

At the end of a behaviour change initiative, ABC can be used to evaluate the new perceived A-B-C equilibrium.

13 - This should not be confused with ABC approach of ACF



### Target / persons involved:

Individuals and groups.

### Method description:

Ask the individual or the group the following questions (compile their answers in a table):

#### Ask the participants to:

A	<ul style="list-style-type: none"> <li>• Explain the actual behaviours or actions that are needed in order to change</li> <li>• Describe how you want the new situation to be.</li> </ul>
B	<ul style="list-style-type: none"> <li>• List the disadvantages of the current behaviour (i.e. the negative implications or consequences),</li> <li>• List the advantages of the new proposed behaviour.</li> </ul>
C	<ul style="list-style-type: none"> <li>• List the advantages of maintaining the current behaviour or situation.</li> <li>• List the disadvantages related to changing to the new proposed behaviour or situation.</li> </ul>

*NB: If row C contains more important issues than B, change is very difficult, and has little utility and meaning from the subject's own stand point.*

**Example:** Use of the ABC technique in a WASH project that aims to provide vulnerable community members with soap to wash hands (so as to reduce the spread of diseases):

A	<ul style="list-style-type: none"> <li>- Current behaviour/situation.</li> <li>- Target individuals wash their hands using well water only.</li> </ul>	<ul style="list-style-type: none"> <li>- New proposed behaviour/situation.</li> <li>- Individuals use soap to wash hands several times per day.</li> </ul>
B	<p><b>DISADVANTAGES:</b></p> <ol style="list-style-type: none"> <li>1. Not as effective as soap.</li> <li>2. Family members are easily getting sick.</li> <li>3. Money has to be spent on medicines.</li> </ol>	<p><b>ADVANTAGES:</b></p> <ol style="list-style-type: none"> <li>1. Reduced exposure to diseases.</li> <li>2. Less money spent on medicine.</li> <li>3. Family members' health (especially for children) is better.</li> <li>4. Soap is easy to use and people are familiar with it.</li> </ol>
C	<p><b>ADVANTAGES:</b></p> <ol style="list-style-type: none"> <li>1. Well water is easy to get.</li> <li>2. Quicker.</li> <li>3. No change of habit required.</li> </ol>	<p><b>DISADVANTAGES:</b></p> <ol style="list-style-type: none"> <li>1. Requires expenditure and time to purchase soap.</li> <li>2. Shame in asking the health centre staff for soap.</li> </ol>

From this analysis, a work of negotiation and support will follow with the target group to reduce/deal with disadvantages of new behaviour and reinforce the advantages of it.

## → C/ FORCE FIELD ANALYSIS

### Definition:

This technique enables a group analysis of the potential barriers (hindering factors) to and supporting factors for behaviour change, using a simple graphic representation.

### Objective:

To identify and list the different hindering and supporting factors in the change process; to analyse these factors and the strength of their influence is and to suggest creative solutions to remove, reduce or reinforce them.

### Target / persons involved:

Community groups.

### Method description:

A graphic representation is drawn on the ground or on paper based on the group's discussion and inputs; the facilitator helps the group to identify suggestions and answers.

### Implementation steps:

- Draw a line, representing the objective (e.g. the behaviour to be changed, practice to be modified etc.).
- Ask the participants to list the supporting and hindering factors for change and to discuss how important they are.
- Draw a series of arrows on both sides of the line, indicating each factor's "strength" by the thickness or length of the line. The arrows on one side represent the "hindering factors" and the arrows on the other the "supporting factors" for attaining the objective or goal.
- Ask what is needed to reinforce the "sustaining factors", and to reduce the hindering ones. Analyse each of the main factors with the group and try to identify creative solutions or interventions that could mitigate possible obstacles to change.

## → D/ COMMUNITY MAPS

### Definition:

This is a collectively compiled community map illustrating the different geographical and social landmarks and resources. The map can also identify problems or issues and can stimulate action to address these issues.

### Objective:

To identify a community's geography, resources, public and private spaces, the spatial and functional distribution of ethnic or religious minorities inside the community, the richest and poorest area or households of the community, WASH facilities, etc. To identify resources and barriers to BC.



### Target / persons involved:

Community members or groups.

### Implementation steps:

- With the help of community members, draw a map on the ground or on paper of the village or a specific area, paying attention to, roads, rivers etc.
- Using symbols, add key landmarks and infrastructures, health centres, religious buildings, WASH facilities etc.
- Use colours or other symbols to identify households or areas where specific groups live (e.g. ethnic groups or people with different economic conditions...).
- Discuss the map with the participants, identifying any areas for concern or things they would like to change and ask them what needs to happen for change to occur.

## → E/ VENN DIAGRAMS

### Definition:

These are diagrams used to represent, in a simple way, the functional relationships between individuals or social groups.

### Objective:

To identify social influence and social dynamics, which are related to the BC proces.

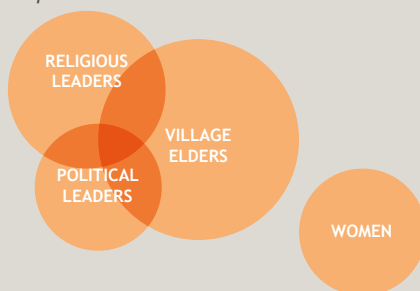
### Target / persons involved:

Community groups.

### Implementation steps:

- Represent each group (institution, stakeholder, subgroup, etc.) with a circle (the relative size representing the relative power or dimensions or influence).
- Represent their relationships with each other through their spatial positioning, overlapping the circles where required.
- Specific conflicts and/or specific areas of cooperation can be represented with arrows or other simple graphic symbols.

*Example of a local “social power map” (the size and degree of overlapping represents the perception of differential power relations and social roles within the community):*



## → F/ SOCIAL NETWORK CHARTS

### Definition:

These are diagrams used to represent, in a simple way, the individual's "social world".

### Objective:

To collaboratively identify people's key social relationships and social resources that can be employed in the BC process.

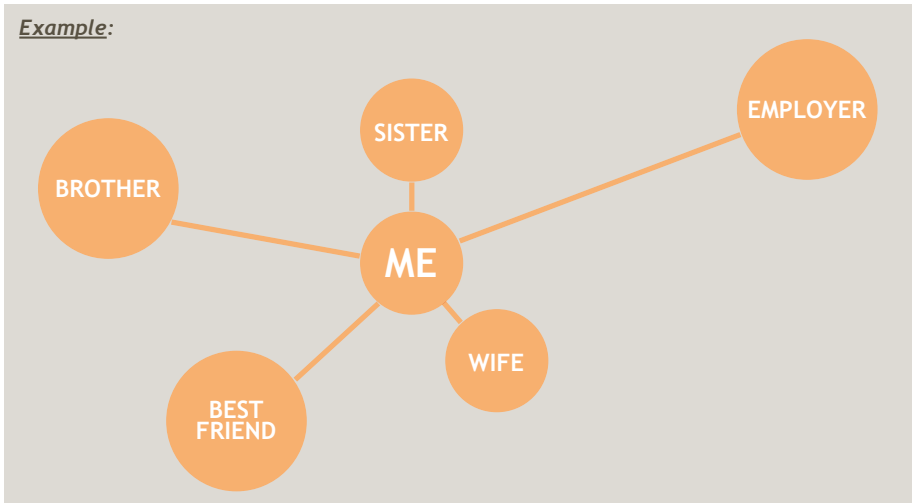
### Target / persons involved:

Individuals (it is possible to involve family members or other significant persons also).

### Implementation steps:

- Ask the individual to list their main "social resources": such as relatives, extended family members, friends, colleagues, etc.
- Draw a circle in the middle of a sheet of paper to represent the person.
- Ask them to draw other circles representing their social resources, arranging them on the paper in order of their level of closeness or availability for support.
- Draw lines to show the relationships between the individual and these other people. Use dotted lines to indicate a difficult or confrontational relationship.

### Example:



*Note that this technique may also be applied at the group or family level, asking the household as a whole to represent their main connections and social resources in the local community (friends, other families, local authorities, etc.).*



## TIMELINES

While maps, Venn diagrams and network charts focus on the spatial or relational dimensions, calendars and timelines focus on the temporal and causal dimensions that it may be crucial to understand in a BC process.

### → G/ BASIC TIMELINE

#### Definition:

A timeline is a linear representation of the events and eventual points of change and their consequences for social and individual function and dynamics.

#### Objective:

To highlight the relation between different events, the causes and consequences of events (e.g. causal factors of behaviours and practices, and desired changes), in order to explore the change process as it relates to other events within a person's life and context.

#### Target / persons involved:

Community members, groups, individuals.

#### Implementation steps:

- Ask participants to draw a line representing a specific period (e.g. 1 year, 3 years or the last 6 months etc.).
- On the line, participants should position the different, significant events that occurred during this period and which had an impact on the community.
- For each point or event, the community should list and then describe the significant changes (negative but also positive, if any) for the community, for specific groups or for specific individuals.

***Example:** A natural disaster can have a strong impact on feeding and hygiene practices of families. Through a timeline exercise the family/group/individual can realise the changes caused by different events (the natural disaster, the displacement, the arrival in IDP camps...) on their life (and daily life) and the impact of it on their feeding and hygiene practices.*

### → H/ FUTURE TRENDS TIMELINE

#### Definition:

This timeline is a graphic representation of “past”, “present” and “future” trends related to specific situations or practices.

### Objective:

To identify different possible outcomes of a suggested change or innovation. To motivate group members to adopt change, and to monitor and check changes and how change evolves during the project.

### Target / persons involved:

Community members or individuals.

### Implementation steps:

- Ask participants to actively elaborate and discuss, which future trends are the most probable, based on past trends.
- Ask participants to identify possible actions that can be implemented at the local community, group, and individual level, to modify these potential outcomes.

## → I/ LIFE TIMELINES

### Definition:

This timeline is a graphic representation of a person's own life, highlighting the most significant past and present events and their consequences, including behaviour and practice changes.

### Objective:

To graphically represent and reflect on the main life changes, both positive and negative, that have characterized the person's life, and what actions, competencies and resources have been helpful to cope with them and to adjust to change.

To highlight and reinforce positive coping skills and personal competencies and to reflect on what is possible (in many cases this can increase self-esteem and self-efficacy and facilitate BC process).

### Target / persons involved:

Individuals, family members.

### Implementation steps:

- Draw a line, which represents the person's life history from birth until the present moment.
- Ask the person to place flowers (which represent positive changes) and stones (representing the negative changes, or life crisis) on the line in relation to when the events occurred.<sup>14</sup>
- Ask the person to briefly explain the personal, family or contextual factors that led to, or were caused by, these changes.

*Note that the feasibility of this technique needs careful planning as it can be emotionally intense and upsetting (e.g. if it identifies traumatic incidents or the loss of loved ones) In this case it should be used only by personnel trained in psychosocial work and carried out in an appropriate safe and private setting.*

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14 - It is also possible to represent the lifeline and negative/positive crisis moments on a large paper sheet, or on a blackboard.



## → J/ RANKING TECHNIQUES

### Definition:

This technique helps to rank and prioritize issues in a collaborative way.

### Objective:

To facilitate the local assessment of the relative importance, urgency or severity of different issues or practices. Although usually used in an initial assessment phase, ranking procedures can be used at the end of a behaviour change initiative to derive qualitative-quantitative indicators about a programme's outcomes.

### Target / persons involved:

Community members.

### Implementation steps:

- Write the different issues to be ranked on paper cards.
- Present them in pairs to the group, asking for a vote on which is the most important, urgent or serious out of the two. Whichever issue wins the majority of votes is then paired with another issue and the vote is repeated.
- By comparing the various pairs in a series of votes, it is possible to identify the priority issues.

## → K/ RICH PICTURE

### Definition:

A “rich picture” provides a comprehensive representation of a situation or issue, and is compiled collaboratively in a public/group setting, using text, pictures, symbols, diagrams and drawings.

### Objective:

To enable the collaborative analysis of the implications and correlations of a complex issue; to assess what the community already knows about the issue and to broaden their understanding; and to share and develop ideas for intervention projects.

### Target / persons involved:

Community members.

### Implementation steps:

- With the participants, identify the immediate and underlying causes (the distal and proximal antecedents) of a local issue and illustrate these on the ground or on a large sheet of paper.
- Identify the fundamental or root causes (local / external), its correlations, consequences and implications by asking “why”, “what caused this” etc.

**Example:** in a community affected by famine, represent on a piece of paper:

- The distal and proximal antecedents of famine and how it came about.
- The root causes of the famine (e.g. a lack of organization within the community to maximize the harvest time, problems with selling products as cheaper imported goods are available on the local market).
- Its recent “natural” causes (e.g. a severe drought that damaged the fields), and the correlations, consequences and implications (malnutrition, force to resettle elsewhere, growing competition and conflict in the community, etc.).

### 3. PROGRAM DESIGN - STEP 7 OF ACF ABC MODEL

Design the programme (approach and activities) taking into consideration the data collected in the analysis phase

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The previous paragraphs have helped us to collect data and information precious to better understand the context, the individual/social/cultural/traditional practices and the possible change (including the resources and the barriers to the change process) in terms of BC.

All these information are useful and necessary to design and propose a proper program of ABC, adapted to the context, to define an adequate approach and related activities.

Please, remember the importance to have the community participation in the phase of program design. If this step is important in all programs of humanitarian sector, this can be crucial and not negotiable for ABC programs since the community/group/individual needs to be implicated in the identification of the behaviour(s) to be changed and of the adopted process of change.

The programme design stage has to include a comprehensive strategy to enhance reach, involvement and the maintenance of changed behaviours.

A useful general framework to help operators consider these activities and incorporate them in their planning is the RE-AIM framework that was originally used for evaluating behaviour change interventions in the field of cancer control<sup>15</sup>. This framework outlines five key parameters that could be incorporated into evaluations or programme design:

15 - <http://cancercontrol.cancer.gov/IS/ream/index.html>

1. Reach
2. Effectiveness
3. Adoption
4. Implementation
5. Maintenance

Each parameter has specific objectives and the table below outlines the questions that could be asked during the planning phase and how outcomes might be improved<sup>16</sup>:

RE-AIM ELEMENTS	QUESTIONS TO REACH EACH PHASE'S OBJECTIVES	SUGGESTIONS TO IMPROVE OUTCOMES
REACH	How is it possible to reach the targeted population with the intervention? How many people are involved? Are marginal subgroups well represented?	Increase representativeness. Target diversity in income, cultures, gender, age.
EFFECTIVENESS	How is it possible to know if the intervention is really effective? Which positive and negative outcomes result from the intervention?	Tailor interventions to local context and individuals. Support individual change with socio-environmental strategies. Reinforce with feedback, especially if behaviour effects are delayed. Assess benefits and unintended consequences.
ADOPTION	How is it possible to develop organizational support to deliver the intervention?	Lower complexity of proposed interventions. Maximize compatibility with socio-cultural and family constraints. Customize interventions to special local needs, actively involving local stakeholders.
IMPLEMENTATION	How is it possible to ensure that the intervention is delivered properly, in a consistent way? Do implementers act according to the planned activities?	Emphasize quality evaluations. Train, supervise and ask for and give continual feedback.
MAINTENANCE	How is it possible to develop the intervention so that it is delivered over the long term, and its effects will be maintained?	Reinforce positive changes, continue contact, organize regular feedback/follow-ups. Provide individual counselling when a behaviour seems to relapse for personal/family reasons. Increase social support and regular sharing initiatives. Tailor interventions to specific maintenance barriers.

16 - <http://cancercontrol.cancer.gov/IS/reaim/whatisre-aim.html>

The checklist provided in *appendix 4.3* at the end of this document is a simplified version of the original ones (available on the RE-AIM website at: <http://cancercontrol.cancer.gov/IS/reaim/index.html>).<sup>17</sup>

The following “tactical tips” should also be considered when designing programmes:

- Emphasize self-efficacy, and promote and sustain it through the reinforcement of positive experiences.
- Make good use of information sources (that have to be authoritative and credible), and emphasize active learning, and peer-sharing processes and the opportunity to discuss, question and internalize the information provided.
- Focus on and promote processes that support an internal locus of control.
- Integrate normative and informative influences (make use of majority and minority influences). Therefore targeting several groups of people.
- Adapt interventions to the stage of change in which the majority of people involved are situated (refer also to the Change Curve - handbook part 1).
- Integrate different types of interventions, that work on different levels, so that knowledge and attitudes are acknowledged as relevant but ensuring that the ultimate aim is to change practices and behaviours.
- Respect local cultural meanings and interpretations and use them as leverage to influence change.

## 4. IMPLEMENTATION, MONITORING & EVALUATION - STEP 8 TO 10 OF ACF ABC MODEL

Quick reminder of the 3 steps of the ACF-10 step Model for ABC that relate to implementation, monitoring and evaluation.



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8.	Supporting the process of change - change phases	M O N I T O R I N G & E V A L U A T I O N
9.	Sustaining BC and ritualization	
10.	Evaluation of the BC process	

<sup>17</sup> - RE-AIM methodology is useful in evaluations, but its original focus was more quantitative. For field operations, the use of some of the RE-AIM parameters is recommended. They can be simplified and used in a more qualitative way (cf. some examples of adapted RE-AIM checklists are in appendix 2 of this document).

## 1. IMPLEMENTATION

Implementation is a very dynamic process; the ongoing application of the different phases and methods has to be carried out in a flexible way, adapting the intervention whenever new information comes to light or if it appears that an approach is not working effectively.



- **Test before applying:** Whenever possible, test solutions before applying them. Testing allows you to check if the “basic concepts” are useful and comprehensive, if the approach or technique is being implemented in the right way or if the new practice has unintended consequences or does not involve the right people or does not involve them adequately.
- **Share knowledge:** The implementer shares information and knowledge with the context and environment but at the same time the context and environment conveys information, knowledge and interpretations with the implementer. It is very important to maintain an open attitude towards this continuous process of knowledge sharing .
- **Ask for feedback:** It is essential to ask for feedback from peers, national and international colleagues, local implementers and community members as well as feedback from people who are “outside” the context to obtain a variety of perspectives.
- **Ongoing assessments:** This aims to verify the processes and procedures as the programme progresses, both through the use of standardized methods (e.g. structured observations, questionnaires), and through informal qualitative methods (e.g. group discussions). If an unexpected problem arises it will therefore be easier to correct it as soon as possible.

### a. Techniques and tools for behaviour change implementation

Some techniques described here, are suitable both for assessment/evaluation and for implementation. Techniques that foster the collective elaboration and participatory analysis of a problem can help to deepen the understanding of its determinants and can also help to stimulate the change process.

Some methods are more useful for implementation specifically at the individual, family or

community level while others can be easily adapted to different levels. The techniques will therefore be presented according to their level of application i.e. community, family or individual.

## b. Community level methods

Community-level methods are useful (and often necessary) for motivating the whole community (villages, neighbourhoods, etc.) and to ensure a broader social impact rather than just change at the individual or family level.

Community-level interventions can be very powerful (because this public level influences social norms, cultural values and collective practices that help to define individual behaviours), but, if not properly developed, could be divisive and ineffective. A good preliminary assessment phase is thus necessary.

Community interventions are strongly “culture-based”, and need to be not appropriate within that culture, but also culturally attractive and compelling, using local stories, cultural traditions, symbols and historical figures as tools for change.

Community methods should not be impersonal activities involving mere “information transfer”.

Narrative and interactive methods are the most suitable for sharing and discussing many complex themes and issues with people in their own social context.

### → A/ MEDIA COMMUNICATION

#### Definition:

Mass media communication campaigns (radio songs, mobile phones, posters, leaflets, branding magazines, etc.) that involve the “mass transfer” of information related to initiating, changing, interrupting or maintaining behaviour or practices.

#### Objective:

To disseminate information on a specific topic (awareness raising) or to remind people about a specific practice (cues to action).

#### Method description:

After having defined the local target “health or care behaviours” (using participatory methods) and obtained a baseline, a basic set of messages and of communication channels (favoured by the target population) are defined a period of pre-testing is implemented (using focus groups), and the material is evaluated (according to clarity, usefulness, cultural consistency, etc.). Then the implementation phase begins with the diffusion of messages followed by a final evaluation phase, in which the campaign’s results are analysed and discussed.

#### Implementation steps:

- The content of the messages and the channels of communication should be defined with the target population as much as possible, using an iterative and collaborative process (comprising careful testing and evaluation of the material before mass dissemination).
- Use different types of media, addressing the different target groups (youth, women, adults, elderly) through different channels and couching the information in different ways.

- Use techniques to “tell stories and share meanings”, instead of “listing technical information”; human knowledge is embedded in “stories”, and thus it is better remembered in a more contextualized way.
- Adapt the content of social communications so that it is culture-appropriate, but also culture compelling, to leverage on local cultural values and traditions<sup>18</sup> (traditional values, symbols, songs, images, stories, etc.).

### ***For example***

*Communication efforts often aim to “reframe” a current attitude through the use of traditional stories and cultural values; e.g. in a context in where you want to involve husbands much more in child care practices, or convince them to restructure the nutritional allocation of resources within the family, it is useful to identify stories, cultural references or symbols that help to “reframe” the cultural values attached to “masculinity” towards valuing “family protection” more. In other contexts, in which food security interventions need to foster local conservation of environmental resources, tales, myths or historical events focused on the value of land protection, or the connections between social and environmental order could be used.*

### **NOTA BENE**

Mass media approaches usually have a strong focus on “knowledge”. As presented in the theoretical part of this handbook, the belief that providing technical information in a clear and widespread manner can modify attitudes and behaviours has been proven to be far from correct by numerous social psychology research studies. If the behaviour change barriers are of a normative or psychosocial nature, then it is almost pointless using information alone<sup>19</sup>. Nonetheless, in cases in which there is a lack of information or knowledge about an issue, and this has been identified as a main barrier to the adoption of a new behaviour, then mass media campaigns, if well developed, have the ability to disseminate information and knowledge to large numbers of people, and to give regular “cues to action” to people and communities involved in the behaviour change process.

## **➔ B/ MAGNET THEATRE AND THEATRE FOR DEVELOPMENT**

### **Definition:**

This is the use of community events and the collective representation of social issues using “Magnet Theatre” or “Theatre for Development” methods<sup>20</sup>.

18 - Panter-Brick, C., Clarke, S., Lomas, H., Pinder, M., Lindsay, S. (2006). Culturally compelling strategies for Behavior Change. *Social Science and Medicine*, 62, 2810-2825.

19 - Recent studies have shown a very low effect of using only information health communication campaigns focused on behavior change: their average influence was on less than 10% of the target population, with a mere 3%-5% for prevention-type campaigns, both for the commencement of new behavior or cessation of old behaviors (with a 17% efficacy rate only for “enforcement-type” campaigns, i.e., information about new regulations or laws, such as seat-belt use). Therefore, information alone is of very little use.

20 - Kidd, R. Theatre for Development; diary of a Zimbabwe Workshop. *New Theatre Q.*, 1, 1985; Cornwall A., Jewkes, R, What is Participatory Research, *Social Sciences and Medicine*, 41, 12.

### Objective:

To initiate, facilitate and develop a social dialogue within the community about behaviour or practice change, in a shared and emotionally positive way that helps to stimulate awareness and action.

### Target / persons involved:

Community members.

### Implementation steps:

- Define a relevant theme for the play (e.g. a desired behaviour change).
- Select and train the actors (e.g. volunteers from the local community, participants of discussion groups, participants in ACF initiatives, mothers in nutritional centres, etc.).
- Provide them with a general script only. The play should focus on a short "story" that involves situations and the dynamics of social roles, problematic behaviours or health-related decisions, in which the protagonists are faced with difficult situations and ambiguous decision-making constraints.
- Identify an appropriate time and venue to show the play (in a public place: a main street, a square etc.).
- Organize and disseminate publicity about the play (as much as possible, involve local health, educational or social authorities).
- Once a certain amount of people have gathered, begin the play.
- At the climax of the scene, the actors "freeze" the performance, and the facilitator asks the audience "what should the protagonist do now?"
- The facilitator enables an informal discussion on this; people can make suggestions to the actors, propose solutions, discuss with each other and identify together a behaviour or choice that may improve the situation.
- The players restart the play, acting out the proposed solution and its probable consequence.
- After a while, they stop again when another "tough dilemma" presents itself, and the facilitator again invites the participation of the audience (repeat this process two or three times).
- Actors bring the play to a conclusion that is directly related to the public's choices and ability to find a suitable way to manage the presented problems.
- At the end of the performance, the facilitator holds a brief discussion with the audience and actors and summarizes the most useful suggestions that have been proposed.

*Note that this technique is mainly focused on knowledge and on provoking doubts and dilemmas in order to start to promote deeper reflection. It is therefore a technique used mainly in the first steps of the BC process (knowledge level - awareness campaigns)*



## → C/ COMMUNITY NARRATIVE AND STORYTELLING

### Definition:

This technique uses the medium of narration and storytelling to share oral histories, community legends, myths and traditional knowledge that reveal implicit social rules and important local practices.

### Objective:

To understand local traditional practices and social norms in order to identify a culturally based and culturally coherent behaviour change path.<sup>21</sup>

### Target / persons involved:

Social groups and community members.

### Implementation steps for the “Story with a Gap”:

- The facilitator tells the group a short story, representing a typical member of the community who is facing some difficulty or crisis related to the issue at hand. The story represents the main issues that the majority of group members have to face in their everyday life, and tell the difficulties that the protagonist has to face<sup>22</sup>;
- At the story climax, when the protagonist has to make a tough or ambivalent choice, the storytelling is interrupted;
- The operator asks the participants to suggest a continuation of the story that “fills the narrative gap” between the climax and a more positive conclusion. Examples of the type of questions that might be asked are: What happens? Why? What actions are necessary to overcome the protagonist’s problems? What alternative courses of action can be pursued?

### For example

*“A mother has to decide whether to carry her malnourished child to the feeding centre, many kilometres away from the village, and leave her husband and older sons at home alone for three or four days. She has finally taken the decision to go, but her husband is angry with her, and some other women of the clan criticize her for the decision to go alone, leaving the household and other children unattended for such a long time. The mother is very confused, and...”*

*At this point, the story is abruptly interrupted, and participants are asked to imagine the possible outcomes, to elaborate and provide alternative solutions and to hypothesize how the various logistical problems and conflicts that have arisen, etc.*

21 - Ntshembe, O., Pitso, JMN, Segobye, AK. (2006). The use of culturally themed HIV messages and their implications for future behavior change

22 - The shared narrative, and the following group discussion, has to analyse the contextual constraining factors, positive social resources, psychological motivations to facilitate a change and a positive evolution of the proposed situation.

### c. Group level methods

The *group* is a powerful tool to help foster behaviour change, to analyse and overcome barriers to change and to support individual members who face a variety of psychosocial obstacles. Group work allows norms and habits to be redefined and provides social support.

- Groups, peers and families form the basis of relationships and social networks in all cultures. In a deep and pervasive way, both positively and negatively, they influence individual behaviours, both normatively and informatively (e.g. through peer-pressure, family dynamics, etc.).
- Peers can act as “force multipliers” for information and awareness-raising activities, adding the “deeper” dimension of personal experience, informal communication channels, direct understanding of the local context, and greatly increasing the programme’s reach in difficult contexts. Good selection, training and supervision of peers is essential to make them truly effective.
- Groups are essential and very powerful “social tools” that can generate learning, understanding and support for both participants and facilitators, in many types of intervention. Different settings and techniques (learning groups, discussion groups, support groups; role-play, simulations, psychodrama, etc.) can be adapted to facilitate the proposed objectives and to support the most diverse practice and behaviour change efforts, at various levels.
- Many individual or social “target behaviours” in nutrition, hygiene or child-care areas are family-related. Families can be both a resource and a barrier to change. For more complex behavioural changes, family members and other resources need to be actively involved to sustain and maintain individual and systemic change.



### ➔ A/ PEER EDUCATION AND PEER-BASED PROGRAM

#### Definition:

Peer programmes involve community members in disseminating information to other members of the community and discussing and sharing their own experience and “good practice”.

#### Objective:

To facilitate community involvement, by recognizing the important and active role that groups and individuals can play in the implementation and diffusion of a change programme.

To share information that is not only “technical”, but also that is based on one’s own experiences and feelings in an informal yet structured and helpful way. To ensure the intervention becomes more widespread and “source-credible”.<sup>23</sup>

23 - Cornish F, Campbell C., (2009). The Social Conditions for Successful Peer Education. American Journal of Community Psychology, 44, 123-135.



### Target / persons involved:

“Active” community members (involved in an ACF programme), community members, specific target groups (such as pregnant and/or lactating women, people in distress, health clubs, people living with HIV...).

### Implementation steps for the “Story with a Gap”:

- Define the objectives (providing information, activating discussion groups across a wide area, etc.).
- *Contact local leaders, key persons and institutions*, to analyse with them the feasibility of such an intervention, and to establish a working relationship with local leaders.<sup>24</sup>
- *Define the required characteristics of “peers”*, and disseminate information locally about the activity.
- *Select and train the peer educators*. The selection process, although not too strict, is necessary to filter out people that are clearly unsuitable. Next, peers need to be motivated and trained in basic communication skills (e.g. how to organize a discussion group, how to provide information in a one-to-one setting, etc.) as well as specific behaviour change skills (e.g. breastfeeding techniques, household hygiene, personal hygiene, etc.).
- *Define information tools* with the help of the peer educators. To facilitate discussions and the provision of information, it is useful to provide good quality IEC material or toolkits for the peer educators. Wherever possible, it is useful to compile these materials with their help, using their local knowledge. This is also a way to involve them better in the first phase of the project.
- *Provide regular “checks” and supervision*. It is necessary to plan regular discussion groups with the peers, to support them, receive their feedback, refine the operational strategy, to solve problems together and to help them to stay focused on the scope of their work (not only with regard to the information they provide but also their communication skills and capacity to facilitate discussion), etc.
- *Peer recognition*. It is important to recognize the efforts and contribution of the peer educators through symbolic and social rewards that have the support of local leaders.
- *Integration*. Peer education activities have to be carefully integrated with the broader initiatives that have been planned and implemented, in order to foster behaviour change. Peer education can be a major asset, but should not be the only method employed.

## → B/ LEARNING GROUPS, DISCUSSION GROUPS AND SUPPORT GROUPS

### Definition:

These are specific group settings in which it is possible to discuss social norms, community dynamics and the impact of traditional or new practices on everyday life. Coping strategies can also be discussed and this can therefore potentially help to facilitate behaviour change.

24 - There may be an opposition from other powerful stakeholders if the local culture does not allow or understand the logic of peer-based approaches (e.g. in very closed and extremely traditional cultures empowering and focusing on women or youth can be seen as potentially endangering the perceived social order).

### Objective:

To enable the shared assessment of a complex situation, the analysis of group or community processes, the elaboration of collective solutions or suggestions or to provide knowledge and information. To experiment with new behaviours or practices and receive immediate feedback, support and suggestions, in a protected and supportive environment.

### Target / persons involved:

Group members.

The following table compares different types of group:

	Learning Group	Discussion Group	Support Group
Type of participants	Heterogeneous/homogeneous	Heterogeneous/homogeneous	Homogeneous (for example, groups composed only of women who are breastfeeding.)
Objective	Teaching and Learning; Assessing complex situations with a group, to discuss and share knowledge or information.	Assessment and Analysis Sharing experiences of a situation, a problem or a difficulty (discussion groups are useful in crisis management).	Social and Emotional support Sharing of experiences and ideas. Using problem-solving skills to help the individual to develop his own behaviour strategies, and to receive emotional and social support during difficult transition periods of life.
Target	People who need primary information or knowledge.	People who need to discuss a particular situation or problem, and/or who need more information and/or a key person in the community to discuss an issue with.	People who experience similar types of difficulty or who are in a transitional period in their life (e.g. mothers staying with their children in a nutrition centre, pregnant women).
Implementer's role	Teaching role, then facilitator (requires active involvement of participants).	Facilitator	Facilitator and supporting and care role.
Setting	Public / open	Public / open	Closed (to ensure privacy)
Focus	Knowledge	Social norms, practices	Personal experiences and practices
Implementation steps	<ul style="list-style-type: none"><li>• Involve local leaders / health/education structures.</li><li>• Identify the venue and the participants (12 to 20)</li><li>• Organize widespread community information about the group. Share inputs and provide explanations about the defined topic, with the active involvement of participants.</li></ul>	<ul style="list-style-type: none"><li>• Involve local leaders / health/education structures.</li><li>• Identify the venue and the participants (12 to 20)</li><li>• Present the identified issue to be discussed and facilitate the sharing of various ideas and opinions expressed by the participants.</li><li>• Synthesize the discussion's main points, and suggest conclusions.</li></ul>	<ul style="list-style-type: none"><li>• Identify the participants (6 to 12)</li><li>• Define the venue (quiet private place)</li><li>• Present the theme to be discussed and facilitate the sharing of experiences and problems and how people have coped. Provide, and enable other group members to provide, emotional support and very practical advice<sup>25</sup>.</li></ul>

25 - A support group is not a psychotherapeutic group: the implementer is only a facilitator. Nonetheless, it is advisable that facilitators of support groups have a psychological background, and if critical individual situations emerge, it is necessary to refer the individual to appropriate Social Services/Mental Health Services (i.e. ACF MH personnel).



## → C/ INTERVENING WITH CHILDREN

The relative number of young people is growing worldwide and age pyramids in developing countries in particular, will be clearly skewed towards youth cohorts, in the following years and decades.

In many traditional cultures, young people have less socio-economic power than adults and this can be a barrier to implementing change. However, young people are generally more open to a certain degree of change in traditional practices, and are more willing to accept the modification of social norms. In many countries their median level of education is comparatively higher than their parents, and they are more media-oriented.

Thus, young people are a powerful resource to initiate and support behaviour change efforts and specific initiatives (such as interventions in schools) are required to empower and motivate them (“youth mainstreaming”).



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### CHILD to CHILD approach

#### Definition:

Child to child is a specific interactive approach that recognises the important role that children can play as change agents. In many countries children are responsible for looking after their younger brothers and sisters and can therefore influence their behaviour and practices. Children can also influence their peer group as well as sometimes being able to influence older family members such as their parents or grandparents.

#### Objective:

Child to Child works with children to promote health amongst their younger siblings, peers and other members of the community. Child to child activities can be initiated in the school or community and the intention is that there is an on-going interaction between both settings.

#### Target / persons involved:

Children young people in school and community, teachers, youth club leaders.

#### Implementation steps:

- Identify places where child-to-child activities could be initiated: e.g. schools, health clubs, young people’s religious groups.
- Define the objectives of your intervention: e.g. to provide information on a specific topic, to increase self-esteem, to reduce early pregnancies, to improve hygiene practices...
- Select the most appropriate activities and modalities (theatre, experiments, games, role play etc.), consulting children and adults working locally with children.
- Monitor the impact of the activities on children and their families but also the capacity to promote and maintain changed behaviours.

For more information and a variety of tools and resources see: <http://www.child-to-child.org/>

#### d. Role play and active group methods

Role-playing and “active group methods” can be used to attain different goals and at different psychological levels. Role-playing allows the critical enactment and elaboration of social roles, situations and social norms in a group setting, and facilitates shared reflection.<sup>26</sup> Those techniques are also very useful to reinforce behaviour ritualization and facilitate behaviour maintain.



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#### NOTA BENE

Even though these tools appear simple and fun, they require well trained and properly supervised facilitators. Only trained and supervised psychosocial teams should use them because these methods may involve the revelation of deep and crucial personal themes and difficulties that only trained people are able to deal with.

#### → A/ BEHAVIOUR SIMULATION AND REHEARSAL

##### Definition:

The simulation of a new behaviour, before its actual implementation, carried out with a group of people that have similar experiences and needs.

##### Objective:

To experiment with a new behaviour, with the support and help of other participants who can advise, help solve problems and provide feedback on how to implement the behaviour and overcome barriers. To support the practice of new behaviours.

##### Target / persons involved:

Small groups (6-12 persons) of people experiencing similar situations / needs.

##### Implementation steps for the “Story with a Gap”:

- Arrange an appropriate setting (ensuring comfort and privacy).
- Propose that participants try out the new behaviour as a role-play (i.e. breastfeeding, caring for a sick child, etc.) in front of the group.
- Encourage other participants to provide support, suggestions and to help to the “actor”.
- Debrief each participant on their emotional experience of taking on the role e.g. ‘how did it feel?’, ‘what were your thoughts?’ etc.

26 - These tools are very active and sometimes emotional methods that allow the strong involvement of the participants; they are therefore to be used carefully with the supervision of trained personnel.



## → B/ PERSONAL REPRESENTATION (of difficult interactions, choices or situations)

### Definition:

This technique involves the simulation of difficult conversations or interactions, related to a specific critical decision, relationship or interaction with another family member relating to a specific theme.

### Objective:

To prepare oneself for a potentially difficult situation or decision-making process.

### Target / persons involved:

Small groups (6-12 persons) Implementation steps:

- Identify the “actors”: i.e. one person who has a specific (real) problem or situation they want to address and another actor(s) to take on the role of a husband, son, family etc.
- The participants act out the potential interaction.
- During the role-play the rest of the group observes the communication dynamics.
- After the role-play, the observers can provide useful information and suggestions, helping the person to reflect on their own ability to cope and manage the situation and the interaction.

### For example

*A woman who needs to talk with her husband to ask him to be more closely involved with some child-care activity in the household, and who fearfully anticipates this difficult interaction, can be helped to repeatedly simulate the anticipated discussion with her husband, within the group. She is offered communication advice, hints, tips, feedback and emotional support from other women that have experienced similar situations.*

## → C/ HOT SEAT<sup>27</sup>

### Definition:

This method aims to help a group member present a personal difficulty they are experiencing when changing or trying to influence others’ behaviour. The person will take the “hot seat” to express her problem to the others and will listen to the others’ advice about what she could do differently.

### Objective:

To help analyse a personal difficulty in changing a behaviour, or adopting/adapting a practice to one’s own constraints, by mobilizing the support of the group.

<sup>27</sup> - Other, more complex, uses of this technique (shifting seats or points of view) allow a person to analyse more deeply his/her own difficulties and ambivalence about the issues at hand, or his/her own attitudes and relationship dynamics; however, some of these methods are used by clinical psychology interventions, thus requiring a specialist training.

### Target / persons involved:

Small groups (6-12 persons).

### Implementation steps:

- The person with the problem sits in the centre of the group.
- For a few minutes, the group asks them the questions necessary to understand the situation and its determinants.
- Together, the group looks for a shared solution, trying to identify the various strategies and suggestions together as a group.
- The emphasis is on the emotional support provided by the group and the capacity of the group to generate new ideas and solutions.

## → D/ PSYCHODRAMA<sup>28</sup>

### Definition:

A psychodrama is a role-play based on improvisation, around a defined theme, where each participant uses their imagination to act out their role.

### Objective:

To raise awareness of participants' attitudes and interpretations of a certain issue or situation. To analyse complex situations and support changes in attitudes and to understand the other persons' feelings and point of view.

### Target / persons involved:

Small groups (6-12 persons).

### Implementation steps:

- Define a theme or problem for the psychodrama.
- A group of people enact a "scene" organized around the defined theme or problem, using improvisation.
- The facilitator (or "director") may assist in the development of the play, and helps the actors to focus on the processes of interaction and relationships.
- At the end of the short play, the group discusses the issues raised and the way in which they were represented and developed by the protagonist and the other "characters" that participated.
- An emotional debriefing is necessary because psychodrama is a technique that can arouse strong emotions amongst the participants.

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28 - Invented by J. L. Moreno (1930-1932), psychodrama is a technique derived from psychotherapy and is mainly used in clinical settings, but it can sometimes be adapted to educational and social contexts. It is a very powerful and technically complex process and because of its possible high emotional intensity for participants, psychodrama work must necessarily be conducted by qualified personnel (e.g. psychologists, mental health specialists).

### e. Family based-approaches

Family focused approaches are extremely widespread and useful in behaviour change interventions. In many cases, the barriers and motivation to behaviour change are at the family level, and the family is the main social support network for the individual. Families play an essential role as agents for social order and for the reproduction and transmission of social norms. They can also influence a wide range of micro-level processes affecting individuals and communities; such as cultural traditions, practices and social roles, traditional child-care, nutrition and health practices and the use of economic and productive resources.



#### SOME IMPORTANT POINTS TO KEEP IN MIND:

The family has to be considered as a “whole system”, it is not just the sum of the individual members. Relationships and communication roles, personal power dynamics, complex socio-affective and hot emotive-motivational issues are the “core” of family life; the family intervention has to take into account this invisible complexity, and respect it.

Behaviour change often has emotional, symbolic or relational consequences that affect every member of the system, and change has to be supported (or tolerated) by the system as a whole. It is therefore, very important to discuss the perceptions and anticipations that each member of the family (wife, husband, parents, children, etc.) has about the proposed change, which roles could be threatened by this, what risks (if any) there are to internal cultural or family traditions and what adaptations have to be made as a result of the behaviour change process.

## ➔ A/ HOME VISITS AND FAMILY SUPPORT

### Definition:

This involves the recognition of the complexity of family dynamics and working with different family members to achieve positive outcomes.

### Objective:

To initiate, support and facilitate sustainable behaviour change processes by intervening at the family level, focusing on the influential role that different family members may play (e.g. mothers, grandmothers, fathers, etc.).

### Target / persons involved:

Families

### Implementation steps for the “Story with a Gap”:

- Identify, prioritize and involve families following quantitative or qualitative assessment or according to predefined family-specific characteristics (severe poverty, known psycho-social problems, previous child malnutrition cases, very young mothers, very low educational level, affected by traumatic events etc.).
- Assess the family’s needs and dynamics in partnership with the family members.
- Identify the “family gatekeeper” (an educated son, a responsible father, a mother looking for help for her children, etc.), and through them access the family as a whole.<sup>29</sup>
- Where possible, involve key family members in efforts to overcome barriers, and to encourage the provision of resources (from an emotional, physical and economic point-of-view).
- Use the ABC method in a family session to discuss the positive and negative implications of the proposed change for different family members (e.g. mothers and fathers can be motivated to start and maintain a change, even in difficult conditions, if they clearly perceive that it is essential for their children; sons might do the same for their ageing parents etc.)
- Assess the family progress and change.

*A change in the intervention context (e.g. returning to the family after staying at the nutrition centre), can be a difficult moment of transition, and personal choices and behaviours that were modified during the stay at the centre can be “challenged” or undermined in the family context (or by some key family member: the husband, parents, etc.). It is necessary not only to support the mother by providing follow-up, but also to support the “mother within her family context”, and to view the family as a system, so that the whole family can work together to understand and accept the changes necessary and to help to maintain them.*

29 - In many cases, the involvement of mothers (i.e. during a stay at a nutrition centre with their babies) can be the first step that allows a direct contact (for educational, support or follow-up reasons) with the rest of the family. The educational or behaviour change work begun at the nutrition centre can then be extended to the whole family system in which the child’s dysfunctional nutrition problem arose and grew.

## → B/ FAMILY DEVELOPMENT APPROACH<sup>30</sup> (FD)

### Definition:

This approach involves a programme of structured social work with specific families with a particular focus on the poorest and those that are socially marginalized, helping them to draw on their own strengths and resources.

### Objective:

To facilitate and empower social participation and to encourage a better use of local resources and problem-solving skills by family members. To encourage better family support, improved relationships and communication in order to increase autonomy and make people less dependent on handouts.

### Target / persons involved:

The poorest and most marginalized families living in identified deprived communities.

### Implementation steps for the “Story with a Gap”:

- Hire and train psychosocial workers.
- Identify target areas for the family development intervention.
- Select families based on pre-defined criteria (poverty levels, children’s health status etc.).
- Conduct regular home-visits to develop a trusting relationship with the family and its members.
- Provide support to identify precise objectives and provide counselling and support to reach them.
- Support the family to develop more stable and appropriate relationships.
- Support the family to have better access to local resources and services.
- Use simple quantitative indicators alongside qualitative ones to assess the success of the interventions in terms of behaviour change.

## f. Individual methods

### → A/ MOTIVATIONAL INTERVIEWING

#### Definition:

Motivational interviewing is an approach to counselling that is well known for supporting people through the change process and is based on exploring and solving the ambivalence that is commonly felt towards change. It is more a relational style of counselling than a distinct method and is based on empathy, resistance identification and respect and the reinforcement of self-efficacy. The individual is gently nudged towards change but has to make choices of their own free will.



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30 - The Family Development (FD) approach, devised by Inter Aide, presents some interesting elements that can be incorporated in behaviour change programmes. For a more detailed explanation, please refer to the ACF briefing document on the FD approach.

### Objective:

The objective is to help and support the individual to initiate and maintain behaviour change. To get to this final step, the counsellor will identify and support intermediate objectives, according to the individual's stage of change.

### Target / persons involved:

Individuals.

### Implementation steps for the “Story with a Gap”:

- Establish a trusting relationship with the person.
- Assess their readiness to change and their resistance to change.
- Assess motivation and confidence in the change process.
- Enable the individual to explore the problem and possible solutions.
- Identify concrete actions and follow-up.

### The principles for motivational interviewing are:

- Warm and welcoming relationship.
- An atmosphere of empathy.
- Good listening to encourage discussion and the change process.
- Respect the priorities, concerns and rhythm of the individual to reduce any resistance to change (“roll with resistance” rather than challenging it).
- Encourage the person, praise and support their capacity to change and identify things they have already managed to change.

## ➔ B/ INDIVIDUAL SUPPORT (“COUNSELLING”<sup>31</sup>)

### Definition:

This is an intervention focused on the individual who encounters problems in changing a behaviour because of lack of information or knowledge or low self-efficacy, relationship and communication problems with other members of his family or social group (lack of social support) or mild personal psychological difficulties related to fear, anxiety, stress, depressive symptoms etc.<sup>32</sup>

### Objective:

To help the person overcome difficulties by helping them to analyse the main hindering or facilitating change factors at the individual, family and social level, by providing knowledge or information within a supportive relationship and by enhancing their problem-solving or social skills.

31 - Counselling is an approach in which therapists or experts offer advice and support to someone for a specific problem (Acf-In MHCP Policy)

32 - We must clearly distinguish the individual support intervention from other types of clinical psychology/ psychotherapy counselling interventions, because they have very different objectives, relational structures and settings. Broadly speaking, this individual support is directed at people with specific difficulties with the aim of offering advice for specific problems; “psychotherapy” is more open-ended and is an exploration of thoughts, feelings and behavior for the purpose of problem solving or achieving higher levels of functioning. Psychotherapy aims to increase the individual's sense of his/her own well-being



### Target / persons involved:

Individuals.

### Implementation steps for the “Story with a Gap”:

- Support the individual in the analysis of the context (individual, family, social network), and help them to define possible objectives for behaviour change.
- Use the ABC and Force Field methods to identify their personal motivation to change or to “remain in the same state”, and help the individual to explore their readiness for change.
- Identify the barriers to change (e.g., a lack of information, lack of economic resources, lack of social support, etc.) and the resources for change (family resources, social network, motivation, personal competencies, etc.).
- Provide the required information or knowledge, and (if necessary) work on developing the problem-solving and social skills needed to empower the individual.
- Refer, whenever necessary, to local Social/Health/Education services; linking to nutrition or counselling centres; personal support and/or other support groups.
- Assess progress towards behaviour change and in the personal or family situation; provide individual feedback and social support related to problem solving.

#### NOTA BENE

A short series of meetings (2-3 initial encounters, followed by regular follow-ups on a biweekly/ monthly basis), is much more useful than a single on off encounter (“spot intervention”).

**To integrate individual support into behaviour change initiatives requires certain pre-conditions:**

- The presence of trained psychosocial personnel (psychologists, social workers, trained and experienced local implementers).
- A very clear definition of objectives, limits and technical modalities of the intervention and
- Continuous supervision provided by psychologists/psychotherapists.
- Training of staff is essential to ensure that ethical principles are adhered to (non-judgmental attitude, respecting and recognizing the complexity of individual’s behaviour change and the barriers to change, and the use of active listening methods).

*A way to also work during counselling sessions for facilitating and supporting BC can be to work with the person to identify several options to be implemented to achieve the identified change objective. Once the option is chosen, the work of support for it can start.*

33 - See here the implementing agency objective versus the beneficiary’s objective of change.

### For example

*In a certain area a medical NGO has noticed high rates of anaemia among women, especially pregnant women. Women are not very concerned about this problem and the importance to have a higher iron intake (change objective of the medical NGO), but most of them report to be frequently tired and would like to feel more healthy (personal problem of women and change objective for them)<sup>33</sup>. This fatigue can be clearly associated to the anaemia problem, so the team of the NGO starts to work with mothers on the reported fatigue. They propose to the women several options to get the objective:*

*They can start to take micronutrients pills*

*They can start eating more iron enriched food (as green leaves)*

*They can reduce their tea consumption*

*.....*

*During the counselling session the woman decide which option is ready and will to try and all the support will be provided to achieve this objective.*

## **g. Ritualization methods**

It is important to help people, groups, and individuals to ritualize the new behaviour, to integrate the process of change and to maintain it on the long term.

As we have already seen several techniques presented above can be also used to reinforce the ritualization process of BC. In particular the role-playing/active methods can help people to identify and anticipate future difficulties in maintaining the changed behaviour, so this aspect can be worked (and solved) in time. So instead to use these techniques to experiment the new behaviour, they will be used to identify on long terms the barriers to it that may reduce the maintain of it. We can ask and work with people on: what other people think about the new behaviour? Who are these people? And what they could do to boycott the new behaviour? Working on these aspects in group can help the person to face in advance the eventual difficulties and to be ready when he/she will face them in the reality.

Another method that may be used is to propose simple home exercises to people between one session to another one to test the new behaviour in different contexts (at home, at work, with friends...) and to discuss the result of it during the following session. This can help the person to reinforce the BC process, to be aware of it and to better integrate it.

A third method could be to ask the person to write about the BC in an agenda and to describe it with the aim of supporting the awareness process of change, crucial for the BC maintain.



## **2. MONITORING AND EVALUATION**

Monitoring and evaluation of a change initiative is strictly connected to the type of change we are pursuing, in which context we are working and what means we are employing. But “change in and of itself” is not the objective; and neither is the quality of implemented processes. It is necessary to evaluate the facilitated “change” for its objective impact on public health.

For example: focusing on the feeding and care skills of mothers in a nutritional centre could have short-term positive effects; but if these women, after their stay, return to very difficult family situations in which they don’t have sufficient interpersonal skills or social influence to maintain the good nutritional status attained by their children, the “changed behaviour” runs the risk of having little effect in the long-term on public health outcomes. In this case, we need to implement a broader intervention promoting behaviour change in a more complex way.

**Therefore, monitoring and evaluation processes have to answer, both at the qualitative and simple quantitative level, the following questions:**

- Which behaviours were changed (and how much)?
- How stable (maintenance) is the changed behaviour?
- If, and what, negative unintended effects were caused by this behaviour change (e.g. in another part of the social system)?
- How, and how much, has this behaviour change actually had an impact on the desired public health objectives?

It is thus necessary to investigate each of these points and to indicators that will help us to measure or judge the nature of the change that has taken place:

- 1) Define some parameters for behavioural baseline assessment with which to compare the results (e.g. number of mothers with children <6 months that are not breastfeeding).
- 2) Evaluate if the change is stable at six months or a year after the intervention (e.g. % people initiating the new behaviour compared to the % maintaining it at 6 months).
- 3) Evaluate the consequences on other behaviours or practices (mostly with qualitative methods or simple quantitative methods).
- 4) Evaluate the link between the behaviour change that has occurred and the impact of the initiative in terms of public health (proxy indicators); e.g. the ratio of severely malnourished children in the community six months after the end of the behaviour change initiative, compared to the baseline at the beginning of the intervention.

*Note that some subtle but important behavioural changes in nutrition or sanitation practices will not show an immediate effect. Thus, evaluations have to check also for behavioural changes that have a delayed impact on public health outcomes (e.g. the evaluation of whether new household hygienic practices related to child-care have been adopted can be done in the short term, but the effect of these new practices on lowering child infection rates has to take place some weeks or months later; the two types of evaluation should not be confused).*

## Monitoring and evaluation methods

To collect the information above detailed and necessary to properly monitor and assess the change process, the changed behaviour and the sustainability of it, we can easily use techniques and tools already described in the Paragraph 3.2 related to tools and techniques for assessment.

The objective of the exercise will change but not necessarily the technique. Here are a few examples:

- Interviews and observations may be used to monitor and/or make a final evaluation of a process of change and/or of a specific changed behaviour, asking and observing the changes in terms of practices.
- ABC technique done in several moments of the change process can show the implemented differences: less advantages associated to the new behaviour and in the same time more advantages.
- Venn diagrams can also show how the other people around are supporting or not the new behaviour and this helps to re-orient or re-adjust the approach, the activities or the target of intervention.
- Basic or future trends baselines done to represent the work and the changes since the beginning of the program can help to show the progress and to assess the realised change made by groups/individuals/families.

## 3. AN EXAMPLE OF ABC PROGRAM AND ITS PHASES OF DEVELOPMENT

*In a rural area with a high rate of malnutrition in children under 1-year of age, and an apparently low rate of exclusive breastfeeding practice, Anne, a psychologist from ACF, chooses to integrate behaviour change methods into the nutritional project proposed in some of the local villages. The aim is to increase the exclusive breastfeeding rate and in this way, prevent child malnutrition in the area.*

*First of all, she needs to understand the causes, the local interpretations (social meanings) and the psychosocial implications of these problems.*

*A preliminary organizational meeting is arranged with local leaders and local health staff to explain the initiative. To begin the assessment phase, Anne then arranges to carry out some semi-structured interviews with them, to analyse the interpretations that different key informants can provide about the general socioeconomic context, local perceptions of causal factors and how this affects child malnutrition. In addition, the interviews also aim to collect some general information about local childbearing practices, the social role of women, and traditional cultural representations of breast-feeding practices. This exploratory phase is necessary for Anne to “enter” into this new and unfamiliar context.*

*After this first “orienting” phase, Anne has a general overview of the situation, and now needs to analyse and verify this data, in more depth with local women. She chooses to organize a community interview in a public space, involving women with the help of local health staff,*



in order to collect other data on the local social structures and their perception of child malnutrition. She prepares some questions for debate, and asks the women for their own view of the problem.

After the meeting, having verified some of the preliminary data derived from the initial semi-structured interviews, she can organize a last round of assessment and local involvement in the participatory analysis process; she chooses to use group-based work (discussion groups), specifically with young mothers, to better analyse the outcomes of the community interview in smaller settings.

In these groups she suggests the use of some simple PLA-derived tools (Participatory Learning and Action), such as “Rich Picture” and “Story with a gap”<sup>34</sup>, to get both a comprehensive and in-depth description of the situation, as well as a narrative understanding of what mothers themselves perceive to be solutions to the problem, involving them in an interactive discussion about the issue, the impact that it has on their lives and their family life and what they think could be potentially viable and acceptable as a solution in their social context. Using the ABC technique, focused on the specific social practices and individual behaviours that have been identified as possible “targets for change”, she learns about the barriers and motivations for changing feeding practices in the local context.

Following this assessment phase, she can start a multilevel intervention phase. She has identified some high-value “target behaviours” and their causes and consequences. involve the early adoption of complementary feeding at too young an age and a lack of expertise in breastfeeding practices amongst younger mothers. She organizes a public level intervention to address some of these problems.

Initially, she organizes short learning sessions at the nutrition centre. These are for groups of mothers and use role-play and behaviour simulation to share experiences and allow the mothers to experiment with correct breastfeeding practices. In these groups, young mothers can learn, discuss, try out and give and receive support, with other women who face the same problems. Then, she involves some of the more active and motivated women in a peer-based education programme, to help reach the most isolated families in far villages. Women are involved in training sessions to teach them basic communication skills and information on complementary feeding and to help them cope with the challenges and specific issues they might face when carrying out peer-education activities. She also organizes a biweekly supervision session for them. The peer-based initiatives seem to work well, but after two months it is clear that in some families there are problems implementing the proposed changes and that there is a need to better understand the role of traditional birth attendant, key persons in the community on child care.

Anne organizes two on-going assessments based on discussion groups with the women who are involved in the peer-support group, with local social workers and TBAs. From these encounters the opportunity emerges to include a family counselling initiative for some women to provide more intensive support and also to involve more traditional birth attendants highly implicated in knowledge transmission on feeding practices. With the help of the local social workers and other ACF staff, Anne incorporates these elements into the programme.

Finally, using the simple RE-AIM parameters, Anne evaluates how many people of the targeted population were reached, how many of them changed their feeding practices, and if these changes were maintained in the long-term.

34 - The details of how to do these techniques will be described later.



## IV. “FUTURE TRENDS” AND THOUGHTS ON BEHAVIOUR CHANGE





## 1. INCREASE IN URBAN CONTEXTS<sup>35</sup>

As more and more people live in cities, interventions have to progressively focus, in the next years, on a more “disadvantaged urban community” centred approach (with its very complex social dynamics).

An urban community is more socially complex, interconnected and subjected to different and heterogeneous cultural and economic influences than a rural one. These socio-cultural aspects have to be carefully evaluated when behaviour change interventions are projected and implemented, and have to be taken into account in particular when organizing interventions at the local community or neighbourhood level (that are more complex and less culturally homogeneous, with a more developed ecosystem, external influences and social mobility issues, multiplicity of cultures/traditions/habits).

For example, in complex urban settings social norms can be more fragmented, heterogeneous and less “normative” for individuals; different communities of practice can live side by side without interacting; there may be many local leaders with different spheres of influence. Social and geographical mobility is stronger than in rural settings; social, health and educational services are more accessible and somewhat more “advanced” and so on.

*The family development approach*, with its specific methodology adapted for complex social settings, is particularly suitable for implementation in such urban settings.

## 2. NEW MEDIA AND BCC

In many developing countries the majority of people, despite their low socio-economic status, have and use mobile phones (70% of the total population in developing countries in 2010<sup>36</sup>) and have increasing internet access (21% of the total population in developing countries in 2010). The digital divide is being challenged worldwide and is breaking down and mass communication is evolving very quickly. It is vital to explore the new opportunities that will arise in the next few years for BCC, health promotion and humanitarian aid as a result of the spread of personal communication tools, even in the poorest countries and lowest social groups of society.

Is it possible to think of how to adapt information packages or group sharing support also through personal communication tools, Will it be possible in the future to adapt this new media to working in remote areas or not-so-easily accessible social groups? The answer to this is not clear because behaviour change is not based only on information provision. The “new media” cannot at present substitute for the personal and group relationships that are essential in many behaviour change interventions. However, it is vital to keep abreast of the rapid evolution of BC interventions and the, future potential of the new media.

35 - A major geographical and demographical world trend is the continuing relocation from countryside to cities: in 2008, according to the UN, for the first time more people lived in urban areas than in rural ones. It is estimated that 5 billion people, also in developing countries, will live in cities by 2030.

36 - See: <http://www.itu.int/ITU-D/ict/statistics/>

### 3. INTERVENTIONS IN CRISIS AND EMERGENCY SETTINGS

In emergency interventions, “social meaning” is deeply disturbed (due to displacement, extreme poverty, environmental or man-made threats that undermine the community, etc.), and people need to rapidly adapt to new living, economic and social conditions. In these rapidly changing and troubled situations, can happen sometime that “old values and norms” are reinforced, in a desperate search for a stable identity.

However, crises (external but also internal!) also present key opportunities to implement behaviour change interventions simply because the “behaviour ecology” is in a very dynamic state and the old economic and social context is being challenged. Therefore, it can sometimes be easier to work on traditional and dysfunctional behaviours and practices. However, it is important to be aware of a possible psychosocial resistance to change and the tendency to emphasize the “old ways of doing something” and implementers can also be faced with additional barriers to change that can be extremely difficult to overcome.

### 4. CONCLUSION AND FINAL REMARKS

In presenting the ABC approach and techniques, we hope that we have shown the complexity of behaviour change. The main operational implications for ACF are summarized below:

- 1. Behaviour change is not a separate component of the humanitarian intervention: it should be in general integrated into the programme (even if stand-alone ABC programs are possible).**

Behaviour change is challenging, but it is essential to at least try to optimize the outcomes of humanitarian interventions.

Behaviour change is not an “add on” or activity that is separate from the usual projects and initiatives: it is one of their core components, and it has to be integrated in almost every type of intervention. Indeed it can act as a “force multiplier” and make the intervention more effective.

Behaviour change issues are a fundamental aspect of working on child caring practices, nutrition interventions, health care programmes, illness prevention, health promotion, management of land resources in food security programmes and water sanitation and hygiene practices. Behaviour change can play a major “facilitating” role in almost every intervention in which ACF is involved.



## 2. Behaviour change is not a “here-is-the-outside-expert-fixing-what-is-wrong” intervention.

Behaviour change, even when it targets a specific behaviour or a well-defined practice, is not a “mechanical fix”. Behaviours and practices are almost always linked to other behaviours, some of them positive, some negative or problematic.

Behaviour change interventions that take a holistic approach can also have systemic effects and can sometimes enable the “empowerment” of the individual, family or social group and not just work on a behaviour change in isolation of the context in which it occurs.

Assisting behaviour change is not about “fixing something” or “teaching something to someone”, but it is about recognizing and supporting existing positive practices. It is about working in partnership with people to define new practices. It is about creating safer and more sustainable “social” environments to enhance people’s quality of life and help them to maintain changed behaviours. Lastly it is about motivating more positive and healthy lifestyles within the existing contextual constraints.

## 3. Behaviour change is based on the smart integration of different approaches that work at different levels.

There are many models, theories and methods of behaviour change, that work at different functional levels (social, group, individual). It is essential to integrate them “intelligently”, carefully adapting and customizing the methodology or strategy (drawing on a variety of techniques and approaches) to address the specific needs of a given situation.

Many models and techniques have become popular in the past, based on very high expectations of their potential universal applicability. In most cases, recent scientific research has often significantly reduced these expectations<sup>37</sup>.

Even when used properly, the methods and approaches described only have, on average, a “low” or “low-to-medium” rate of effectiveness, when used on their own, according to the available research. What are the implications of this?

One possible solution is to use a variety of approaches and methods, based on the needs and characteristics of the local context and target groups. This has to be planned in an organised and strategic way, with very clear objectives. This is not often the case currently and many programmes use a casual and heterogeneous, “mix” of techniques that are used unsystematically and without clear objectives). It is therefore very important to carefully plan the intervention and to ensure that ongoing monitoring is in place and that continual feedback is sought on its effectiveness.

In this way, the active integration and the mutually reinforcing synergy of different techniques, methods and best practices, each running on a different functional level

37 - For example, the classic models of health psychology, such as the HBM or the TRA / TPB, have demonstrated a predictive ability smaller than expected; stage-oriented models (such as the transtheoretical model), which showed initial promise have provided positive but controversial research results; classical “top-down” mass communication efforts, based on the rationalist assumption of “information transfer” (within a classical Knowledge-Attitude-Practices paradigm), have often provided low or very low public health effects. Even “participatory approaches”, which are based on a very different logic, and had great success in the ‘80s and ‘90s, have received criticism and have proven, in many cases, inadequate with respect to the initial high expectations of effectiveness in changing behaviour.

(social, group, family, individual), and acting in parallel through different psychological mechanisms and social processes, could lead to an effectiveness that is greater than the sum of its parts.

**Amongst the most effective factors are:**

- Active community involvement and initiating a "social dialogue" and debate about which practices to maintain, which can be improved and which can be changed;
- A "socio-ecological" intervention, which takes place at the "contextual" or situational level (normative, regulatory, collective culture, supportive environment issues) and at the individual behaviour one at the same time;
- A collaborative partnership with all key stakeholders, local leaders and social subgroups;
- Paying attention to the cultural meanings and social norms that determine and influence traditional practices and individual behaviours;
- Having an attitude of respect and putting people more in control of decision making (empowerment);
- Focusing not merely on short-term changes (that are easy to obtain), but on initiatives that facilitate the long-term maintenance of the changed behaviours within the constraints of their social context.

#### **4. Behaviour change, as a humanitarian intervention, is not about "using ideal methods in an ideal world", but rather about acting pragmatically in a real and complex world to make an intervention as effective as possible.**

A realistic and pragmatic approach to behaviour change methods is vital. Even though several classical BC models have not always demonstrated their universal applicability in the research setting, they can nonetheless help to inform the way we assess and plan programmes. The individual components of these models have been shown to be important in behaviour change and can be used pragmatically to inform a strategic and well-planned intervention that will be more effective than the ad hoc use of mass dissemination techniques.

#### **5. Behaviour change is also a matter of ethics.**

It is important to remember that certain ethical principles need to be strictly respected in all behaviour change programmes and that such programmes have an impact on the very people's lives, habits, traditions, capacities, etc. Therefore, it is essential to show respect and to adopt a non-judgmental attitude towards the people you are working with and their history, beliefs, social organization, current situation, existing constraints and capacities. For this reason we cannot support the use of approaches based on producing shame or negative feelings. The population targeted by ACF is by definition experiencing psychologically disturbing events (war, violence, poverty, famine etc.), and the relationship between the people we work with and many of our staff, particularly international staff, is often unequal. For this reason, it is all the more important to respect these ethical principles.





## V. APPENDICES

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# 1. SOME NOTES ON PARTICIPATORY FRAMEWORKS

## PARTICIPATORY METHODOLOGIES: STRENGTHS AND WEAKNESSES

Field researchers and implementers have developed various interactive approaches to deepen their understanding of the contexts and situations in which they work. Participatory approaches are widely used and can be powerful tools if used well.

Participatory methodologies, such as PRA (*Participatory Rural Appraisal*)<sup>38</sup> or PLA (*Participatory Learning and Action*), aim at facilitating the link between “knowledge” and “action” through a direct and active involvement of the stakeholders and have a preference for qualitative approaches. They tend to focus attention on the more marginal and less empowered social groups in the community.

However, participatory approaches have been criticized for the following weaknesses:

- Idealism - a participatory approach, by itself, cannot ensure real and comprehensive “participation”, social empowerment, social equity, or the initiating of a “virtuous self-sustaining active involvement process” in a community.
- The expectation of community heterogeneity - the notion that the “community” is a homogeneous social reality is just a myth<sup>39</sup>.
- The expectation of equity - equity of access to resources, to opportunities and also to project initiatives is seldom assured.
- The question of long-term efficacy - Brown et al., (2002) suggest that PRA methods seem to fail in changing structural relations<sup>40</sup>.
- The way techniques are used - participatory approaches offer many methods, techniques and tools, and it is essential not to use them in a mechanical, chaotic, techno-centric and uncritical way.

## THE USE OF PARTICIPATORY METHODOLOGIES

A participatory methodology can be very useful to obtain certain results in different contexts:

- To analyse the psychosocial and cultural operational context and the main practices of interest.
- To analyse the “type of change” that the community needs to focus on and facilitate and whether the community perceives the necessity of behaviour change or opportunities for such change in relation to current practice.

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38 - McCracken, A., Pretty, W. and Conway, G. R. (1988), *An Introduction to Rapid Rural Appraisal For Agricultural Development*, International Institute For Environment And Development, London.

39 - A community is composed of various subgroups, often with different dimensions, socio-economic power, social roles, and cultural and ethnic roots.

40 - In their review, Brown et al also noted that the desired “igniting” of long-term positive and self-sustaining initiatives in the community is lacking. Also, if social groups’ involvement is good during the project, their autonomy and expected self-sustainability process seems to disappear after the end of the project itself. Brown, D., Howes, M., Hussein, K., Longley, C., Swindell, K. (2002). *Participatory Methodologies and Participatory Practices: Assessing PRA use in the Gambia*. ODI - AgReN, Network Papers, 124; <http://www.odi.org.uk/resources/docs/5204.pdf>

- To assess perceived needs and their associated interpretations within a specific context.
- To identify with the community, strategic changes and their associated implementation steps (causative variables, correlations, implications and consequences etc.) and the tactical ways (specific techniques) that can be used to facilitate change.
- To collect “accurate enough” data about contexts and stakeholders.

Participatory methods have been classified by Pretty and Vodouhe<sup>41</sup> into four general categories:

- Group and team dynamics (e.g. group-based work, team empowerment, etc.).
- Sampling (widely applied for the representation of issues and social groups: e.g. transects, social rankings, social maps).
- Interviewing and dialogue (e.g. key informant interviews, community interviews).
- Visualization and diagramming (e.g. visualization techniques, Venn diagrams, community maps, rich pictures).

*For further reading on this chapter's topics, see also: Reason, P. & Bradbury, H. (Eds.) (2001) Handbook of Action Research: Participative Inquiry and Practice, Sage; Action Research Resources, <http://www.scu.edu.au/schools/gcm/ar/arhome.html>*

## 2. SOME INFORMATION ON BCC, CSC, CLTS AND POSITIVE DEVIANCE

In recent years, the use of certain methodologies has become more widespread in the international humanitarian aid community. BCC (*Behaviour Change Communication*), CSC (*Communication for Social Change*), Positive Deviance and, for the WASH sector, CLTS (*Community Led-Total Sanitation*) are discussed below.

These approaches are now used in various operational contexts. However, whilst they can provide useful operational guidance, they are not without ambiguity. They are “general frameworks”, that if applied in a standard way in all programmes may lack the methodical application of behaviour change theory. It is therefore important to adapt them to the specific context.

With some methodologies, such as CLTS, there is an attempt to use explicit psychological and psychosocial influences to facilitate changes in hygiene practices at the community level. There are some promising results but also controversies and criticisms. For example, CLTS uses a powerful psychological construct - “social shame” and if this is used in a de-contextualized and rigid way it can create more problems than it solves. This underlines the need for a professional psychological assessment of groups and communities, before using such interventions.

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41 - Pretty, J. N., & Vodouhe, S. D. (1997). Using Rapid or Participatory Rural Appraisal. In Swanson (ed.), Improving Agricultural Extension: A reference manual, 47-55. Rome, FAO; cit. in: Evaluating Socio Economic Development, Sourcebook 2, 2003.



## 1. BEHAVIOUR CHANGE COMMUNICATION

Behaviour change communication (BCC) is described as, “the strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change”.<sup>42</sup>

BCC represents an evolution of classical IEC (Information - Education - Communication) initiatives. In IEC initiatives, “mass communication” is usually only used as a tool to raise awareness at the individual level: communication is one way and the individual is ‘passive’. The BCC model offers a more comprehensive perspective on behaviour change issues, drawing on contextual variables, and on the use of more interactive and varied communication channels (communities, families, individuals).

Many BCC programmes incorporate different principles derived from health psychology models, such as the Health Belief Model, the TRA/TPB or Stages of Change models, focusing their communication efforts on some of the psychological variables provided by these models.<sup>43</sup> For example, they can focus on the effect of a specific “barrier” to behaviour change (as suggested by the HBM model), or craft messages aimed to specifically support “behavioural intentions” (an important element of the TRA/TPB model), or differentiate messages and the timing of delivery for people in the “contemplation” or “preparation” stage of change (stages of change model).

In this sense, BCC is partly “**psychologically-oriented**”. BCC is often defined as a comprehensive approach for communication, based on a structured contextual analysis (examining the socio-cultural and community levels, using a participatory approach), theoretically sound psychological principles (derived from behaviour change models), and a sophisticated technical and strategic approach to “communication design”. These factors explain its recent success in many social programmes around the world.<sup>44</sup>

**A BCC programme is often structured as follows:**

1. Analysis, conducted through the use of participatory methods and an active involvement of key stakeholders and focused also on contextual “barriers” at the cultural and social level.
2. Strategic design, to ensure that the target will be reached with a sound and carefully adapted communication.
3. Development and pretesting, using community participation, to help develop and test materials, using quality control procedures.
4. Implementation and monitoring.
5. Evaluation (measure outcome, impact using quality indicators).

However, BCC has some important limitations. Firstly, its “framework” leads to a lack of operational standardization of approach. Thus, in the field there are many different kinds of “BCC” interventions, with different interpretations and focus and all implemented differently. In certain

42 - Johns Hopkins Bloomberg School of Public Health (2008). Tools for Behavior Change Communication, Info Reports 16, 2008.

43 - Ibid.

44 - C-Modules, A Learning Package on Social and Behavior Change Communication (SBCC). <http://c-changeprogramme.org/focus-areas/capacity-strengthening/sbcc-modules>

situations, where communities are targeted or programme has a communication element, it seems that it is by default labelled as “BCC”. It is a strategy that is too vague and generically defined.

Second, evaluation of outcomes is somewhat unsatisfactory; many programmes do not obtain their expected results, and this is an essential issue that needs to be addressed.

*As previously stated, recent scientific research showed a low rate of efficacy the use of health communication approaches using predominantly mass media (less than 10%-20% of the targeted population).<sup>45</sup>*

BCC is a useful development (both at a theoretical and methodological level) compared to traditional IEC programmes **but it is essentially a “comprehensive approach to mass communication”**.

Throughout this document on behaviour change, we have shown that complex behaviour change initiatives have to be developed at **both the mass communication level**, as well as at other levels such as the family and group and using interactive methods (community narratives and events, discussion and support groups, role-playing, etc.), individual counselling and so on. **Therefore, BCC seems to be a general framework that enhances mass communication efforts, but alone is insufficient to achieve a real and lasting behaviour change in many communities.**

*For BCC for improved Infant feeding, see also: [http://www.globalhealthcommunication.org/tool\\_docs/22/bcc\\_and\\_if.pdf](http://www.globalhealthcommunication.org/tool_docs/22/bcc_and_if.pdf)*

## **2. COMMUNICATION FOR SOCIAL CHANGE**

The concepts employed by BCC are also widely used in Communication for Social Change (CSC). CSC is an international initiative to disseminate concepts, tools and good practice about communication activities that aim to promote and support social dialogue and social change, in particular in poor communities and emphasizing the importance of participation. The CSC Consortium defines its mission as:

*“...to help people living in poor communities communicate effectively so that they can be the best advocates for the change needed to improve their lives, communities and countries.”<sup>46</sup>*

Through its official website, the CSC provides many useful training and reference materials relating to different types of social change initiatives, BCC programmes, and participatory methods.

*For tools on SBCC see also: <http://c-changeprogramme.org/focus-areas/capacity-strengthening/SBCC-Toolkit>*

*Useful references on CSC: [http://www.communicationforsocialchange.org/pdf/cfsc\\_bibliography.pdf](http://www.communicationforsocialchange.org/pdf/cfsc_bibliography.pdf)*

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45 - Snyder et al. (2004), cited.

46 - <http://www.communicationforsocialchange.org/>



### 3. CLTS BASIC CONCEPTS

*Community-led Total Sanitation* is a methodology developed in 2000 in Bangladesh. It aims to improve the sanitation and hygiene standards in poor rural communities. In recent years CLTS approaches have received much interest from international NGOs and the WASH community, because it appeared to easily obtain high degrees of compliance with safe sanitation practices, such as the use of toilets and has helped to reduce the practice of open defecation.

CLTS is based on a community approach, which, enables people to appreciate the dangers of poor sanitation and open defaecation.<sup>47</sup> The focus is to mobilise “social pressure” against such open defecation. The behaviour change achieved in this approach, derives not from a mere cognitive decision-making process, but from the use of *peer and social pressure* and the *social stigmatization of “deviant” behaviour*. Feelings of “*social shame*” and *disgust* are triggered towards the behaviour. In this sense, it is a type of “*negative behavioural modelling*”.

However, CLTS proponents would argue that the feelings of pride at ensuring that a community is open defaecation free actually exert positive behaviour modelling.

Nowadays, the initial positive results from CLTS are questioned and it has been sometimes criticized for the use of shame and disgust in this way. The main criticisms are:

- The “shame-based” process of CLTS is used in the same way in different cultural contexts, where social shame, social identity and social worth develop differently.
- The social stigmatization of already socially marginalized individuals and families, could lead, not to better compliance, but simply to more stigmatization and reactionary behaviours.
- There is a lack of analysis of contextual, cultural and economic variables that can undermine the process of social pressure.
- It is suggested that the psychological costs of the “shame-inducing” processes can perhaps be too negative for the individuals involved, and such a critical attitude can reduce social solidarity and cooperation in already socially deprived communities?

*These are critical issues and the potential risks of using such an approach for the individuals and communities that we are working with must be considered. There is also the crucial ethical question about the process of stimulating negative feelings (shame) especially knowing that these target populations are vulnerable by nature, due to the difficulties they are facing. Finally, there is a theoretical inconsistency with the latest research, that supports the importance of self-efficacy, self-esteem and social support, in bringing about long-lasting behaviour change.*

A thorough analysis of cultural interpretation and meaning attributed to the practice of open defecation appears essential in order to understand the social dynamics behind this practice.

It is also vital to acknowledge that where people are living in extreme poverty, the resources for building toilets are just not available and in such resource poor settings it is important to avoid an

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47 - Some elements of this seem to be derived from the theory of Protection Motivation and the process of “threat appraisal”.

over-stigmatization of those who are most vulnerable.<sup>48</sup> New ways to enhance and adapt CLTS-like methodologies, modifying and correcting their potential for negative social outcomes, are currently being developed.<sup>49</sup>

*Handbook on Community-led Total Sanitation (2008)*, <http://www.communityledtotalsanitation.org/resource/handbook-community-led-total-sanitation>

#### 4. POSITIVE DEVIANCE BASIC CONCEPTS

Whilst CLTS is based on the concept of “negative deviance” (focusing on negative social behaviours), the positive deviance (PD) or so called “Hearth” approach is based on “positive deviance” (focusing on positive actions and behaviours).

The positive deviance/or “Hearth” methodology is a community methodology that identifies those people in a community or group who practice ‘positive behaviours’ despite living in ‘resource poor’ settings. The approach then uses these people (social outliers) as examples and as an inspiration for other people to learn from.

The positive deviance approach recognizes that it is possible for community members to take a very active stance when facing problems, and to thrive despite a lack of resources, and without outside interventions<sup>50</sup>.

The methodology was developed in the context of child health programmes in the ‘70s, with the objective to enhance child nutrition practices using a very pragmatic approach. It examined what was “functioning well” in the families who were doing a good job bringing up their children and extended these solutions to other families in the same context who were doing “less well”. This approach thus identifies a so-called “positive deviant”, or “positive outlier”. The “positive outliers” are initially identified using participatory methods such as “wealth ranking”. Then, in-depth semi-structured interviews are carried out with the “outliers” and their strategies and coping mechanisms are shared, discussed and disseminated amongst their peers, in groups or community meetings etc. and their widespread adoption is promoted. Family and individual counselling by trained implementers can help facilitate the adoption and adaptation according to the specific needs and contexts.

The approach has been adapted to different contexts, with a focus on child malnutrition, and with quite interesting results, but its specific impact has been difficult to evaluate, and there have been cultural barriers to its adoption in certain communities.

Positive Deviance or Hearth is thus a “**positive behaviour modelling**” approach, in which simple “behavioural imitation” is enhanced through group discussion, sharing suggestions and individual

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48 - More recent applications of CLTS have focused more on these variables, both on economic resources as well on cultural meanings and social implications of sanitation practices (cf. the very interesting cultural analysis of Dittmer, A., Towards Total Sanitation: Socio-Cultural Barriers and Triggers to Total Sanitation in West Africa, WaterAid, 2009).

49 - Chambers, R. (2009). Going to Scale with Community-led Total Sanitation: Reflections on Experience, Issues and Ways Forward, [http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Chambers\\_Going%20to%20Scale%20with%20CLTS.pdf](http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Chambers_Going%20to%20Scale%20with%20CLTS.pdf)

50 - Schooley, J., Morales, L. (2007). Learning from the Community to improve Maternal-Child Health and Nutrition: the Positive Deviance/Heart Approach. *Journal of Midwifery and Women's Health*, 52, 4.



counselling in order to specifically adapt the “positive behaviours” to different personal situations. Problems can arise when a local culture takes a negative stance to “social deviance”, or positive or negative individual differentiation. According to a recent literature review, in some cultures, there is “a strong preference for consensus and a cultural aversion to showcasing any one particular person or family as being better than another”.<sup>51</sup>

**Therefore, it is absolutely necessary, before starting any initiative based on the explicit differentiation of the individual within their own social group, to conduct a thorough socio-cultural analysis with the help of psychologists, sociologists or anthropologists. This is to ensure that the proposed solution is suitable for the specific community and contextual psychosocial dynamics, and that the risk of unintended consequences (reactivity, social stigmatization, conflicts etc.) will be minimized.**

Positive Deviance can have more positive results if it is not used alone, but rather integrated into a broader behaviour change programme.

*To know more about positive deviance, see: <http://www.positivedeviance.org/>*

### 3. RE-AIM PLANNING TOOL

Adapted and modified from: <http://cancercontrol.cancer.gov/IS/reaim/pdf/PlanningTool.pdf>

This “planning tool”, developed by the RE-AIM group, provides a personal or organizational review system, useful in supporting the operational planning of a behaviour change intervention.

The following questions should be adapted to the specific context or requirements and can help staff to think in more depth about the main issues related to different phases of the intervention. They can help to assess potential critical issues, the strengths and weaknesses of the proposed behaviour change initiatives.

*It is also useful to collect some quantitative indicators relating to reach, adoption and maintenance rates and to evaluate the intervention's cost-effectiveness and the tool can be adapted to enable the collection of such quantitative data.*

Indicators have to be chosen wisely, because it is a waste of time to choose generic and vague metrics that are not really useful to help understand the four tenets of any behavioural change evaluation: i.e.

1. If the target population was reached (and in what measure),
2. If the target behaviours / practices were modified (and in what measure),
3. If this change produced positive outcomes in terms of nutrition or public health objectives (and which ones),
4. If this change is maintained in the long-term (and for how much time).

The RE-AIM website (<http://www.re-aim.org/>) provides material and calculators that (although sometimes generic) can be useful to assist with the process of identifying indicators.

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51 - Schooley, Morales, (2007), cited.

## RE-AIM CHECKLIST

The following checklist can provide some useful questions for planning an intervention.

### Reach

1. Do you hope to reach all members of your target population? If yes, provide an estimate for your target population. If no (due to the large size of the target population, budget constraints or difficult access), provide the proportion of the target population that you ideally want to reach.
2. What is the composition of the demographics of your target population in terms of race/ethnicity, gender, age, and socioeconomic status? Are they truly representative of the whole local population?
3. *Use the rating scale below to rate the following question:*  
How confident are you that your programme will successfully attract all members of your target population regardless of age, race/ethnicity, gender, socioeconomic status and other important characteristics, such as health literacy?

1 2 3 4 5 6 7 8 9 10

*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*

4. What are the barriers you foresee that will limit your ability to successfully reach your intended target population? How do you hope to overcome these barriers?
5. Rate how confident you are that you can overcome these barriers:

1 2 3 4 5 6 7 8 9 10

*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*

### Effectiveness

1. Why did you choose this intervention and its components?
2. What are the strengths and weaknesses of this intervention?
3. List the measurable objectives that you wish to achieve in order to accomplish your goal.
4. Have you come to an agreement with key stakeholders, donors, other health or social services or NGOs and local leaders about how you will define and measure “success”?
5. Have you come to an agreement with the subgroups and individuals involved about how you will define and measure “success”?
6. What are the potential unintended consequences that may result from this programme?
7. Are you confident that your intervention will achieve effectiveness across different subgroups, including those most at risk and having the fewest resources? If no, what can be done to increase the chances of success for these groups?
8. Rate your confidence that this intervention will lead to your planned outcome:

1 2 3 4 5 6 7 8 9 10

*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*



## ADOPTION

1. What are local contextual variables (social norms, cultural constraints, scarcity of economic resources, laws) that could hinder the adoption of the programme by targeted individuals? What can be done to increase the chances of adoption, given these constraints?
2. Is it possible to involve some of the local leaders or “health intermediaries” to overcome or modify these contextual barriers? How?
3. What do you think will be the greatest barriers to other sites or organizations adopting this programme? Do you have a system in place for overcoming these barriers?

## IMPLEMENTATION

1. How confident are you that the programme can be consistently delivered as intended?  
1 2 3 4 5 6 7 8 9 10  
*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*
2. How confident are you that the programme (or some parts of it) can be delivered by staff representing a variety of positions, levels and expertise or experience of the organization?  
1 2 3 4 5 6 7 8 9 10  
*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*
3. Is your programme flexible (while maintaining fidelity to the original design) to changes or corrections that may be required mid-course? Who has to monitor the programme, how often and how?
4. Do you have a system in place to document and track the progress of the programme and effect of changes made during the course of the programme?
5. What is the greatest threat to consistent implementation and how will you deal with it?

## MAINTENANCE

1. What evidence is available to suggest the intervention effects will be maintained six or more months after it is completed?
2. How confident are you that the programme will produce lasting benefits for the participants?  
1 2 3 4 5 6 7 8 9 10  
*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*
3. What resources are available to provide long-term support to programme participants?
4. How confident are you that your programme will be sustained in your setting a year after the grant is over and/or a year after it has been implemented?  
1 2 3 4 5 6 7 8 9 10  
*(Where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)*
5. What do you see as the greatest challenges to the local organizations continuing their support of the programme?
6. Do you have an explicit key stakeholder commitment to continue the programme if it is successful?
7. How will the intervention be integrated into the regular practice of the organization that is delivering it?



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- Action Research Journal,  
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- Action Research Resources,  
<http://www.scu.edu.au/schools/gcm/ar/arhome.html>  
(big repository of articles and resources)
- A learning package for social and behaviour change :  
[http://c-changeprogramme.org/sites/default/files/sbcc\\_modules\\_additional\\_resources.pdf](http://c-changeprogramme.org/sites/default/files/sbcc_modules_additional_resources.pdf)
- CAQDAS Networking Project, University of Surrey;  
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