POSITIONING PAPER

Assisting BEHAVIOUR CHANGE in humanitarian programs

Mental Health and Care Practices

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1. Rationale

In recent years, the concept of "behaviour change" and "changing practices" has become an important topic of discussion in the field of humanitarian aid, in particular when we focus on soft interventions and approaches[1].

Behaviour change (BC) interventions and processes lie implicitly at the core of many humanitarian aid initiatives, in the most diverse operational areas: health-related, nutritional, WASH, child-care, food security-related practices and issues. It can be considered a "cross-cutting" technical approach of analysis and intervention.

Different techniques have been developed internationally and disseminated to implement programs for promoting BC[2]. International donors increasingly ask to work with the aim of BC and to be accountable for this objective, globally perceived as a sign of increased efficacy and sustainability of programs.

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[1] In international assistance, we can differentiate between *hard* approaches of intervention such as building infrastructure or food and NFI distribution, and *soft* approaches of intervention such as awareness, information, education, etc.

[2] See BCC-behaviour change communication approach, CSC – communication for social change, CLTS-community led total sanitation, PD-positive deviance approach…

ACF France, in line with the international debate, is moving forward on this topical issue and has animated a technical debate regarding how the organization defines BC, what are the crucial points to focus on and what is the approach we want to adopt for implementing field programs with a BC objective.

This positioning paper is the outcome of this process of questioning and has several objectives:

- Focusing the debate and the analysis on some technical aspects regarding the subject.
- Presenting the psychosocial perspective of this topic. Behavioural processes were studied in particular by psychological and social sciences which in the last decades produced a considerable body of scientific research on technical issues involved in behaviour structure and management, at the individual and social levels. For this reason we consider important and pertinent the technical input and expertise of psychologists[3] on this discussion regarding assisting practices change.
- Proposing a theoretical and practical positioning framework on BC for ACF.

2. Words and concepts definition – theoretical basis and framework

Attitude, behaviour, practices…are variables involved in the definition and in structuring individual and group behaviour and it is therefore necessary to define them. Everyone has a basic understanding of the following terms, but in this document we will use a more technical meaning, defined by psychology, behavioural and social sciences.

2.1 Knowledge, attitude, behaviours and practices

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 of a person, place, thing, or event by a person (Zimbardo, 1999). E.g.: A person can be in favour or not in favour to breastfeed children. *Attitudes can be measured by interviews and questionnaires (reported answers).*

Behaviour: actions and mannerisms made by people in conjunction with their environment. It is the response of the 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 and ethological way, representing it as "a person's pattern of actions finalized to an aim". E.g.: a woman can breastfeed or not breastfeed her child. *Behaviour patterns can be measured only by observations.*

Practice: acts/behaviours linked to habit, daily life, and experiences and structured by actions that follow a certain order/logic. They are often culturally transmitted. E.g.: feeding practices include several aspects of child feeding (timing, modalities, spaces, relationships…

[3] Consider that the common definition of Psychology is "the science of human nature, mind and behaviour".

	This is about	Work focused on it will be centred around…
Knowledge	*What I Know*	Cognition Information Learning
Attitude	*What I Feel*	Emotions Personal experiences Socio-cultural values
Behaviour/Practice	*What I Do*	Expertise Competence Self-efficacy Beliefs Social norms

➔ Knowledge, attitude and behaviours are not directly linked (Wicker, 1969: meta-analysis)

Example: a mother can be well informed about breastfeeding (high knowledge), she can say that she is in favour of breastfeeding (positive attitude) BUT decide not to breastfeed her child (low performance of BF behaviour).

2.2 Beliefs, habits, norms, and group pressure: variables influencing behaviour

The correlation between knowledge, attitude and behaviour is weak because other variables, mainly psychological, social and cultural variables, interfere in the relationship and reduce the correlation. Beliefs, traditional habits, group pressure, stress, perception of control…are some of these interfering variables.

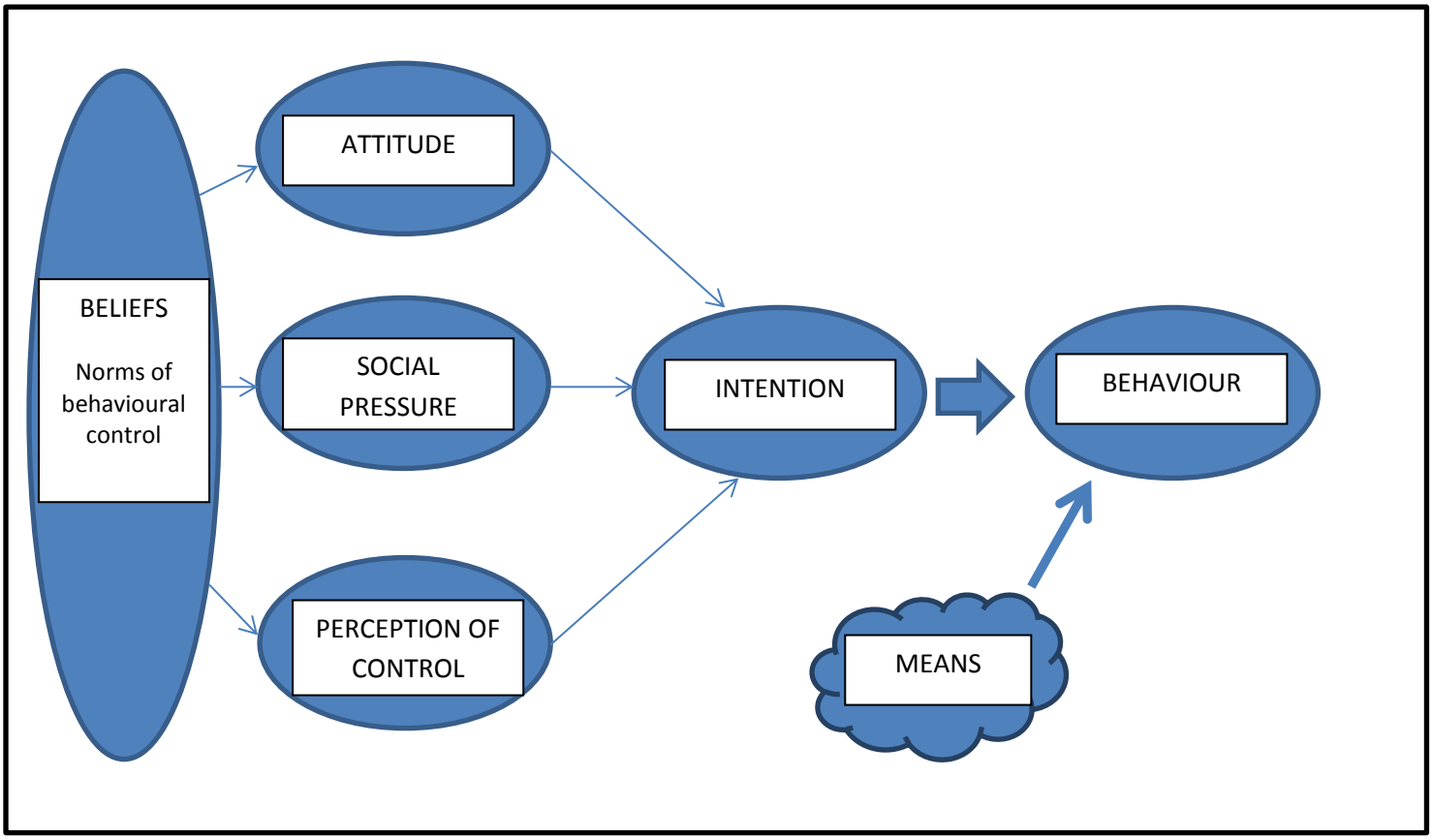
Belief: psychology and related disciplines have traditionally treated belief as if it were the simplest form of mental representation and therefore one of the building blocks of conscious thought. The relationship between belief and knowledge is that a belief is knowledge if the belief is *true*, and if the believer has a *justification* (reasonable and necessarily plausible assertions/evidence/guidance) for believing it is true.

Social norms and social pressure: social norms are "the customary rules that govern behaviour in groups and societies", and 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 and peer pressure processes (social pressure); not respecting well-established social norms is very stressful for individuals, and can lead to strong social criticism and marginalization.

Perception of control (defined also as self-efficacy): refers to the feeling of a person to be or not responsible for his own life and actions. People who view the world as the primary contributor to their life situations and believe forces outside of themselves are responsible for their misfortunes 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 and a sense of self-efficacy.

The picture below shows one of the models (Fishbein and Ajzen, 1975) proposed by social psychology describing the complexity of behaviour and showing the role and impact of psychological and social variables on the performed behaviour. We propose to use it as basis for our discussion on BC and as a framework for BC analysis and implementation.



This model [4] clearly shows:

- ➔ the "indirect link" between attitude and behaviour (see part 2.1).
- ➔ the complexity of variables involved in behaviour's performance. This complexity needs to be taken into consideration and analyzed in the assessment phase of programs with a BC objective, and addressed in the implementation phase.

2.3 Further theoretical concepts and aspects related to the BC process

We would like to draw attention to further technical questions linked with BC that need to be taken into account in our programs assisting BC since they are strongly involved in the BC process:

- ➔ BC can have an external[5] or internal[6] trigger. According to this trigger, the process of BC can be different in terms of time, quality, sustainability, etc.

[4] Consider that this one is one of several models proposed by social psychology explaining behaviour. For an extensive presentation of BC models refer to the Manual XXXXX

- ➔ People tend to change behaviour if they identify a problem/issue in their life. In some cases people do not see or perceive the problem so they do not consider pertinent (or do not wish) to start a process of BC. In this case, the first step is raising awareness of the problem.
- ➔ The triggered event of BC can be internally or externally attributed[7] by the person and accordingly, the individual will perceive higher or lower concern in BC.
- ➔ A process of BC often includes a phase of denial and resistance to change[8]; these phases need to be taken into consideration and properly supported.
- ➔ New behaviour/practices need to fit with cultural and traditional values and a phase of transition and ritualization is necessary to maintain BC.

All these theoretical points are important for a program's implementation since they facilitate or hinder the BC process objective of our intervention.

2.4 Approaches and steps of behaviour change

Another point of confusion with regards to behaviour change is related to approaches of interventions: awareness raising, information education and communication (IEC), and assisting behaviour change. It is important to clarify these terms too, since they define interventions with different objectives and they are not synonyms.

Awareness: mainly works at the knowledge level. We spread messages with the aim of increasing knowledge in the target group if there is an identified lack of knowledge. Example: if mothers do not know that breast milk contains important antibodies helping the child to be better protected, we can increase their awareness by conveying this information. Remember: awareness sessions and campaigns cannot be the only activities for a BC initiative, since we work only on knowledge level (in case of identified lack of knowledge).

Education: mainly works at the attitude level. We provide information, data, examples and experiences to change an eventual negative attitude. Example: a mother against breastfeeding (negative attitude) can change her point of view about breastfeeding if she has more data explaining to her the advantages, if she listens to the fruitful experiences of other lactating mothers, and if we show her the example of healthy children exclusively breastfed (but this does not mean that she will breastfeed her child).

Assisting practices/behaviour change: mainly works at the behaviour level. We work with individuals, families, and groups to reinforce positive behaviours/practices, to integrate new behaviours/practices, to experiment changes in behaviours/practices that may be then integrated in daily life, assisting in this way the change process.

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[5] "I need to change because an external situation obliges me to do so", e.g.: an emergency situation or a social/organizational change.
[6] " I want to change behaviour because I consider it important for me" e.g.: because it is good for my health.
[7] See the concept of causal attribution (internal or external) of Heider.
[8] See the Change Curve, adapted by the Kubler Ross's stages of grief.

3. Conditions for programs assisting practice change – practical elements

Time

As we have seen, behaviours/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 these variables to allow individual/families/groups to integrate new practices in their system of reference (cultural, social, traditional, normative, subjective…) that will necessarily change. The intervention needs to assist this process with attention and precaution 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. If we work on specific variables and the target group is engaged in BC, the process need not be long.

Expertise and resources

Assisting behaviour/practice change requires expertise and experience because as we have seen it is a complex and structured process that has a strong impact on the life system of people (their daily practices first, but it can also impact their ways of interacting with others, their roles in the groups, daily time and spaces, etc.). People handling this kind of intervention need to be able to assess properly the practices, the life system and how the two are interrelated, they need to understand well human nature, behaviours and processes of change to assist the process of change. Therefore an expertise in the psychosocial sector is required and a regular supervision by an expert in psychosocial sciences able to have this global vision and approach of intervention is necessary.

Measure

Measuring BC and BC indicators is a broad topic.

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

- ➔ Knowledge can be tested by questions
- ➔ Attitudes can be measured through scales and/or questionnaires
- ➔ Behaviour and practices only by observation

- ➔ BC needs specific qualitative and quantitative tools for monitoring (observations, grids, transects, qualitative analysis of the field worker supporting the process of BC, etc..) and data triangulation methodology

BC can also be measured by proxy indicators that show clearly the impact of the change on variables external to the BC process. Example: the reduction of diarrhoea cases in a certain area can be considered the proxy indicator showing the change in hygiene practices if all other underlying factors for diarrhoea have been controlled and remain stable.

Approach

As a first point, we consider important to highlight the difference between approach and technique since it is a critical point in discussing behaviour change. An *approach* is a system of techniques, practical tools and a theoretical basis that orient an analysis and/or an intervention. It is flexible and it can be adapted according to specific needs, context and a population's characteristics. A *technique* defines a detailed procedure, a more specific know-how and it is more restrictive than an approach. In speaking about behaviour/practice change, we consider more pertinent to speak about an approach rather than a technique in order to keep a more holistic vision and intervention.

As described before, the ***objectives*** of BC interventions are:

- ➔ Reinforcing positive behaviour/practices
- ➔ Assisting the process of integrating new practices/behaviours and helping their maintenance in daily life.

An approach to assisting BC includes several ***levels of intervention*** and ***components*** with the aim of working on the multiple variables involved in behaviour performance; all these levels of intervention are necessary[9]:

- ➔ Assessment related to behaviours, knowledge, barriers and resources
- ➔ Awareness and educational activities to disseminate information and increase knowledge (such as health sessions, mass media campaigns, etc;), however these activities cannot be conceived as the only activity promoting a BC process
- ➔ Group work to promote knowledge and experiences' sharing 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.)
- ➔ We cannot forget that in programs focused on BC, it is important to work also on the means to favour BC, if necessary. A family cannot improve its hygiene practices if no

[9] We cannot refer to an indicator of BC if not all these levels of intervention are included in our initiative

water is available in the household or in the village. Therefore a BC program should be integrated with hard interventions responding to the identified lack of needs.

➔ Monitoring activities with the aim of verifying BC maintenance and helping ritualization (observations, journal, self-monitoring, etc..)

Lastly, we would like to propose **ACF's 10-step model for assisting the BC process**.

This model is the output of ACF's theoretical and practical analysis on BC and it is a guidance tool for implementing programs with a BC objective.

The 10 steps are 10 key points of analysis and of attention that we consider crucial while designing and implementing BC programs. Each step gives us important information and warning points for triggering, facilitating and maintaining a BC process.

Each step is necessary for promoting BC, but alone is not sufficient.

ANALYSIS

1. Analysis of life systems and practices
2. Analysis of problem perception
3. Analysis of causal attribution
4. Analysis of change phase
5. Analysis of behaviour and its determinants
6. Analysis of barriers, benefits and resources for BC process

DESIGN

7. Design the program (approach and activities) taking into consideration the data collected in the phase of analysis

IMPLEMENTATION and SUSTAINABILITY

8. Supporting the process of change – change phases
9. Sustaining BC – ritualization
10. Evaluation of the BC process

Field implementation

In terms of making BC initiatives into operational practices, ACF requires that every BC initiative implemented in the field need to be technically supported by a psychosocial expert, in order to ensure a proper analysis, supervision and work on psychosocial aspects related to the BC process (impact on social dynamics, individual self-efficacy, family daily practices, social roles, and empowerment dynamics.).

Two possible operational scenarios:

1. If the BC is a small component of a larger program for supporting better use of new infrastructures, technologies or inputs (for example, new food in a garden project, latrines use, etc.), an occasional technical support in methodology will be provided by the MHCP HQ advisors or by the MHCP HoDs in the field (if any) and the program will be implemented by the sectorial team.

2. If the BC is a program/initiative in itself with the aim of improving/reinforcing / changing practices (related to care, health, nutrition, or hygiene.), the program should be implemented by the MHCP teams, that have the appropriate needed expertise in behavior change, and are trained and supervised by the BC expert (psychosocial profile).