



# Behaviour Change Guidance

Pilot draft 2021



---

**© International Federation of Red Cross  
and Red Crescent Societies, Geneva, 2016**

Copies of all or part of this study may be made for noncommercial use, providing the source is acknowledged. The IFRC would appreciate receiving details of its use. Requests for commercial reproduction should be directed to the IFRC at [secretariat@ifrc.org](mailto:secretariat@ifrc.org).

The opinions and recommendations expressed in this study do not necessarily represent the official policy of the IFRC or of individual National Red Cross or Red Crescent Societies. The designations and maps used do not imply the expression of any opinion on the part of the International Federation or National Societies concerning the legal status of a territory or of its authorities. All photos used in this study are copyright of the IFRC unless otherwise indicated. Cover photo: Juozas Cernius/IFRC.

P.O. Box 303  
CH-1211 Geneva 19  
Switzerland  
Telephone: +41 22 730 4222  
Telefax: +41 22 733 0395  
E-mail: [secretariat@ifrc.org](mailto:secretariat@ifrc.org)  
Web site: [www.ifrc.org](http://www.ifrc.org)

Follow us on:



# Behaviour Change

## guidance

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest volunteer-based humanitarian network, reaching 150 million people each year through our 189 member National Societies. Together, we act before, during and after disasters and health emergencies to meet the needs and improve the lives of vulnerable people. We do so with impartiality as to nationality, race, gender, religious beliefs, class and political opinions.

Guided by *Strategy 2020* – our collective plan of action to tackle the major humanitarian and development challenges of this decade – we are committed to "saving lives and changing minds".

Our strength lies in our volunteer network, our community-based expertise and our independence and neutrality. We work to improve humanitarian standards, as partners in development and in response to disasters. We persuade decision-makers to act at all times in the interests of vulnerable people. The result: we enable healthy and safe communities, reduce vulnerabilities, strengthen resilience and foster a culture of peace around the world.

## Acknowledgments

---

Special thanks to the Swiss Red Cross, Finnish Red Cross, Netherlands Red Cross, Nadulpan LLC and the University of Geneva for their expertise, ongoing support, commitment and contributions to the development of the Behaviour Change guidance and application to the work of health promotion and emergency response. Your work saves lives everyday.

**Author :** Lisa Moussaoui, Ph.D.

**Editor:** Vivienne Seabright

**Layout & design:** Nadulpan LLC

**Cover Photo:** Remo Nägeli, Swiss Red Cross

## Target Audience

---

This guide is written to national level programme managers with some behaviour change background that wish to apply a behaviour change lens to field level work. This guide was written for the community health sector but note that the tools can be applied to any sector.



IN 154+ COUNTRIES

# eCBHFA VOLUNTEERS

SAVE LIVES EVERYDAY BY  
BUILDING AND EMPOWERING  
COMMUNITY  
CHANGING HARMFUL BEHAVIOURS  
PREPARING FOR CRISES  
BUILDING HEALTH LITERACY  
SERVE VULNERABLE POPULATIONS

[ECBHFA.IFRC.ORG](http://ECBHFA.IFRC.ORG)



# Table of contents

---

<b>Summary</b>	<b>5</b>
<b>Introduction</b>	<b>7</b>
<b>Glossary</b>	<b>10</b>
<b>Step 1 - Problem and target behaviour</b>	<b>13</b>
<b>Step 2 - Barriers and motivators, determinants and sub-determinants</b>	<b>17</b>
<b>Step 3 - Change techniques</b>	<b>28</b>
<b>Step 4 - Implementation of the intervention</b>	<b>47</b>
<b>Step 5 - Evaluation and monitoring</b>	<b>50</b>
<b>Conclusion</b>	<b>55</b>
<b>Sources</b>	<b>56</b>
<b>Appendix</b>	
<b>Guidance on how to do the doer/non-doer analysis</b>	<b>57</b>

# Summary

This document aims to guide you through the process of developing a behaviour change intervention. If we want people to achieve behaviour change, we encourage them to follow five stages:

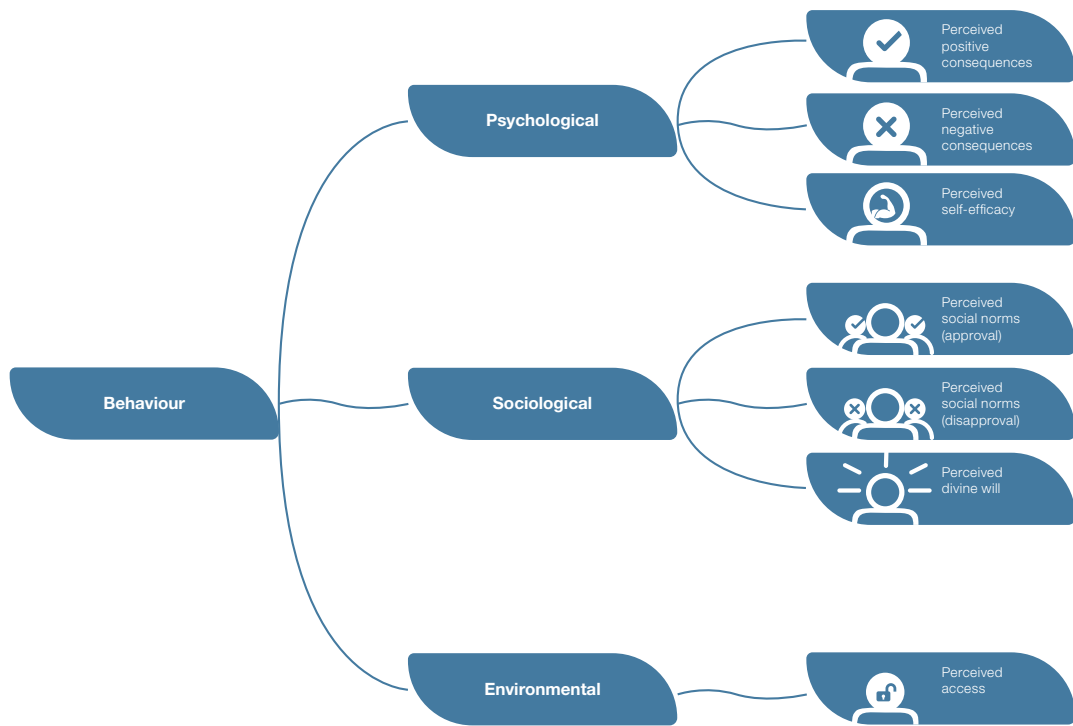
1. Knowledge
2. Approval
3. Intention
4. Practice
5. Advocacy

Behaviour change can be tackled at any of the five levels of the socio-ecological model (SEM). See the diagram. In this guide, we will focus mostly on determinants at the first three levels: individual, interpersonal and community levels.

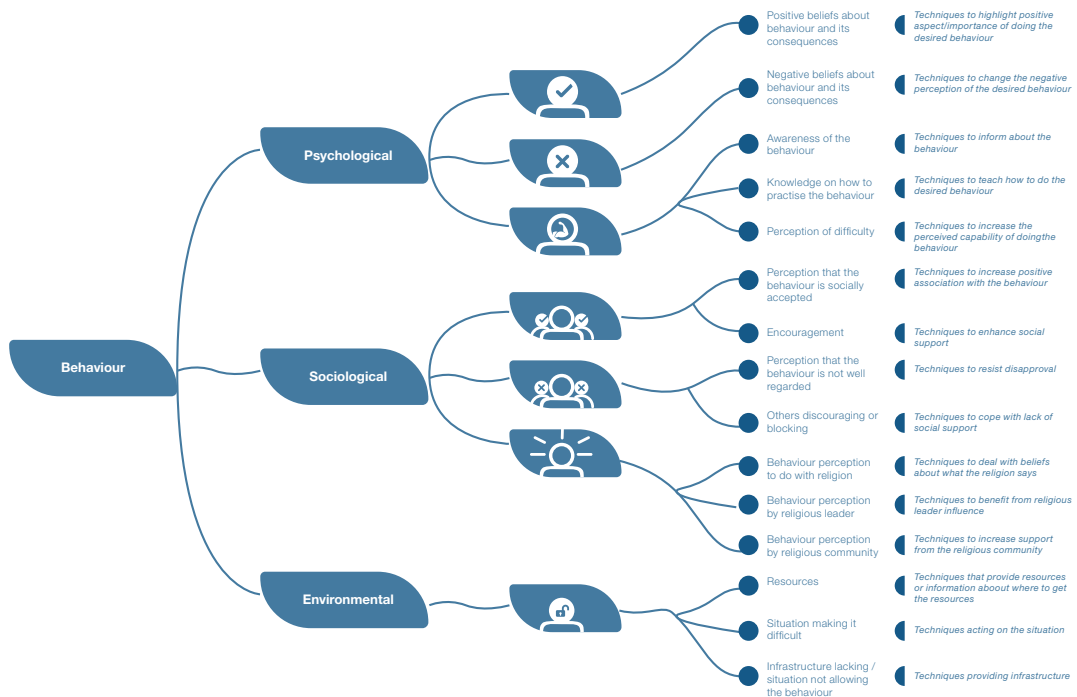
Assessment is made through the various eCBHFA tools (such as observation, community mapping, seasonal calendar, individual or group interviews) in order to understand what the priorities are for the community, and which behaviour is practised or not.

Following community assessments, volunteer groups select specific behaviours and can do a barrier analysis to find out what prevents or motivates the behaviour. The doer/non-doer tool included in the CBHFA assessment package can be used for this. The determinants of behaviour can be classified in three categories: psychological, sociological and environmental.





Depending on the determinants, sub-determinants and barriers identified, behaviour change techniques are suggested in this guide.



Finally, monitoring behaviour change should be done by looking at which stage in the five stages of behaviour change people are and how they move within them. This can be monitored for any of the five levels of the SEM.



# Introduction

Let us consider the situation of Sara, a person who does not eat five servings of fruit and vegetables a day. Sara also does not do much physical exercise. Because of this, Sara is at risk of diabetes, cancer, cardiovascular and respiratory diseases (all noncommunicable diseases). Sara has two children, who are also obese. They do not like vegetables, and prefer fatty snacks at home and at school. People around Sara have told her repeatedly that she and her children should eat better and do physical exercise, but this has not changed her behaviour. As a Red Cross Red Crescent volunteer or staff, you can help Sara and many others improve their health by changing their behaviour. Because behaviour change is a process, it is important to consider at which stage Sara is: is she aware of her risk of illness or not? Does she intend to change her diet or not? Influences from her context are to be considered too: does she have the money to buy healthier food and does she have the skills to cook it? When you obtain answers to those questions, you will know how to effectively plan an intervention to promote a healthier diet for Sara and others. If behaviour change principles are not taken into account, it is very probable that the “intervention” will consist of telling Sara that she should eat better and do physical exercise, which people around her have done repeatedly but which has not been an effective solution to date.

## Why this guide

A behaviour change intervention aims to improve a situation that has a behavioural dimension, or in which the human factor plays a role. For example, in a project that supports reduction of malaria cases through distribution of long-lasting insecticide-treated bed nets, behavioural factors must be considered as it is not guaranteed that bed nets will be properly used once provided. Although some causes for problems are out of our control (e.g. heavy rains which can trigger malaria outbreaks) there are often contributing factors that can be directly addressed. That is why it is important to dig deeper until you find a **cause in human behaviour**, because behaviour is something you can change. For example, malaria can at first sight seem to be due to heavy rains which are uncontrollable, but human behaviour such as removing pools of stagnant water (e.g. in an abandoned car tyre or plant saucer) can reduce the potential for mosquitoes to breed and sleeping under bed nets reduces the possibility that mosquitoes will bite.

People do not always behave in their own best interests. Because of that, giving people information about what is good or not for their health and raising awareness is often not enough to change behaviour. Knowledge is a starting point, but **knowledge alone is not the driver for behaviour change**.

This document is a **toolbox accessible for all sectors** and thus is broad in scope, but it is not exhaustive of all possible reasons why people do or do not do a certain behaviour. It is important to remain open to the possibility that data gathered in the community might not exactly fit with what you will read here. What is most relevant in the particular context should be considered and thus assessing the situation by talking with the target audience is the most effective way of determining the barriers and motivators for a behaviour. Sometimes we might be biased and unconsciously rely on our own understanding of the causes of a behaviour, but it is crucial not to fall into this trap. It is essential to go and question people in the community about their perceptions and their reasons for doing or not doing a behaviour. **Start by thinking you know nothing, make no assumptions and then study the behaviour, or the “chain” of behaviours** which are causing the health problem.

Understanding why people do what they do and what the barriers and motivators are for a behaviour is part of the guide, as well as how to choose the content of the interventions to eliminate barriers and use motivators to change “undesired” behaviour into “desired” (e.g. healthy) behaviour. These are crucial steps in designing an intervention that is most likely to be effective.

The following example provides an illustration of the importance of understanding the barriers and motivators of the behaviour. Researchers compared two interventions to promote fluoride-free water in rural Ethiopia (Huber et al., 2014). The problem identified was a bone disease due to excessive fluoride consumption, for which there is no effective treatment available. The behaviour leading to this problem was the consumption by individuals of unfiltered water although a filter was available. The first intervention was a standard information campaign, NOT based on a barrier analysis. The second intervention was based on assessment in the local community to understand the reason why people did not drink filtered water. Interviews showed that people thought that the price of the filtered water was too much, they did not like the taste of it and were used to consuming contaminated water. The intervention built by the researchers then addressed one of these barriers: the perceived cost. A facilitator visited households and calculated with the head of the household how much exactly it would cost to use the filtered water. The aim was to show that it was not as expensive as householders imagined. Impact evaluation showed that the information campaign had a negative effect (it increased the undesirable behaviour), while the intervention based on behavioural barriers analysis had a positive effect on the target behaviour.

## For whom

The main target audience for this document is Red Cross Red Crescent staff, volunteers and managers who are responsible for planning, implementing and/or monitoring behaviour change interventions (action in the community). The aim of this document is to provide guidance for National Societies in developing behaviour change interventions based on a behaviour change plan.

## How to use this guide

This guide accompanies you through the five stages of behaviour change:

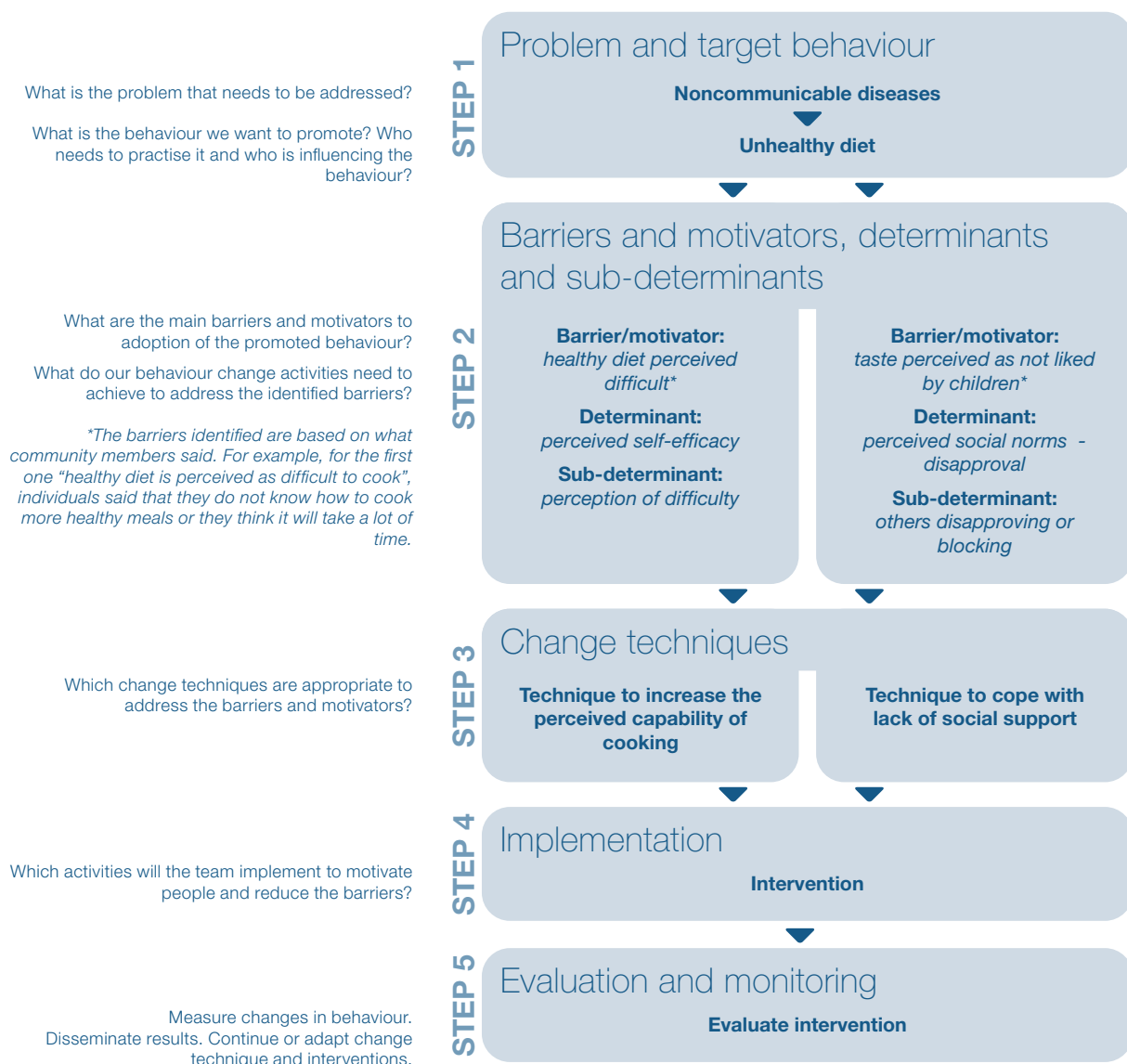
1. Identifying the health problem and defining the target behaviour

**Behaviour Change guidance**

2. Identifying barriers and motivators of the behaviour, including determinants and sub-determinants
3. Choosing appropriate change techniques
4. Implementation of interventions
5. Monitoring and evaluation

In order to illustrate the steps, we will use one example: the problem of increased noncommunicable diseases caused through a rise in obesity due to an unhealthy diet. All steps in this guide can be applied to any other behaviour in the same manner.

This is a schema presenting the steps of behaviour change intervention development using the example of healthy lifestyles. Each step will be explained in detail in the guide.



As you progress through the steps, you can draw the schema of your intervention following the above model. It can help ensure that the steps flow logically together.

---

# Glossary

---

Here are some terms that will be used throughout this guide.

The glossary outlines under each term an example related to the problem of noncommunicable diseases caused through an increased number of obese people in the society.

**Intervention:** A set of planned activities that have the aim to change people's behaviour.

*Example: Starting exercise groups, offering cooking classes, identifying role models, changing social norms, etc.*

**Target behaviour:** The behaviour that the intervention aims to change. The target behaviour is chosen from the different behavioural factors that are related to the problem.

*Example: Target behaviour can be unhealthy eating; too much time sitting*

**Behaviour barrier analysis:** The purpose of barrier analysis is to identify behavioural barriers and motivators, so that more effective behaviour change communication messages, strategies and supporting activities can be developed. The barrier analysis study asks people a series of questions aiming to identify which barriers and motivators have the biggest influence on whether they do or do not practise a particular behaviour. The barrier analysis study uses the doer/non-doer methodology that consists of interviewing a number of people (at least five but preferably around 40) who already do the behaviour (doers) and the same number of people who have not yet adopted the behaviour (non-doers). The differences between their answers are what matters most as they reveal the barriers and motivators to practising the studied behaviour. The behaviour barrier analysis (short-term and long-term) is explained in the [eCBHFA BC guide](#), and you can also find some information in the Appendix to this document.

*Example: Responses given by the doers show that most of them hold beliefs about the positive consequences of eating five servings of fruit and vegetables a day, they feel able to cook accordingly and feel supported by their close ones. Among the non-doers, some of them also have beliefs about the positive consequences of eating healthily, but the majority of the non-doers do not feel able to cook so as to eat five servings of fruit and vegetable every day. They are also unsure about support from people in their household. In this situation, the barriers that differentiate doers and non-doers are perceived social norms (non-approval from others) and perceived self-efficacy (inability to do something).*

**Determinants and sub-determinants of the behaviour:** The determinants and sub-determinants of the behaviour are what the intervention will act on to modify the behaviour. They may be internal to the person, such as their beliefs, but may also be related to the social environment or context. It is important to bear in mind that determinants can be changeable or non-changeable. Changeable means that the intervention, if appropriately designed, can have an impact on this determinant, while non-changeable means that even the best intervention will not succeed in changing that determinant. Choosing changeable determinants is thus a criterion for success. What is changeable and non-changeable can be subjective, and thus must be assessed in the community. Sub-determinants are more precise aspects of determinants.

*Example: Determinants for an unhealthy diet may be unavailability of affordable vegetables for slum dwellers (unchangeable, as they have no access to land and gardens), or dislike of healthy vegetables (changeable, can be tackled through innovative recipes and cooking classes).*

**Target population:** The segment of the population to whom the intervention will be addressed. It may be directly the at-risk population, but not necessarily. For example, we may want to work with parents to influence the health of children, with peers to influence young people's health, or with medical staff to influence the health of patients.

*Example: Direct target population can be obese schoolchildren. Indirect target population might be grocery stores or kiosks around a school (often selling unhealthy school snacks).*

**Behavioural models:** Many models have been developed by researchers in the field of behavioural sciences. They all share the goal of explaining why people do or do not do a behaviour. In this guide, we rely on the Transtheoretical Model, the SEM and RANAS model (Contzen & Mosler, 2015a) on which the doer/non-doer analysis is based. A description of other models can be found in the Behavioural Drivers Model document from UNICEF (Petit, 2019) and the IFRC Behaviour Change Framework (Claxton, 2013).

**Socio-ecological model (SEM):** The socio-ecological model (Bronfenbrenner, 1994; Golden et al., 2015) explains that behaviour is influenced at different levels: individual, interpersonal, community, organizational and societal/policy levels. The individual level identifies determinants such as beliefs of the person about the behaviour, willingness to do the behaviour or not, personal history related to practising the behaviour, or even biological determinants such as hormones making it difficult to change a behaviour. The interpersonal level refers to influence (positive or negative) that other persons can have on the behaviour of the individual: partners, family members, friends, peers. The community level looks at influences coming from groups to which the individual belongs (school, cult, religious group, neighbourhood, interest group) and how the place in which the individual lives can affect behaviour, either by providing obstacles or by making it easy to do. At the organizational level the determinants inside an institution are considered (workplaces, schools, hospitals, leisure places) as to whether they can promote a healthy behaviour or are making it more difficult to achieve. Finally, the societal level includes laws, taxation and policies that influence individual behaviours by making them illegal, more expensive or more difficult, or on the contrary by providing incentives to do the behaviour in question. For more details, see [eCBHFA BC guide](#). In this document, we will focus on the first three levels: individual, interpersonal and community levels.



*Example: Individual level of behaviour: schoolchildren's preference for unhealthy snacks and sugary drinks during school break.*

*Interpersonal level: friends also eat potato chips and drink soda and do not bring a health snack to school.*

*Community level: caretakers give children money to buy snacks and drinks rather than preparing a snack from home. Preparing a snack from home is perceived as being "poor".*

*Organizational level: school allows sale of unhealthy snacks in the school canteen and in the shops surrounding the school.*

*Policy level: regulations to reduce sugar in drinks and trans-acid fats in snacks not yet endorsed by the government due to a strong lobby by the local food industry.*



**Five stages of behaviour change:** Changing behaviour is not a one-time event: it is a process that goes through a number of stages. The stages start from learning about the health problem (1 = Knowledge), having a positive opinion about a change of behaviour to tackle the health problem (2 = Approval), the development of an intention to change behaviour (3 = Intention), incorporation of the new behaviour into one's habits (4 = Practice) and finally promotion of this behaviour to others (5 = Advocacy). People can go up and down through the stages, for example if there is emerging information, or a change in motivation. The stages of change help to tailor the intervention.

*Example: see [eCBHFA BC tools](#) (Stages of behaviour change tools)*

**Behaviour change techniques:** Change techniques are methods to act on the determinants of the behaviour. One method can be communication, but there are also other things such as facilitating access to a resource important for performing the behaviour (e.g. condoms for safe sex) or offering a reward when the desired behaviour is achieved. In this guide, relevant change techniques will be proposed based on the identified determinants. Techniques mentioned in this guide are compiled from several sources (Contzen & Mosler, 2015b; Kok et al., 2016; Michie et al., 2013; Theory and Technique Tool, s. d.).

*Example: Advise to identify and compare reasons for wanting and not wanting to change a behaviour (i.e. pros and cons); demonstrate how to perform the behaviour; build skills for resistance to social pressure; work with religious leader to promote the behaviour; introduce prompts/memory aids in the environment of the person; use peer pressure and surveillance ("weight watchers").*

# Step 1

## Problem and target behaviour



As obvious as it seems, it is important to specify a problem. The first question to be answered is “what is the problem?”. The answer to this question must come from the individual and/or community itself. The individual and/or community drives prioritization of health issues. The role of volunteers is to help the community identify the key issues affecting the community at that time. Criteria for prioritization will be what the individual and/or community considers as most important, as well as capacity of the individual and/or community to address the problem.

There are multiple tools that can be used in the community to understand who, what, where, why, when of the problem and the behaviour which underlies or causes the problem:

- Transect walks and observation
- Community mapping
- Seasonal calendar
- Individual interviews (key informants)
- Focus group discussions
- Questionnaires
- Household visits

More information on how to use each of these tools can be found in the IFRC Guidelines for assessment or the [Assessment module of eCBHFA](#).

*Example: Qualitative and quantitative data in the community highlight several issues concerning obesity. People are suffering from diseases related to being overweight, and it is observed that more and more children are starting to be overweight at a young age. Interviewing key informants reveals that individual level determinants, such as genetic predisposition, and varying levels of motivation to eat healthily and do physical exercise, have an influence. Focus group discussions show that interpersonal determinants also play a role as what children eat is determined by what the parents choose to cook, and conversely parents tend to cook what the children want to eat. Observations make apparent that the canteens in schools and workplace do not always provide enough healthy choices.*

The assessment should answer the following questions:

- What are the specific problems or problem behaviours?
- What or who contributes to the problem?
- How many people are affected by the problem?
- Who in the community is affected by the problem? (i.e. the at-risk population)
- Where and when are the people most affected?
- What are the consequences of the problem for the at-risk population and the entire community? (e.g. health consequences, economic impact ...)

Those questions can be asked for any of the levels of the SEM. Take for example the question “who contributes to the problem?”: the answer to this question is probably not only at the individual level but also at the interpersonal level by considering relationships among people and how their behaviour influences one another. You should focus on only one behaviour at a time. For one behaviour



there is often the need of a multi-faceted intervention which covers the different determinants identified for the behaviour. Once it is decided which behaviour causes the problem and thus needs to be changed, a target behaviour can be defined in terms of “WHO does WHAT, WHEN and WHERE?”. The target behaviour is what we want to promote (i.e. the “healthy behaviour”).

Use multiple tools to triangulate (meaning to use several sources) the data, by using various methods and sources of data to verify the information. Triangulation builds a stronger case for how reliable the data are. It is important to ensure the data are informative and reliable, because important decisions will be made based on these data. Reviewing secondary data such as statistics on the number of people affected by the health problem and the characteristics of the at-risk population (sex, age, level of education, type of work, etc.) can help to identify the extent of the problem and to consider which segment of the population to target. The process is iterative (needing repetition) and going back to secondary data after field work is also helpful to see gaps in the data and where further questioning may be helpful. Any problem takes place in a context in which influences cannot be ignored.

*For example, you can visit schools and record how many schools have vending machines. Information provided by the community committee can complement this observation, by informing you that there was a legal project to forbid vending machines in schools, but that the law failed to be validated by the government. Thus, vending machines will stay in schools, and children have easy access to sweets and sweetened beverages. Focus group discussions with parents and teachers can provide information about why children do not eat healthier snacks. A survey among children can confirm the views of the parents and teachers and provide data on the reasons children give for their behaviour.*

To organize and analyse all the information from the assessment using the different tools (transect walks and observation, community mapping, seasonal calendar, individual interviews, focus group discussions, questionnaires and household visits), write down the findings with one data point per note on coloured post-it notes (one colour per tool, e.g. yellow = observation, pink = interviews, green = seasonal calendar, etc.).

Once developed, ask the group to consider whether the data point is a positive element or resource for encouraging the target behaviour, a negative element which discourages the positive behaviour or a neutral element that may or may not affect the target behaviour. Then ask them to think about where the data point belongs on the first four stages of change. Place the post-its on a wall or large blank surface. Organize the slips like this:

	Positive	Negative	Neutral
Knowledge			
Approval			
Intention			
Practice			



*Pictures from a data analysis in Malawi*

This will help everybody picture the results of assessment and see how data intersect. This process will be the starting point for later discussion. As a volunteer, you will guide people in deciding if the data points they wrote on the post-its are positive, negative or neutral. You will also help decide if each post-it belongs to the stage of knowledge, approval, intention or practice.



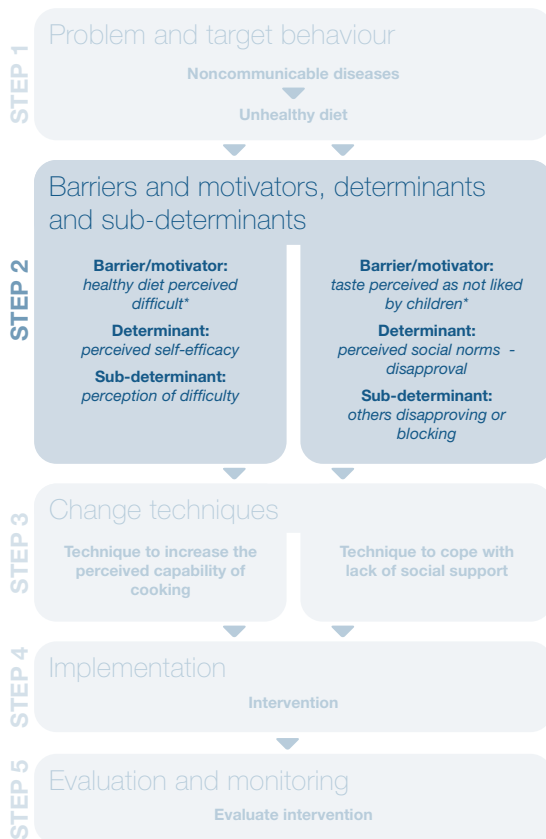
Does the information that you got through focus group discussions reflect what key informants said about the problem? Do your observations match more or less with what local statistics describe? If the results from the triangulation are inconsistent (e.g. what was said in the focus group does not match observations in the field), more data need to be collected in order to understand the full picture.

Note: This preliminary analysis of the health problem and target behaviour can already make explicit who is doing the behaviour, and who are the non-doers of the behaviour. This is important to know for having a population sample to conduct the behaviour barrier analysis (see Step 2, Part 3).

*Example: The problem of obesity in the community has been set as a priority, and results of your investigation in the community conclude that most of the concerned people do not practise physical exercise, and that they have an unhealthy diet. As an intervention should focus on one behaviour at a time, it is decided to start with changing people's diet, and then at a later time to work on physical inactivity. More specifically, observations and interviews reveal that it is the head of the household who is in charge of meals and cooking, a fact that has the most impact on the diet of the whole family. It is noticed that often vegetables are lacking from the menu. Recommendations for a healthy diet are to eat five servings of fruit and vegetables per day. Thus, the target behaviour is that the head of the household should cook at least two servings of vegetables for each meal, every day..*

## Step 2

# Barriers and motivators, determinants and sub-determinants



Providing knowledge is not enough to induce a real and long-lasting change in people's behaviour. The key to successfully trigger behaviour change is to investigate the barriers and motivators of the behaviour. It is crucial to listen to what people from the community are saying about their behaviours, what barriers they experience and what are their motivations. Only when the barriers are eliminated and the motivators are further encouraged, a behaviour change can successfully take place.

Step 2 will:

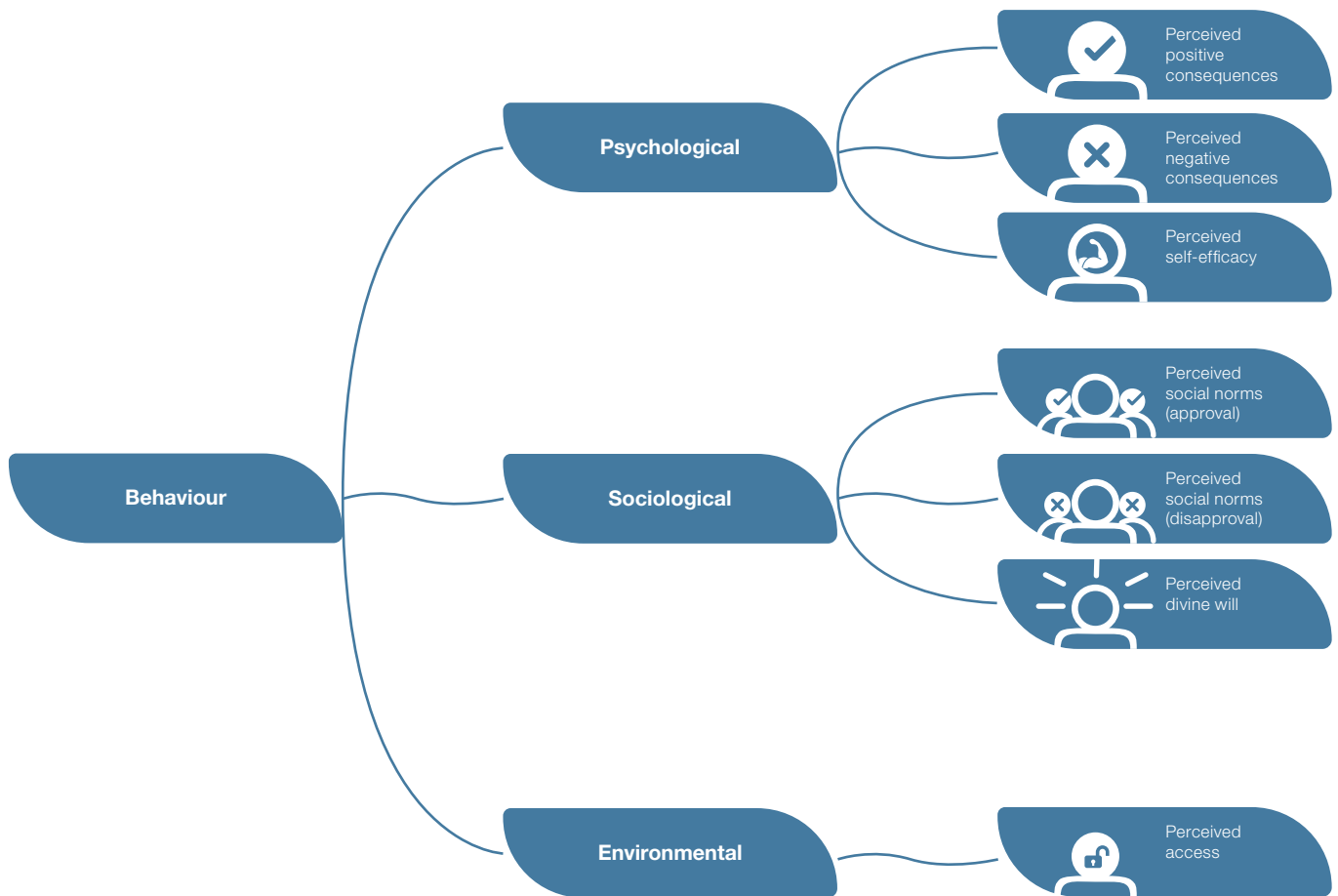
1. Explain the concept of barriers, motivators, determinants and sub-determinants of the behaviour
2. Explain how to do a behaviour barrier analysis using the doer/non doer tool

## Part 1: What are barriers and motivators, determinants and sub-determinants?

Reasons why a person does or does not do the target behaviour need to be understood before those reasons can be tackled. Those reasons can be barriers preventing the target behaviour being done, or motivators that encourage the target behaviour. Barriers and motivators will be analysed in the community as they are specific and cannot be known in advance.

*Example: Individuals in a community can face barriers to change their eating habits, because they lack time to learn new recipes and change their usual groceries. They have low levels of motivators in favour of a healthy diet, because they think healthy food does not taste so good.*

Barriers and motivators can be related to three categories of universal determinants of behaviour, psychological determinants, sociological determinants and environmental determinants. The behaviour barrier analysis used in eCBHFA uses the following determinants and their related categories:



Psychological determinants include the perceived consequences of the behaviour (positive and negative = good and bad), and if the person believes he/she is able to do the behaviour (perceived self-efficacy). Sociological determinants include the perception of what others think (social norms approval and disapproval) and perception of divine will, if the behaviour is perceived as contrary to a religious principle for example. Lastly, environmental determinants are the perceived access to what is needed to do the behaviour (resources, infrastructure).

Each determinant is further divided into sub-determinants. This is necessary for choosing the appropriate techniques to use in the intervention, as determinants are still rather broad entities. For example, perceived self-efficacy contains several sub-determinants (does the person know about the behaviour and does the person know how to do the behaviour). Techniques to increase knowledge about the behaviour are not the same as techniques to teach people how to do the behaviour.

Here are explanations of each category of determinants and their relationship with SEM levels, as well as the determinants in each category, questions to identify sub-determinants and an indication of their link with stages of change.

**Psychological determinants:** This first category of determinants refers to beliefs that the person has about the behaviour and its consequences. Psychological determinants can be at the individual level, but also at the interpersonal and community levels. For example, in schools the teachers can pass on information that influences the beliefs of the children.



## Psychological determinants

**Determinant:** Perceived positive consequences

*Positive beliefs about the behaviour and its consequences [stage: approval]*

Do people see advantages of doing the behaviour? Do they think doing the desired behaviour makes their life better/easier? Why? Do they consider the behaviour attractive? Do they understand why the behaviour is important?

**Determinant:** Perceived negative consequences

*Negative beliefs about the behaviour and its consequences [stage: approval]*

Do people see disadvantages of doing the behaviour? Do they think doing the desired behaviour affects them in a negative or bad way? Why?

**Determinant:** Perceived self-efficacy

*Sub-determinants:*

*Awareness of the behaviour [stage: knowledge]*

Do people not know about the behaviour?

*Knowledge on how to practise the behaviour [stage: intention]*

Do they not know how to do the behaviour?

*Perception of difficulty [stages: approval-intention-practice]*

What makes it easy or difficult to do the behaviour according to the person?



**Sociological determinants:** The category of sociological determinants can also refer to individual level, interpersonal level and community level determinants. At the individual level, the person can think others (whose opinion matters) would not approve if he/she did the behaviour. This perception might be accurate or not, which is linked to the interpersonal and community level of sociological determinants. There might exist norms in the community and social rules that do not promote the behaviour.

## Sociological determinants

**Determinant:** Perceived social norms: approval

*Sub-determinants:*

*Perception that the behaviour is socially accepted [stages: approval-intention]*

Is the behaviour associated with positive feelings? Do people have the belief that others would see them positively?

*Encouragement [stages: intention-practice]*

Would some people approve of this behaviour or encourage the person when he/she does the behaviour? Who? Would the person benefit from social support to perform the behaviour?

**Determinant:** Perceived social norms: disapproval

*Sub-determinants:*

*Perception that the behaviour is not well regarded [stages: approval-intention]*

Is the behaviour associated with negative feelings? Do people have the belief that others would see them negatively? Is there stigma towards certain people in relation to the behaviour?

*Others discouraging or blocking [stages: intention-practice]*

Would some people disapprove of the behaviour or discourage the person when he/she does the behaviour? Who? Is there a lack of social support for the person to perform the behaviour?

(continued)

**Determinant:** Perception of divine will**Sub-determinants:*****Behaviour perception in religion [stage: approval]***

What does the person think her/his religion says about the desired behaviour? Is the behaviour "forbidden" or not well regarded?

***Behaviour perception by leader [stage: approval]***

What does the religious leader say about the desired behaviour?

***Behaviour perception by the religious community [stage: practice]***

Would those in the person's religious community support him/her in doing the desired behaviour?

**Environmental determinants:** The third category of determinants refers to the perceived access and ease in getting the necessary resources to do the desired behaviour. This can take place at both individual level and community level determinants. Individual-level determinants are notably the perception that resources are missing to do the behaviour (e.g. time or money). At the community level, structures can sometimes not allow the behaviour to be performed, or not facilitate its performance.



Environmental determinants

**Determinant:** Perceived access**Sub-determinants:*****Resources [stages: intention-practice]***

Does the person believe they have the skills to do the behaviour? Does the person believe they have the time to do the behaviour? Does the person believe they have sufficient money to do the behaviour? Is it easy or difficult for the person to find or get the things he/she needs to do the desired behaviour? Where could the person get these resources from? Would getting these things negatively affect other areas of the person's life or her/his financial situation?

***Infrastructure lacking/situation not allowing the behaviour [stage: practice]***

Does the situation not allow the behaviour? Are materials or infrastructure missing?

***Situation not helping [stage: practice]***

Does the situation make the behaviour difficult to be done?

## Part 2: Doing a behaviour barrier and motivator analysis with doers and non-doers

In order to identify the barriers and motivators of the people, you will need to follow these steps:

- Collect data in the community using the doer/non-doer tool. Using this tool, try to search for answers related to the three categories of determinants (defined in Step 2 Part 1: What are barriers and motivators, deter-

minants and sub-determinants?) by asking people who do the behaviour and those who do not questions related to those three categories of determinants.

- When data are collected, analyse the results (explained in Step 2 Part 3: How to use results of the behaviour barrier and motivator analysis)

To identify determinants and sub-determinants of a behaviour, you will need to understand the barriers and motivators related to the target behaviour using the doer/non-doer tool for behaviour change (see *eCBHFA volunteer modules, “Assessment” section, “Community assessment tools – Part 2”*).

The basic idea is that people who are doing the target behaviour (the doers) and those who are not doing the target behaviour (the non-doers) differ on barriers and motivators. The tool helps to find out the differences in barriers and motivators in those two groups. For example, if doers know how to do the target behaviour while the non-doers state that they do not know how to do it, this difference in knowledge can explain why the former do it and the latter do not. On the contrary, if both doers and non-doers believe that the target behaviour is good for health, it is unnecessary to communicate on the health benefits of the behaviour because both groups already know that the target behaviour is good for health. Check then for differences in other determinants.

The analysis will highlight both barriers (i.e. negative elements) and motivators (i.e. positive elements). The goal will be to **diminish the barriers and increase the motivators** toward the target behaviour. (You may have noticed that we orientated the guide towards increasing the target behaviour, but that the same reasoning can apply to reducing a risky behaviour. In this case, the goal would be to increase barriers toward the risky behaviour, and reduce the motivators towards this behaviour. For example, we could try to increase perception of disapproval toward drinking sweetened beverages and reduce access to those beverages.)

For the behaviour barrier and motivator analysis, questions on the above-mentioned determinants are asked to doers and non-doers of a behaviour, by means of a questionnaire. Doers and non-doers have already been identified during Step 1. If not already identified in Step 1, conduct initial focus group discussions to get an idea about the doers and non-doers (see [eCBHFA initial FGD tool](#) for doer/non-doer analysis and the Appendix to this document). eCBHFA provides questionnaire samples for different target behaviours.

1. Choose the target behaviour
2. Open cheat sheet (example healthy eating)
3. Use the specific behaviour questions in the sample [questionnaire for doers](#).
4. Use the specific behaviour questions in the sample [questionnaire for non-doers](#).
5. Conduct individual interviews with doers and non-doers, normally having a sample of around 45 persons for each group. (For more detailed guidance on how to conduct the doer/non-doer analysis, see Appendix). Enter all responses a person gives in the Interview Sheet (one per person), and clearly indicate if the person is a doer or a non-doer.

As there might be several barriers and motivators for one behaviour, it is recommended to try answering all the questions in order to understand all the possible reasons to do/not do the target behaviour.



Determinants		DOER You eat healthy	NON-DOER You do not eat healthy
1	Perceived positive consequences	What is something positive about eating healthily? Is there someone or something in your environment that can affect you positively when/if you eat healthily? What are some positive consequences to eating healthily? What are the ways that eating healthily is helpful to you or someone else? How important is it to you to eat healthy foods?	
2	Perceived negative consequences	What is something negative about eating healthily? Is there something or someone in your environment that can affect you negatively if/when you eat healthily? What are some negative consequences to eating healthily? What are the ways that eating healthily is detrimental to you or someone else?	
3	Perceived self-efficacy	What makes a food healthy according to you? Do you know how to eat healthily? What do you know about preparing food in a nutritious manner? What are some ways that help you eat healthily?	
4	Perceived social norms - approval	Who in your family approves when you eat healthily? Do they encourage you? Is it easy to eat healthily around them? What are some ways that they help you eat healthily? How about your friends? Or the people in your community in general? Do people eating healthily around you influence you to eat healthily as well? Are your eating habits healthier when people around you eat healthily.	
5	Perceived social norms – disapproval	Who in your family disapproves when you eat healthily? Do they discourage you? Is it difficult to eat healthily around them? What are some ways they dissuade you to eat healthily? How about your friends? Or the people in your community in general? Do people's unhealthy eating habits around you influence you to eat unhealthily as well? Are your eating habits unhealthier when people around you eat unhealthily?	
6	Perceived access	Where do you usually get your food? Does your local grocery store/market have healthy foods (fruits, vegetables, whole grain products...)? How do you pay for your food (cash, food stamps...)? Are the prices affordable to you? If food is not available to you nearby, is transportation to food resources accessible to you? What type of transportation? Does your workplace/school/community garden provide food? If yes, what type of food does it usually provide?	
7	Perception of divine will	Does your religion promote healthy eating? What does your religious leader say about healthy eating? Would those in your religious community support you in eating healthily? How does your religion affect your diet (feast days, fast days, avoidance of certain types of foods such as pork, meat, dairy products, caffeinated or alcoholic beverages, requirement to use animals that provide meat slaughtered in a specific way...)?	

The answers to the questions listed under each category will allow you to spot all the barriers and motivators concerning the behaviour. Please note that these questions constitute only a starting point. When you identify a potential clue for why people are not doing the behaviour, pursue the investigation to understand the specific reasons.

*For example, if the behaviour is not perceived as pleasant, try to understand why exactly. This will be helpful when you try to address this barrier. Similarly, is it only a perception of the person that the behaviour is difficult or does the situation really make the behaviour impossible to perform?*

### Part 3: How to use results of the behaviour barrier and motivator analysis

After conducting the assessment including the doer/non-doer assessment, compile the answers from each Interview Sheet in one data sheet.

1. Enter all Interview Sheets and answers in the [data analysis form](#).
2. Calculate the number of doers and non-doers for each response in each determinant.
3. Calculate the difference between the doers and non-doers.
4. Determine the implications for each of the findings. In places where there is a large difference, interventions need to be developed that target the specific sub-determinant, using behaviour change techniques.

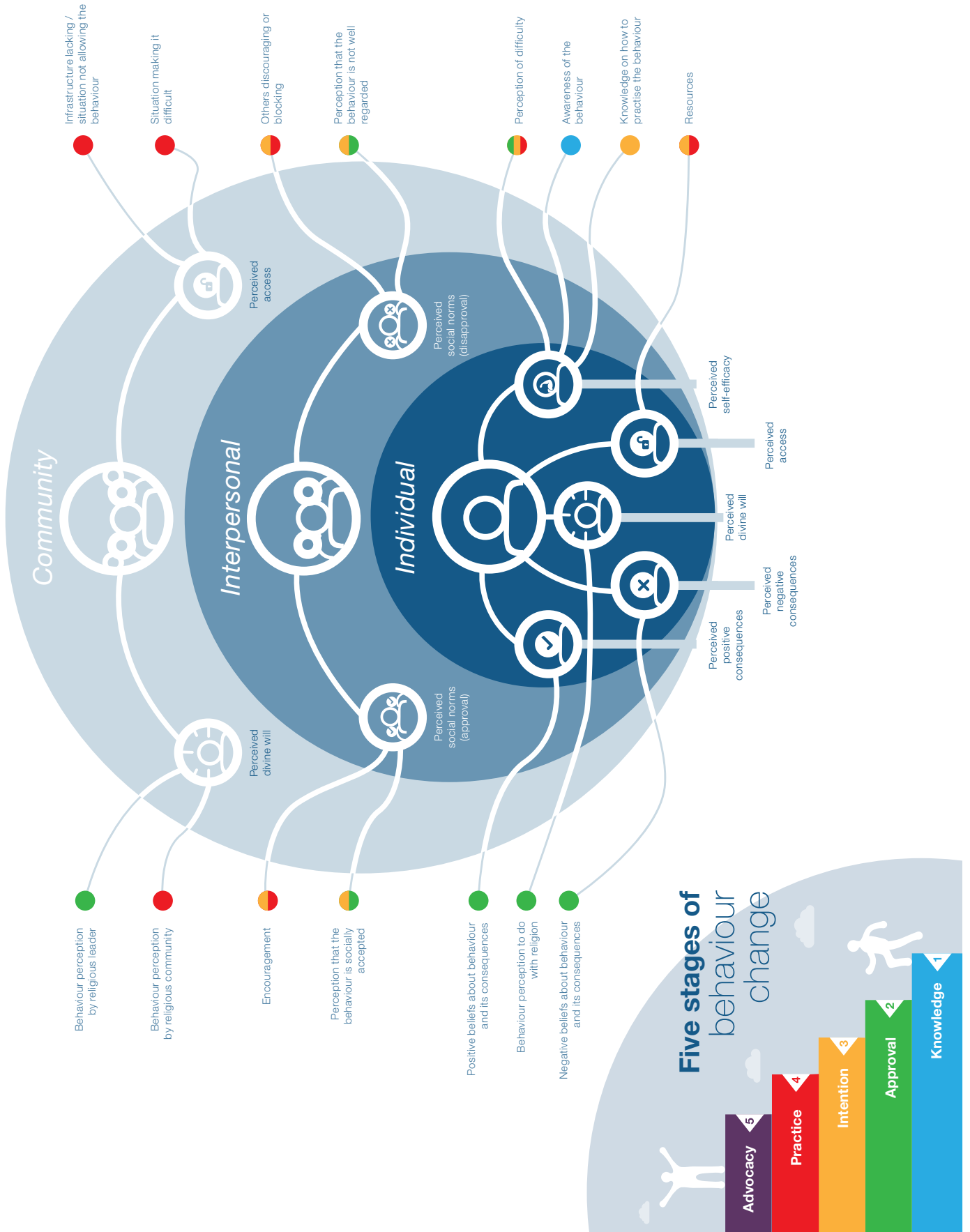
The calculation of the difference between the doers and non-doers may look like this: (examples only for psychological determinants, but you should have the same table for sociological and environmental determinants as well)

Determinants and sub-determinants	Doers %	Non-doers %	Implications	Focus		
				High	Medium	Low
Perceived positive consequences						
I believe that eating healthily improves my physical condition and makes me feel better	92%	87%	Very similar			<b>X</b>
Perceived negative consequences						
I think eating healthily does not taste as good as my regular cooking	25%	80%	<b>Difference</b> -> you should use techniques to change the negative perception of healthy eating behaviour	<b>X</b>		

Determinants and sub-determinants	Doers %	Non-doers %	Implications	Focus		
				High	Medium	Low
Perceived self-efficacy						
I know that eating five servings of fruits and vegetables per day is necessary for a healthy diet	70%	66%	Very similar			X
I know how to cook in order to eat five servings of fruits and vegetables	69%	57%	<b>Possible difference</b> -> you may use techniques to teach how to do the healthy eating behaviour		X	
I think it is difficult to cook healthy food	16%	93%	<b>Difference</b> -> you should use techniques to increase the perceived capability of doing the healthy eating behaviour	X		

It is quite likely that several barriers and motivators will be identified in this analysis where doers and non-doers differ. How do you know whether to target one of them, some, or all of them? The basic principle to guide your decision is that the more barriers you address, the better the chances that behaviour change occurs. However, if it is not feasible to address all identified barriers, do a selection. A criterion can be quantitative: priority can be given to the barriers cited by most people. In the doer/non-doer Excel sheet, the yellow cases highlighting the most frequent determinants will tell you the most important barriers, for which the difference is more than 15 per cent between doer responses and non-doer responses. In the example above, the cases where the focus is "High" means that you should use techniques for this determinant, i.e. it is a priority. Cases where the focus is "Medium" mean you may use techniques for this determinant, i.e. if it is possible to address this determinant that would be good, but it is not a priority because the difference between doers and non-doers is not very big). Another possibility is to think in terms of stages of change: given that it is a temporal process, it is possible to start by addressing the determinants in the earlier stages (knowledge, then approval). You will want to implement interventions that "move" through the stages towards advocacy, and then when the target group reaches this, other determinants can be addressed. Another option is to start with determinants that people perceive would be the easiest and quickest to succeed to change, thereby motivating them to continue with the determinants that are perceived to be more difficult to change.

The figure below demonstrates how SEM levels, stages of change and sub-determinants go together. The three grey circles are the three levels of SEM: individual, interpersonal and community. Inside it the determinants are presented using icons, and sub-determinants are presented outside the circles. The colours represent the stages of change (you can refer to the colour code of stages of change indicated in the bottom left corner).

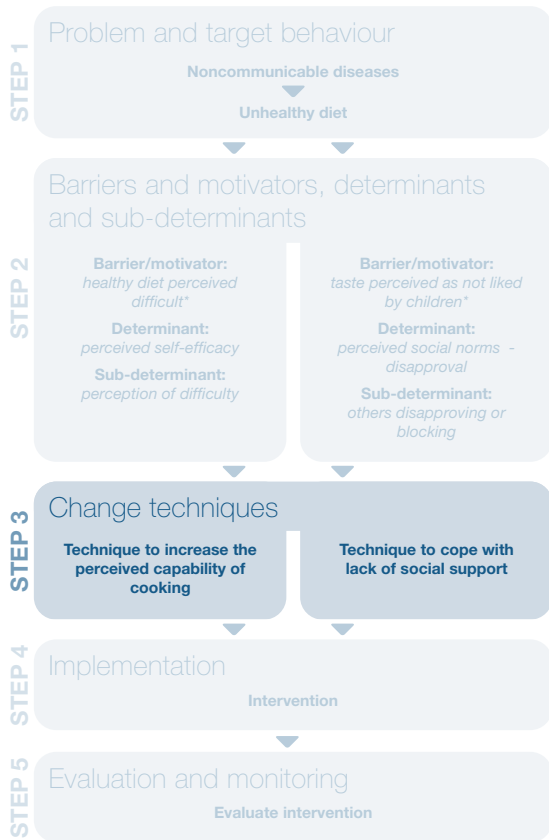


Considering determinants in each of the SEM levels will help you address the barriers of behaviour holistically. The stages of change allow you to follow the sequence of steps that the person has to achieve to progress toward behaviour change.

You can create such a figure with the data you have in order to define who the intervention is for and where it should be delivered. You can draw the three circles of the SEM and report the results of the barrier and motivators analysis on the circles. For example, if the data of the barrier and motivator analysis show that people do not cook vegetables at home because they think their children and spouse will not like them, this places the intervention at the interpersonal level, “perceived social norms (disapproval)” icon, sub-determinant “others discouraging”. Maybe you will identify other barriers that can be placed at other levels of the SEM. For example, if people do not know how to cook more healthily, this places the intervention at the individual level, corresponding to the “perceived self-efficacy” icon, sub-determinant “knowledge on how to practise the behaviour”.

## **Step 3**

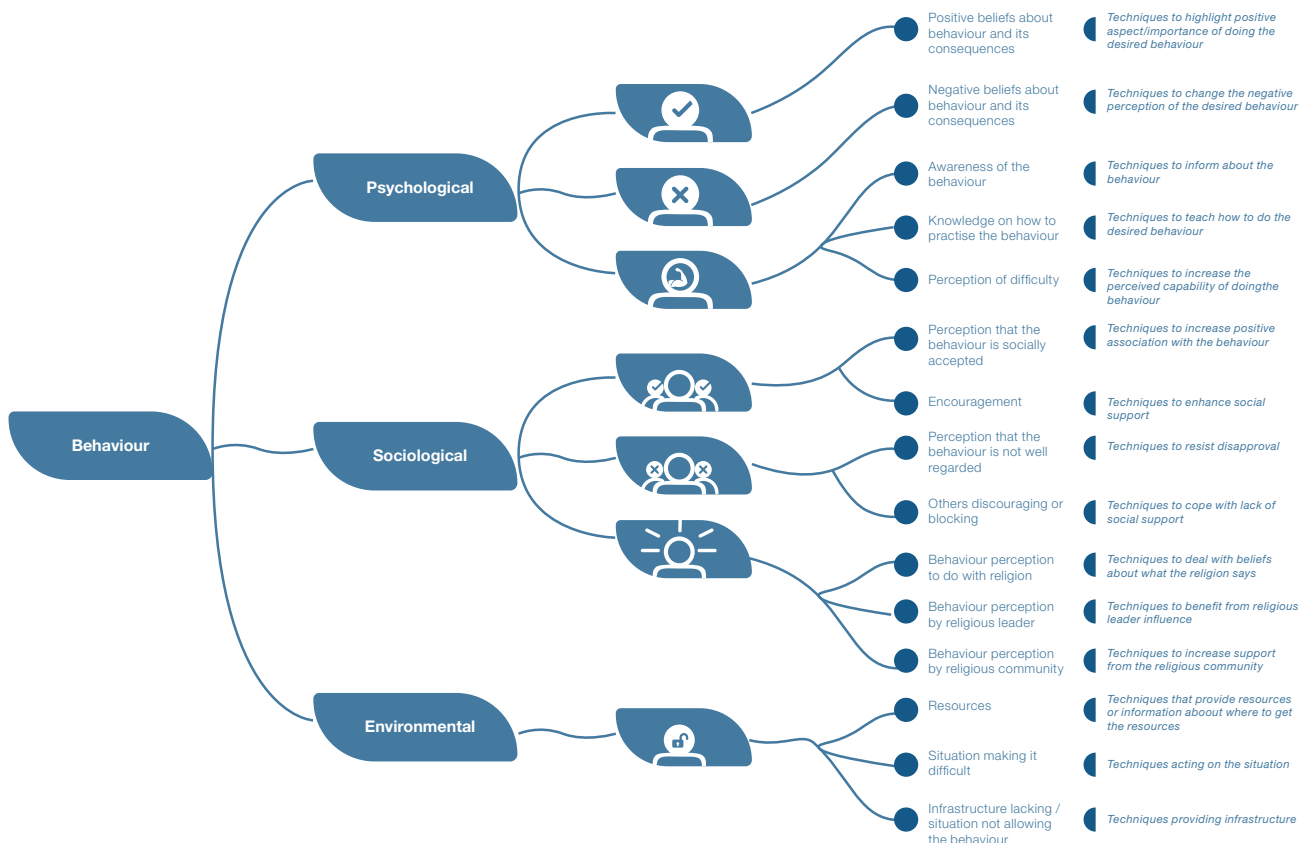
# **Change techniques**

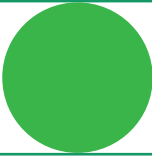
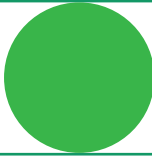
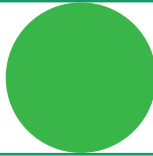


The significant barriers and motivators and determinants and sub-determinants of behaviour have now been identified and the differences between doers and non-doers elicited. The following step is to select the behaviour change techniques that address the differences between doers and non-doers and are most likely to have an impact on those determinants.

The figure below gives an overview of techniques to address the broad categories of determinants (psychological, sociological, and environmental), down to the determinants and sub-determinants, and then to techniques for change.




On the next few pages, you will find three tables, one for each category of determinant (psychological, sociological, environmental). Those tables contain a list of suggested techniques. Definitions and examples of use of the techniques are provided. You will also find references to the SEM levels and stages of change. **To use these tables, start with the columns “Determinant” and “Sub-determinant” to find suggestions of techniques that are relevant according to your barriers and motivators analysis.**








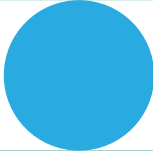
Techniques for psychological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequences	<b>Information about health consequences</b>	Provide information (e.g. written, verbal, visual) about health consequences of performing the behaviour	Provide information (e.g. written, verbal, visual) about health consequences of performing the behaviour
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequences	<b>Arouse fear</b>	Use threatening information that stresses the danger of contracting a disease. Requires that the person feels able to do the behaviour to prevent the threat, and that the action is perceived as effective to relieve the threat	Show scary information about the severe effects of an unhealthy diet. But ensure that the person feels able to change their diet, and that they believe that a healthy diet is an efficient way to prevent diseases.
Individual		Perceived positive consequences Perceived negative consequences	Positive beliefs about behaviour and its consequence Negative beliefs about behaviour and its consequence	<b>Feedback on behaviour or on outcomes of behaviour</b>	Monitor and provide information or evaluative feedback on performance of the behaviour (e.g. mode, frequency, duration, intensity) or on outcomes of the behaviour	Watch daily diet of people and give them feedback on the proportions of what they eat













<b>Techniques for psychological determinants</b>						
<b>SEM level</b>	<b>Stages of change</b>	<b>Determinant</b>	<b>Sub-determinant</b>	<b>Technique</b>	<b>Definition</b>	<b>Examples</b>
Individual		Perceived positive consequences Perceived negative consequences	Positive beliefs about behaviour and its consequence Negative beliefs about behaviour and its consequence	<b>Information about social and environmental consequences</b>	Provide information (e.g. written, verbal, visual) about social and environmental consequences of performing the behaviour	Inform that the majority of people disapprove of people drinking a lot of sweetened beverages
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequence	<b>Information about emotional consequences</b>	Provide information (e.g. written, verbal, visual) about emotional consequences of performing the behaviour	Explain that a healthy diet increases feelings of well-being
Individual		Perceived positive consequences Perceived negative consequences	Positive beliefs about behaviour and its consequence Negative beliefs about behaviour and its consequence	<b>Framing/reframing</b>	Suggest the deliberate adoption of a perspective or new perspective on behaviour in order to change beliefs or emotions about performing the behaviour	Suggest that the person might think of improving their diet as taking care of themselves (rather than following external norms)

Techniques for psychological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequence	<b>Anticipated regret</b>	Stimulating people to focus on their feelings after unintended risky behaviour, before any losses actually materialize	Ask the person to assess the degree of regret they will feel if they do not start eating more healthily
Individual		Perceived positive consequences Perceived negative consequences	Positive beliefs about behaviour and its consequence Negative beliefs about behaviour and its consequence	<b>Pros and cons</b>	Advise the person to identify and compare reasons for wanting (pros) and not wanting (cons) to change the behaviour	Advise the person to list and compare the advantages and disadvantages of changing diet
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequence	<b>Incentive</b>	Inform that a reward will be delivered if and only if there has been effort and/or progress in performing the behaviour	Examples of reward: -money, vouchers, other valued objects -social reward (verbal or non-verbal) -or other type of reward Delivered if the person manages to eat five servings of fruit and vegetables daily, three times a week for one month

<b>Techniques for psychological determinants</b>						
<b>SEM level</b>	<b>Stages of change</b>	<b>Determinant</b>	<b>Sub-determinant</b>	<b>Technique</b>	<b>Definition</b>	<b>Examples</b>
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequence	<b>Comparative imagining of future outcomes</b>	Prompt or advise the imagining and comparing of future outcomes of changed versus unchanged behaviour	Prompt the person to imagine and compare likely or possible outcomes following healthy diet versus eating lots of sugar, salt and fat.
Individual		Perceived positive consequences	Positive beliefs about behaviour and its consequence	<b>Prompt to talk to others</b>	Invite the person to talk to others about the healthy behaviour in question	Suggest that the person talks with others about healthy eating
Individual		Perceived efficacy	Awareness of the behaviour	<b>Information about health consequences</b>	Provide information (e.g. written, verbal, visual) about health consequences of performing the behaviour	Explain that eating five servings of fruit and vegetables has a positive impact on health

Techniques for psychological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Individual		Perceived efficacy	Knowledge on how to practise the behaviour	<b>Instruction on how to perform behaviour</b>	Advise or agree on how to perform the behaviour	Advise on the proper way to cook with less fat
Individual		Perceived efficacy	Knowledge on how to practise the behaviour	<b>Demonstration of the behaviour</b>	Provide an observable example of the performance of the behaviour, directly in person or indirectly e.g. via film, pictures, for the person to aspire to or imitate	Demonstrate how to cook with less fat
Individual		Perceived efficacy	Knowledge on how to practise the behaviour	<b>Prompt guided practice</b>	Train participants in behaviour enactment by giving instructions, demonstrating the behaviour, letting him/her practise and giving feedback about the correctness of the performance	Train people to practise cooking healthy meals

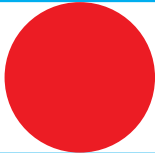
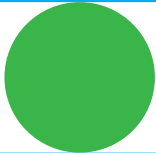
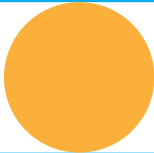
<b>Techniques for psychological determinants</b>						
<b>SEM level</b>	<b>Stages of change</b>	<b>Determinant</b>	<b>Sub-determinant</b>	<b>Technique</b>	<b>Definition</b>	<b>Examples</b>
Individual		Perceived efficacy	Knowledge on how to practise the behaviour	<b>Prompt behavioural practice</b>	Prompt participants to practise the new behaviour in their daily life	Prompt people to practise cooking healthy meals at home
Individual		Perceived efficacy	Perception of difficulty	<b>Verbal persuasion about capability</b>	Tell the person that they can successfully perform the wanted behaviour, arguing against self-doubts and asserting that they can and will succeed	Provide encouragement about the capacity of the person to successfully cook healthy meals
Individual		Perceived efficacy	Perception of difficulty	<b>Graded tasks</b>	Set easy-to-perform tasks, making them increasingly difficult, but achievable, until behaviour is performed	Propose to increase by one each week the number of servings of fruit or vegetables

Techniques for psychological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Individual		Perceived efficacy	Perception of difficulty	<b>Focus on past success</b>	Advise to think about or list previous successes in performing the behaviour (or parts of it)	Prompt to remember the previous time he/she succeeded in increasing consumption of fruit and vegetables
Individual		Perceived efficacy	Perception of difficulty	<b>Self-talk</b>	Prompt positive self-talk before and during the behaviour	Prompt to do positive self-talk before and during cooking

## Techniques for sociological determinants









SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Interpersonal		Perceived social norms: approval	Perception that the behaviour is socially accepted	<b>Inform about others' approval</b>	Provide information about what other people think about the behaviour. The information clarifies whether others will like, approve or disapprove of what the person is doing or will do  (condition for success: the proportion of other people in favour of the desired behaviour should be substantial, not a minority)	Communicate about the percentage of other people who are in favour of people adopting a healthier diet
Interpersonal		Perceived social norms: approval	Perception that the behaviour is socially accepted	<b>Inform about others' behaviour</b>	Point out that a desired behaviour is already adopted by other persons  (condition for success: the proportion of other people already doing the desired behaviour should be substantial, not a minority)	Communicate about the percentage of other people who are following a healthy diet

Techniques for sociological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Interpersonal		Perceived social norms: disapproval	Others discouraging or blocking	<b>Resistance to social pressure</b>	Stimulating building skills for resistance to social pressure	Expose people to challenging sentences about why it is useless to eat vegetables. Their task is to systematically refute those sentences
Interpersonal		Perceived social norms: approval	Perception that the behaviour is socially accepted	<b>Information about social and environmental consequences</b>	Provide information (e.g. written, verbal, visual) about social and environmental consequences of performing the behaviour	Inform that the majority of people disapprove of people drinking a lot of sweetened beverages
Interpersonal		Perceived social norms: approval	Perception that the behaviour is socially accepted	<b>Social comparison</b>	Draw attention to others' performance to allow comparison with the person's own performance	Draw attention to the fact that most people have a healthy diet



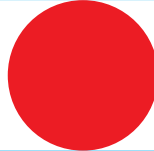




## Techniques for sociological determinants




SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Interpersonal		Perceived social norms: approval	Encouragement	<b>Social support</b>	Advise on, arrange or provide social support (e.g. from friends, relatives, colleagues, buddies or staff) or non-contingent praise or reward for performance of the behaviour, or provide practical help	Arrange that a group of friends of the person will accompany the person to cook healthy meals
Interpersonal		Perceived social norms: approval	Encouragement	<b>Social reward</b>	Arrange verbal or non-verbal reward if and only if there has been effort and/or progress in performing the behaviour	Provide praise if the person makes efforts in reducing sugar consumption
Interpersonal		Perceived positive consequences Perceived negative consequences	Encouragement	<b>Enhancing (or developing new) social network linkages</b>	Training network members to provide support, and members of the target group to mobilize and maintain their networks (or linking members to new networks by mentor programmes, buddy systems and self-help groups)	Train people to be supportive of others who wish to change their diet

Techniques for sociological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Interpersonal		Perceived social norms: disapproval	Perception that the behaviour is not well regarded	<b>Stereotype-inconsistent information</b>	Providing positive examples from the stigmatized group  (conditions for success: many different examples should be provided. The examples should not be too far from the original stereotype)	Provide examples of persons from a stereotypical social group perceived as unhealthy eaters who have a healthy diet
Interpersonal		Perceived social norms: disapproval	Perception that the behaviour is not well regarded	<b>Interpersonal contact</b>  <b>Techniques for others, not the target person</b>	Bringing people in contact with members of the stigmatized group  (conditions for success: the contact experience must be positive. Works better if there are no status differences, intensive contact, common or shared goals)	Create opportunities for people from various sub-groups of the community to meet and do activities in common
Interpersonal		Perceived social norms: disapproval	Perception that the behaviour is not well regarded	<b>Empathy training</b>  <b>Techniques for others, not the target person</b>	Stimulating people to empathize with another person, i.e. imagine how the other person would feel  (conditions for success: participants being able and willing to identify with the stigmatized person)	Suggest people imagine how people who live with a stigmatized condition feel

## Techniques for sociological determinants




SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Interpersonal		Perceived social norms: disapproval	Others discouraging or blocking	<b>Provide negotiation skills</b>	Prompt participants to reflect on others' perspectives to find compromises that benefit both sides and arguments bolstering them	Encourage people to think about how a person who does not want to eat healthily might think and find solutions that work for both parties. For example, find alternatives that taste good but with less fat and sugar.
Interpersonal		Perceived social norms: approval	Perception that the behaviour is socially accepted	<b>Provide a positive group identity</b>	Describe people already engaged in the behaviour in an attractive way, for example as modern and up-to-date so as to increase the attractiveness of the behaviour itself	Describe people who do not drink sweetened beverages as modern
Interpersonal		Perceived social norms: disapproval	Others discouraging or blocking	<b>Restructuring the social environment</b>	Change, or advise to change the social environment in order to facilitate performance of the wanted behaviour or create barriers to the unwanted behaviour	Advise to minimize lunchtimes spent with friends who have unhealthy diet habits so as to reduce one's own unhealthy diet


Techniques for sociological determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Interpersonal		Perception of divine will	Behaviour perception to do with religion Behaviour perception by religious leader	<b>Work with religious leader to promote the behaviour</b>	Exchange with religious leader to understand how they can help promote the healthy behaviour	Arrange that a religious leader promotes a healthy diet as a respectable and valued way to take care of one's own health
Interpersonal		Perception of divine will	Behaviour perception to do with religion Behaviour perception by religious leader Behaviour perception by religious community	<b>Use of lay health workers, peer education</b>	Mobilizing members of the religious community to serve as boundary spanners, credible sources of information and role models	Mobilize the religious community members to diffuse information on a healthy diet and act as role models by improving their own diet

Techniques for environmental determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Community		Perceived access	Infrastructure lacking / situation not allowing the behaviour	<b>Provide technical assistance and infrastructure</b>	Prompt and support the community or household to set up infrastructure, providing technical means to achieve desired behaviour	Provide expertise and materials for people to grow their own vegetables
Individual		Perceived access	Resources	<b>Facilitate resources</b>	Provide financial help	Provide financial support for helping people buy healthy food (e.g. subsidies to reduce the price of vegetables)
Interpersonal		Perceived access	Resources Situation making it difficult	<b>Practical social support</b>	Advise on, arrange, or provide practical help (e.g. from friends, relatives, colleagues, buddies or staff) for performance of the behaviour	Arrange that relatives of the person will help him/her to cook healthier meals



## Techniques for environmental determinants

SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Individual community		Perceived access	Resources Situation making it difficult	<b>Adding objects to the environment</b>	Add objects to the environment in order to facilitate performance of the behaviour	Provide healthy food in places where people might want to eat (e.g. during breaks at schools, workplace)
Community		Perceived access	Situation making it difficult	<b>Restructuring the physical environment</b>	Change, or advise to change the physical environment in order to facilitate performance of the wanted behaviour or create barriers to the unwanted behaviour	Advise to store healthy food visibly, and/or hide unhealthy food
Community		Perceived access	Situation making it difficult	<b>Prompts/cues/memory aids</b>	Introduce or define environmental or social stimulus with the purpose of prompting or cueing the behaviour. The prompt or cue would normally occur at the time or place of performance. And/or remove cues for unhealthy habits	Install stickers on the fridge to remind the person to eat five servings of fruits and vegetables

Techniques for environmental determinants						
SEM level	Stages of change	Determinant	Sub-determinant	Technique	Definition	Examples
Individual community		Perceived access	Resources Situation making it difficult	<b>Problem solving</b>	Analyse, or prompt the person to analyse factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators	Prompt the person to plan how he/she would overcome barriers such as lack of time to cook, e.g. by having home-cooked healthy meals prepared in advance

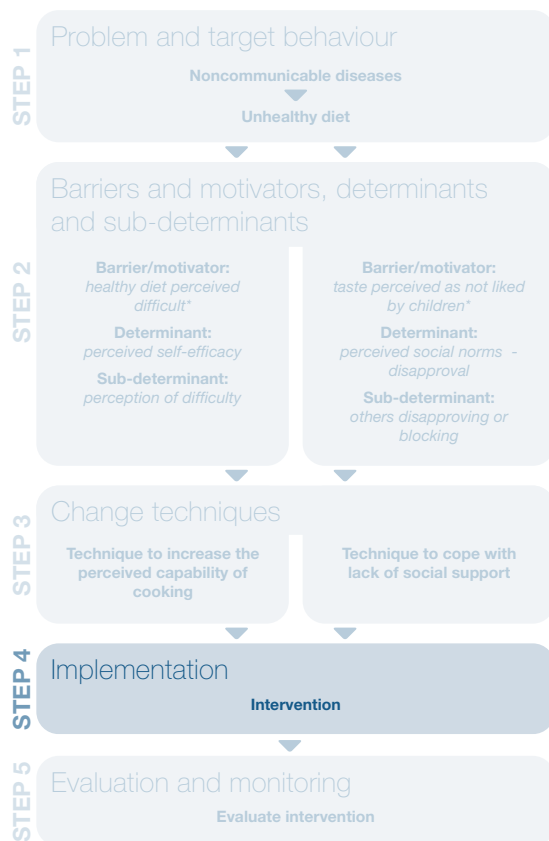
The proposed techniques can serve as a basis for an exchange with community representatives. If one technique appears not to be relevant or fitting in a specific context, it is important to recognize it at this stage. Whatever intervention is selected should be monitored regularly and early to see if it is working. If it is not, it can be modified or another intervention can be identified and implemented.

*Example: Techniques to change skills, capability and self-efficacy are selected by the project's team based on the techniques tables. After discussion with a small subgroup of heads of households, it was decided that "prompt guided practice" was appropriate because direct learning would be more motivating than having to read a cookbook. In addition, to remove the barrier of perceived social pressure, the technique "information about others' approval" was selected. Indeed, during the initial assessment, it was noticed that it was true that members of the household prefer the taste of traditional meals, but they are willing to lose weight and so they would be supportive of a change in their diet.*



## **Step 4**

# **Implementation of the intervention**



## Part 1: Choice of the intervention format and creation of the intervention content

Once one or multiple techniques have been selected with the community, the format of the intervention still needs to be decided for concrete implementation. For example, demonstrating how to do the behaviour could be the technique of change. Different scenarios can be chosen to do that: via gatherings in the community, by conducting household visits, displaying posters in public areas, or teaching children or peer educators at school. Think about your available dissemination channels and decide which is best.

It is important to include the community throughout all stages, and specifically the target groups for behaviour change. The preferred modes of interventions can vary from leaflets, games, community meetings or peer education, and the best channel should be decided with the community. For example, when considering information about health consequences, it will be important to understand how people prefer to receive and pass on information. This will largely determine which communication channels can be considered. For example, what is the level of literacy of most people in the target population? Could they read if a written text was put out? Or is a picture

better? Depending on the age group, maybe the communication channel will be different, such as social media for young people and traditional media and story-telling such as a newspaper for older people. Include ways to reach diverse members of your community, including methods to reach different age groups and inclusive materials that can reach people with disabilities. Be sure to consult them about how this might be done. Another thing to consider is the level of trust people have in the information source.

Test versions of the intervention can be presented to community partners to get their feedback and see how they respond.

Please notice that there are a number of existing tools developed by the IFRC that can be used at this stage. Instead of creating new material, check what exists on the topic, and if there are existing materials use these (as they are or with some adaptations). Possible sources of materials are: [Primary prevention modules of eCBHFA](#), local Ministry of Health materials or World Health Organization briefs.

*Example: “Prompt guided practice” is planned to be implemented in cooking sessions in small groups where they would learn new recipes with vegetables. “Information about others’ approval” will be communicated through a blog where people testify their willingness to lose weight and improve their diet.*

Once you have developed the intervention strategy you are able to flesh out the content.

## Part 2: Budget and team

When the intervention is ready to be implemented, the team in charge of the project up to this point might need to be extended. It is necessary to identify who will do what for the different parts of the programme (e.g. the person who will realize the visual supports, the people who will conduct the intervention face-to-face, etc.); who will decide to implement the intervention in their institution (e.g. school directors, religious institutions, medical clinics, ...); who will bring the resources for the implementation of the programme (e.g. organizations, companies, donors); who will implement the programme in the field; and who are the partners and the stakeholders who will support the project.

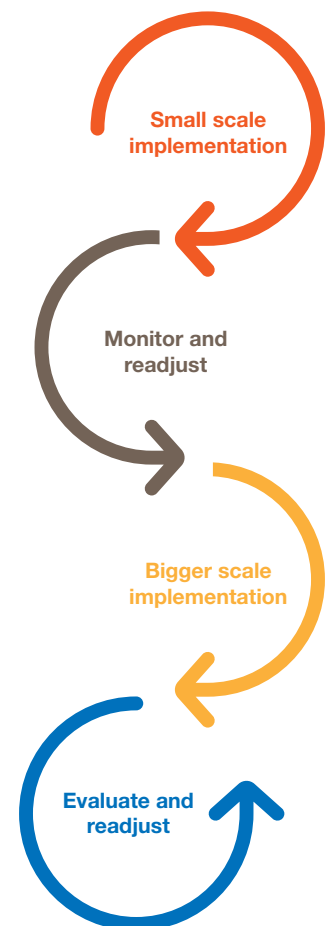
Another task for the implementation is budget planning. You can create a list to plan which equipment is necessary and in what quantity. The time needed to develop the material and to implement it also needs checking.

## Part 3: Dissemination

Many interventions can be implemented progressively, first on a small scale in order to verify that it is feasible and that the material is appropriate and well-received by the population. If well received, it can be scaled up. Steps 4 (Implementation) and 5 (Evaluation, monitoring and readjustments, described below) can be considered as an iterative process, as presented in the following schema:

*Example: A small number of cooking sessions are planned with heads of households in order to get feedback on how the demonstration style is appreciated, if the recipe is a success, if participants think they will cook it at home, etc. A few changes are suggested and made on the intervention material, and the cooking sessions are disseminated to a broader number of households. Regarding the blog, it is first shown to a few key informants to get their insights on the content and how they believe the information is representative from the community members. After improvements, the blog is set online and the link is shared with the participants of the cooking sessions.*

A protocol describing the content of the intervention (updated if modifications are decided after small-scale implementation) is useful for having a standard to monitor implementation. Describe the tasks that must be completed for the programme to be well implemented. Most programmes deviate a little from the plan, but the clearer and more detailed the plan, the more likely the intervention will remain true to it.



## **Step 5**

# **Evaluation and monitoring**

Monitoring the implementation of the intervention (is the activity taking place as planned?) and evaluating its effectiveness (is it working?) are critical tasks to be conducted during implementation and must be planned during the intervention conception.

## Monitoring

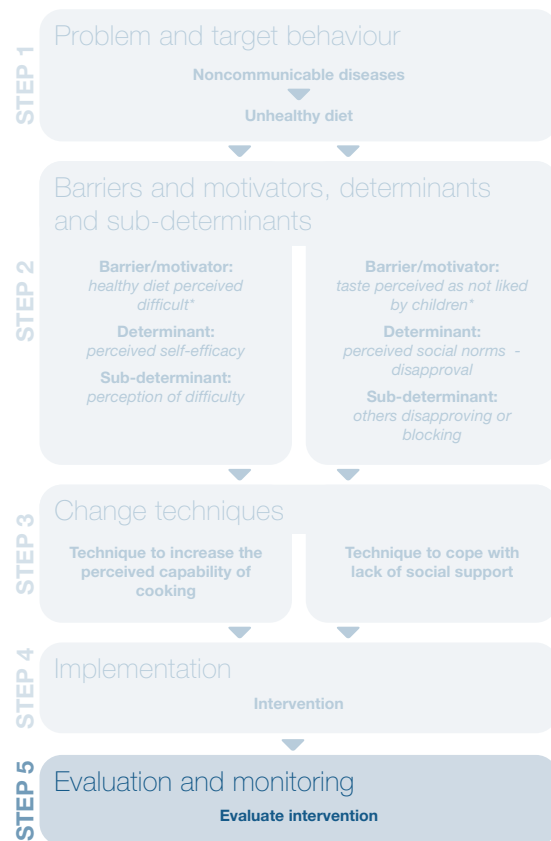
During the small-scale implementation, it is important to monitor the intervention. Both quantitative and qualitative data can be collected. Questioning how the participants perceived the intervention allows you to prevent disseminating at large scale an intervention that would be misunderstood or not well received by the population. Besides this qualitative dimension, it is also useful to collect quantitative data on the number of people reached compared to what was planned (e.g. how many people attended the practice session versus how many were expected, how many visited the webpage, how many displayed prompts in their homes, how many completed the problem-solving activity etc.); quantity of material used/distributed (e.g. number of flyers printed and number distributed, if objects to help the behaviour were provided to the community, how many were actually collected, etc.). Monitoring can reveal if issues of implementation arise such that the intervention cannot be implemented as planned in the protocol. Sometimes it can also provide answers where it is observed that the intervention had not the expected effectiveness. It may be that for reasons external to the content of the intervention it was not adopted by the population. All these things can help you and your team rectify if necessary and maximize the effectiveness of the intervention.

Tools which can be used during monitoring are the same as in the early phases of the intervention development (note that some of these tools are pretty intrusive and should not be used regularly).

- Transect walks and observation
- Individual interviews (key informants)
- Focus group discussions
- Questionnaires
- Household visits
- Repeat the doer/non-doer analysis

Using several sources and mixing quantitative and qualitative data will help understand the bigger picture.

Depending on the results of monitoring, the intervention can be scaled up directly (if results are good and no modifications are required). If good results are achieved in one sub-determinant, another sub-determinant may be tackled in order to further increase the number of doers. If no or only few changes have occurred despite the intervention, the intervention might need to be adjusted before being implemented at a larger scale. If the readjustments are numerous, it might be valuable to start again with a small-scale test and extend the implementation when it is verified that the new version of the intervention is appropriate.



## Evaluation

Once the feasibility and appropriateness of the intervention are verified, the effectiveness of the intervention in achieving its goal should be assessed. Volunteers can start doing the evaluation soon after the intervention has been put in place.

In order to be able to identify an effect of the intervention, three stages are usually compared: baseline (e.g. before the intervention), midterm and endline. For each time point, an agreed set of indicators should be measured.

Use a set of indicators that relate directly to the behaviour that was promoted (e.g. percentage of adults consuming less than five total servings of fruit and vegetables per day; percentage of households consuming vegetables and fruits from their kitchen garden; percentage of communities engaging in health actions for better nutrition). Use also some indicators that match the sub-determinants that were targeted by the intervention. For example if the intervention aimed to increase access to fruits and vegetable, the corresponding indicators could be “percentage of people who gained access to fruits and vegetable”, or “percentage of people who can afford to buy fruits and vegetables” (if financial resources were lacking); “percentage of people who know where to buy fruits and vegetables” (if people did not know where they could get such products).

*Generic examples:*

*Indicators to measure the behaviour:*

- percentage of people doing the target behaviour and related behaviours/ percentage of new people doing the target behaviour and related behaviours

*Indicators to measure the sub-determinants (choose among the following list depending on what your intervention tried to achieve):*

- percentage of people having positive beliefs about the behaviour and its consequences
- percentage of people who reduced their negative beliefs about the behaviour and its consequences
- percentage of people who are aware of the behaviour
- percentage of people who know how to do the behaviour
- percentage of people who perceive the behaviour as easy
- percentage of people who think the behaviour is socially accepted
- percentage of people who perceive they would be encouraged to do the behaviour
- percentage of people who no longer think the behaviour is not well regarded
- percentage of people who think they can cope with lack of social support
- percentage of people thinking their religion is in favour of the behaviour
- percentage of people thinking the religious leader is in favour of the behaviour
- percentage of people thinking their religious community would support them doing the behaviour
- percentage of people who have access to resources to do the behaviour or who know where to get them
- percentage of people who are in a situation that makes the behaviour easy to do
- percentage of people who are in a situation where the behaviour is possible to be performed

You can use qualitative and quantitative data. Tools to measure change in the determinants differ depending on the level of determinants and techniques:

- Increase in knowledge and change in beliefs (about the consequences of the behaviour, what others expect, or beliefs about capacities) can be assessed via individual interviews or surveys.
- Changes in infrastructure can be assessed via observation, or interviews and surveys.
- Changes in norms and social rules can be measured via surveys and interviews.
- Changes in how the intention is translated into action can be measured via surveys and interviews, or observation.

Concretely, evaluation is done by visiting households (20 is a good number), and asking questions about awareness of the intervention, use of the intervention, as well as questions about the target behaviour (are people doing it?), following the set of agreed indicators.

In order to know if an intervention can be considered effective, you can compare also with the matrix used previously to see if things have changed.

	Positive	Negative	Neutral
Knowledge			
Approval			
Intention			
Practice			

Sometimes the intervention will succeed in changing the sub-determinants but is not enough to change behaviour. This is reflected in the stages of behaviour change which are presented in the behaviour change module of eCBHFA, topic 3. The intervention can manage to make people go from knowledge to approval or even to intention, but another intervention might be necessary to lead them to practice or advocacy.

If you and your team observe that the goal of behaviour change was not reached, it is useful to go back to interview the population in order to understand why. To do this, use the same assessment tools that were used initially. Data from the first round can be used as a comparison point. Again, triangulate the data to be sure to see the full picture. You can do a new matrix to sort data according to the categories of positive/negative/neutral and the stages of change. It may be noticed that some beliefs did change due to the intervention, but that some other beliefs are still not in favour of behaviour change. For example, people may have been convinced of the benefits for their health, but they do not feel that other people would support them doing the behaviour. In this case, another intervention targeting this obstacle could be planned. With the new identified sub-determinants, use the tables describing the techniques to select what to include in your second round of intervention.



**Evaluating the effect on health outcomes is necessary.** Firstly, the intervention was set up originally to have an impact on a health issue. And secondly, this allows comparison with other interventions: indicators of health outcomes for a problem will probably be similar. However, health outcomes are not always easy to measure, and they can take time to emerge following an intervention. So, if the target behaviour is known to have an impact on the problem (e.g. eating five servings of fruits and vegetables is known as having a positive impact on health), ensuring that the intervention increased the number of servings of fruits and vegetables is already a success.

The same methods as those described for behaviour change and determinants can be used to evaluate health outcomes, in addition to others that are specific to the impact on health issue:

- recordings of health centres: number of cases of people concerned with the health issues, number of consultations; number of patients with noncommunicable diseases, number of obese patients, deaths if the intervention was supposed to have an effect on mortality
- administrative data: school attendance records if the intervention was ultimately supposed to reduce absenteeism; number of people registered in sports clubs if the intervention aimed at increasing physical activity, etc.

*Example: Once the intervention has reached the first round of persons, a survey is sent to participants of the cooking sessions. It asks them questions about the target behaviour (e.g. how many meals including at least two servings of vegetables do they cook a week), and assesses their perception of ability to do it, and their beliefs about their family approval. Questions about the outcomes of the behaviour such as weight loss in the family and other health consequences (e.g. feeling more energetic ...) are also included in the survey.*



---

# Conclusion

---

If the level of implementation is satisfactory, as well as the results of the evaluation of the effectiveness, congratulations! Continue with the intervention until your community committee decides that it is time to focus on other problem behaviours. We want to support the behaviour change as long as necessary until it becomes part of people's everyday lives.

When people have been practising for at least three months consistently, they can themselves become an advocate of the behaviour for others, trying to help them achieve the same goal. You can find more information of the progression from practice to advocacy in the [eCBHFA BC tools](#) (Stages of behaviour change tools).

---

# Sources

---

- Bronfenbrenner, U. (1994). *Ecological models of human development*. In *International Encyclopedia of Education* (Elsevier Sciences Ltd, p. 1643-1647).
- Claxton, N. (2013). *IFRC Behaviour Change Framework*.
- Contzen, N., & Mosler, H.-J. (2015a). *The RANAS model of behavior change*. Methodological Fact Sheet 2. Eawag, Swiss Federal Institute of Aquatic Science and Technology.
- Contzen, N., & Mosler, H.-J. (2015b). *The RANAS model of behavior change*. Methodological Fact Sheet 4. Eawag, Swiss Federal Institute of Aquatic Science and Technology.
- Golden, S. D., McLeroy, K. R., Green, L. W., Earp, J. A., & Lieberman, L. D. (2015). *Upending the social ecological model to guide health promotion efforts toward policy and environmental change*. *Health Education & Behavior*, 42(1S), 8S-14S.
- Huber, A. C., Tobias, R., & Mosler, H.-J. (2014). *Evidence-based tailoring of behavior-change campaigns : Increasing fluoride-free water consumption in rural Ethiopia with persuasion*. *Applied psychology: Health and Well-Being*, 6(1), 96-118.
- Kok, G., Gottlieb, N. H., Peters, G.-J. Y., Mullen, P. D., Parcel, G. S., Ruiter, R. A. C., Fernández, M. E., Markham, C., & Bartholomew, L. K. (2016). *A taxonomy of behaviour change methods : An Intervention Mapping approach*. *Health Psychology Review*, 10(3), 297-312. <https://doi.org/10.1080/17437199.2015.1077155>
- Michie, S., Richardson, M., Johnston, M., Abraham, C., Francis, J., Hardeman, W., Eccles, M. P., Cane, J., & Wood, C. E. (2013). *The Behavior Change Technique Taxonomy (v1) of 93 Hierarchically Clustered Techniques : Building an International Consensus for the Reporting of Behavior Change Interventions*. *Annals of Behavioral Medicine*, 46(1), 81-95. <https://doi.org/10.1007/s12160-013-9486-6>
- Petit, V. (2019). *The behavioural drivers model : A conceptual framework for social and behaviour change programming*. UNICEF.
- Theory and Technique Tool. (s. d.). <https://theoryandtechniquetool.humanbehaviourchange.org/>
-

# Appendix

## Guidance on how to do the doer/non-doer analysis

In order to hear what the members of the community have to say, a focus group can be put in place. Focus groups are sessions where a small number of people (between seven and ten) gather to discuss a specific topic. Some conditions are required for a focus group to be instructive, such as not too many people interviewed at the same time, and the need for people to act as moderator, facilitator and note-takers/observers. A description of each role as well as a suggestion on how to formulate questions in order to get useful answers and create a trusting atmosphere is given in a document that goes together with the doer/non-doer tool.

Guidance on how to do the initial focus group discussion is provided (see image on the next page).

An initial focus group discussion can have two objectives: the first one is to obtain an idea of the barriers that might block a particular behaviour. Those barriers can be of several types. If it is a structural problem the solution will be different than if it is false beliefs stopping people doing the behaviour or practising a risky behaviour.

A second objective is to identify doers and non-doers of the behaviour. This is the first step of the evidence-based doer/non-doer analysis tool.

Once your team and you have identified people who do the behaviour and people who do not perform it, the **barrier analysis** can start. The idea of the barrier analysis is to understand what differentiates the doer and non-doer while they are living in the same community.

A list of questions to be asked is suggested:

- The consequences of the behaviour (what advantages or disadvantages the person thinks the behaviour provides.)
- The capacity or ability of the person to perform the desired behaviour (does the person know how to do the desired behaviour and does she or he think it is easy to do? Are there resources needed to do the behaviour that are accessible or rather difficult to access?)
- The social norms regarding the behaviour (who is in favour and who is disapproving of the person doing the behaviour).
- Religious beliefs about the behaviour (is there any recommendation in the person's religion about the behaviour, and what the leader and the religious community say about it).
- Beliefs about how likely the person is to be at risk for the health threat, and how severe is this threat.

The Doer/Non-Doer analysis tool can be found at <https://ecbhfa.ifrc.org/guides-and-tools/>. Additionally, you can find supporting documents and worksheets to use the field for common health concerns like handwashing, healthy food choices and physical activity. The doer/non-doer analysis tool looks like this:

**Behaviour Change guidance**

**DOER Individual Barrier Analysis Interview Sheet**

Use this sheet for emergency or short-term behaviour change

This sheet is to be used in interviewing one DOER at a time in an emergency response or epidemic. The DOER should be identified as such before using this interview protocol. Complete one sheet per DOER. If, during the interview, the person is actually a NON-DOER, continue with the interview. The protocol questions are the exact same, just remember to mark their identification of Doer or Non-Doer appropriately during the next stage of data analysis. The short-term barrier analysis contains an additional three questions.

<b>Name/Identifier of Interviewee</b>	
---------------------------------------	--

*Names do not have to be given, but if use of names is not appropriate, provide an identifier of this person for follow-up once the behaviour change intervention has been decided.*

<b>Target Behaviour we want people to practice</b>	
--	--

*If the interventions are specific to a residential community, indicate the area or neighbourhood where they live. If the interventions are for workplace, indicate where in the organisation they work.*

Number	Determinant	Suggested Determinant-related questions to ask	Responses (use as many lines as necessary to capture all data. Ensure the corresponding / appropriate determinant number is on each line).
1	<b>1. Perceived positive consequences?</b> (the advantages of doing the behaviour?)	1. What are the advantages of doing the behaviour? Does doing the desired behaviour make your life better/easier? Why?	1
			1
			1
			1
			1
			1
			1
			1
2	<b>2. Perceived negative consequences?</b> (the disadvantages of doing the behaviour?)	2. What are the disadvantages of doing the desired behaviour? Does doing the desired behaviour affect you in a negative or bad way? How?	2
			2
			2
			2
			2
			2
			2
			2

For each possible determinant there is a series of suggested questions that the person conducting the interview with members of the community can ask. The analysis is conducted among a number of people currently doing the behaviour (the doers), and a number of people that are not doing the behaviour (the non-doers). Note: it is possible that some questions need to be adjusted to the local culture, for example if they do not make sense in a specific context. It is fine to adapt some questions, but it is important that the questions are the same for all the persons interviewed.

After the data have been collected for a sufficient number of people, responses can be entered in the Excel sheet to be calculated. The reasons that are most different among doers and non-doers will be highlighted in order to identify where the intervention should focus (see Part 3: How to use results of the behaviour barrier and motivator analysis for discussion of the analysis).



# The fundamental principles of the international Red Cross and Red Crescent movement

**Humanity** The international Red Cross and Red Crescent movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

**Impartiality** It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

**Neutrality** In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

**Independence** The movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

**Voluntary service** It is a voluntary relief movement not prompted in any manner by desire for gain.

**Unity** There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

**Universality** The international Red Cross and Red Crescent movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

**For more information on this IFRC publication, please contact:**

**International Federation of Red Cross and Red Crescent Societies**

P.O. Box 303  
CH-1211 Geneva 19  
Switzerland  
Telephone: +41 22 730 4272  
Telefax: +41 22 733 0395  
Email: [secretariat@ifrc.org](mailto:secretariat@ifrc.org)