



## Challenges to changing health behaviours in developing countries: A critical overview

Frances E. Aboud\*, Daisy R. Singla

McGill University, Canada

### ARTICLE INFO

#### Article history:

Available online 11 May 2012

#### Keywords:

Health behaviour change  
Developing countries  
Theories of behaviour change

### ABSTRACT

This overview of recent research on health behaviour change in developing countries shows progress as well as pitfalls. In order to provide guidance to health and social scientists seeking to change common practices that contribute to illness and death, there needs to be a common approach to developing interventions and evaluating their outcomes. Strategies forming the basis of interventions and programs to change behaviour need to focus on three sources: theories of behaviour change, evidence for the success and failure of past attempts, and an in-depth understanding of one's audience. Common pitfalls are a lack of attention to the wisdom of theories that address strategies of change at the individual, interpersonal, and community levels. Instead, programs are often developed solely from a logic model, formative qualitative research, or a case-control study of determinants. These are relevant, but limited in scope. Also limited is the focus solely on one's specific behaviour; regardless of whether the practice concerns feeding children or seeking skilled birth attendants or using a latrine, commonalities among behaviours allow generalizability. What we aim for is a set of guidelines for best practices in interventions and programs, as well as a metric to assess whether the program includes these practices. Some fields have approached closer to this goal than others. This special issue of behaviour change interventions in developing countries adds to our understanding of where we are now and what we need to do to realize more gains in the future.

© 2012 Elsevier Ltd. All rights reserved.

### Introduction

Many of the Millennium Development Goals (MDGs) require behaviour change. Whether or not behaviour is the source of poor health, malnutrition and mortality, it is now acknowledged to be a critical part of the solution. The many *Lancet* series on child mortality, maternal mortality, malnutrition, child development, and mental health (e.g., Black et al., 2008; Campbell & Graham, 2006; Engle et al., 2007; Jones, Steketee, Black, Bhutta, Morris, & the Bellagio Child Survival Study, 2003) have drawn attention to the behavioural solutions to these problems and the difficulty in implementing them. Breast feeding, diet, condom use, and hygiene are some behavioural solutions that require low technology and little expense. They are now known to have a significant and long term impact on reducing disease, disability and death.

The health field looks to behavioural and social scientists to provide guidance on how to change these and other simple behaviours. Firm answers are not often found. Instead, the

literature reports as many failures as successes, making it difficult to extract the important messages. Moreover, findings tend not to build on each other. More needs to be done to bring this literature together so that, irrespective of the specific behaviour and country, researchers and program developers can learn from each other and contribute to a foundation of theory and evidence. In this introduction, we discuss a number of current and past interventions in order to outline how program developers have identified strategies to change behaviour, along with their implementation and outcomes. Consensus on strategies related to safer sex practices and psychotherapy has progressed to the point where they have clear guidelines on best practices for the field and a metric for assessing a program's use of them. Before creating guidelines for other areas, we need behaviour change evaluations of interventions built around three sources, namely theory, evidence and an in-depth understanding of the audience.

In many ways, behaviour change research in developing countries fits a similar pattern regardless of the specific health problem. Typically, multidisciplinary teams of biomedical and social scientists collaborate with local organizations to implement and evaluate small- or large-scale programs. Second, they address behaviours to be performed at the individual or household level,

\* Corresponding author.

E-mail address: [frances.aboud@mcgill.ca](mailto:frances.aboud@mcgill.ca) (F.E. Aboud).

that are currently at a low level and so not normative, such as safe water, latrine use, hand-washing, safe delivery, newborn care, child responsive feeding, HIV prevention, health care seeking, and providing social support. Third, the behaviour change activities often include components of behaviour change communication, or social marketing, aimed at informing, mobilizing, and selling a practice or product. Fourth, they usually target an audience whose behaviour is guided by more than cognitions – perhaps by habit, resources or social forces. Finally, and unfortunately, they encounter common problems that often lead to little change. It should be recognized that the behaviours may be difficult to change because they are habitual, normative and preventive. Habitual behaviours are difficult to change because they are performed automatically without much thought; normative behaviours bear the weight of tradition and approval; and preventive behaviours often lack a salient immediate outcome.

### How much change can we expect?

This raises the question of how much change we can expect from interventions in the short term and the longer term. Naively, we often think it sufficient to advise people to dig and use a latrine in order to save their lives and those of their children. But if one has stayed alive for 30 years without a latrine, one may doubt the credibility and urgency of the message. Others with a broader view of the community, a strong motivation to keep one's family healthy, and an abstract understanding of "germs" might come to understand the relevance of sanitation for the health of all members of the community (Kar, 2005). This latter group is often the minority in rural communities. One study reported an increase from 4% to 57% of households with a latrine after a 6-month community mobilization program, and this was considered very successful (O'Loughlin, Fentie, Flannery, & Emerson, 2006). Those who built and used the latrines were more likely to have some schooling and proximity to urban living compared to those who did not.

The Diffusion of Innovation theory identifies people who are likely to change in the short term (Rogers, 2003). They are called "innovators" and "early adopters". In contrast, those who are slow to change are called "late adopters" and those unlikely to change are called "laggards". So who are the innovators and early adopters? Apart from being better educated, they may be convinced by rational arguments, have a social network that supports change, and some self-efficacy to try the new practice before accepting or rejecting it. In contrast, late adopters may not adopt a new practice or product quickly because it requires some cognitive effort and social support to recall the message in the right context, to inhibit the old habit, and to initiate the new one. The strength of the arguments concerning health may matter little if there is a competing agenda to complete one's activity with minimal expenditure of energy and other resources. Late adopters may therefore not change until they see a critical mass of others in the community adopting the innovation. This explanation is based on theories of social learning and habit (Bandura, 1977, 1986; Verplanken & Orbell, 2003), central and peripheral routes to persuasion (Petty & Cacioppo, 1986), and the influence of descriptive and prescriptive social norms and social support (Cialdini, Kallgren, & Reno, 1991; Heaney & Israel, 2008). In any community, the distribution of innovators, early adopters, late adopters, and laggards is thought to be 20%, 30%, 30% and 20%, respectively (Rogers, 2002). Given this distribution, one might expect a 50% rate of change in the short term. Some findings suggest that we cannot hope for more than half of the population to change even in the long term unless extra effort is made to engage late adopters and laggards (e.g., Fink et al., 2012; Korsching, Stofferahn, Nowak, & Wagener, 1983; Levy-Storms & Wallace, 2003).

### Limitations to identifying change strategies

Programs rarely rely on a combination of theory, evidence and insights about their audience to identify what and how to change behaviour. Programs are generally planned using a logical or empirical frame. Using the logical strategy, one builds a program by connecting desired outcomes to current resources within a logic model. According to the Logic Model used for program planning (e.g., Innovation Network Inc., 2007) and adopted by donors, one considers the problem in relation to the desired goals or outcomes. The main starting point is an identification of resources and activities that will logically lead to the outcomes. The major gap in the logic model is the source of these specific activities. Behaviour does not logically follow from activities and activities do not logically follow from resources. Even if one holds group sessions and informs people of what they need to do and why, decisions and behaviours are unlikely to follow. The so-called chain of logic has many broken links. Psychosocial theories and evidence of the link between resources, activities and behaviour change are needed to fill this gap.

The empirical strategy for program planning uses qualitative and case-control evidence about people who do and do not practice the desired behaviour. This kind of formative research on one's audience is necessary but insufficient by itself. Some researchers ask people with well-nourished and malnourished children what and how they feed their children (Lapping et al., 2002; Roy et al., 2005). Given that we already have a 'best practice' guideline on what and how to feed (WHO, 2003), qualitative research by itself may be incomplete as a cohesive base for the program, though useful as a forewarning of potential barriers for that audience. Other research uses self-reports of reasons for not practicing the behaviour. People who did not practice the behaviour (e.g., hand-washing or mammography screening) are asked why they did not. The result is a list of barriers, such as cost, inconvenience, fear, and not knowing its importance. A program is then developed to overcome these barriers. This approach is limited by the fact that people are surprisingly ignorant of what motivates their behaviour. The reasons we normally give are most often *post hoc* rationalizations, that is, reasons that make sense to us and to the person asking the question. The rationalizations are at odds with empirical evidence of the determinants of our behaviour (Wilson & Nisbett, 1978). They are also at odds with the finding that those who practice the behaviour report the same barriers (Curtis, Danquah, & Ager, 2009; Facione & Facione, 2006). So although qualitative, formative research on one's audience is essential, it is incomplete as a method for identifying change strategies.

A case-control design is also frequently used to identify quantitatively determinants of the practice. Those who did or did not engage in hygienic practices or safer sex can be compared on a number of dimensions (e.g., Clemens & Stanton, 1987; Fishbein & Yzer, 2003). Unfortunately these dimensions are usually limited to socio-demographic variables such as assets and education, to related practices such as care seeking, and to social cognitions regarding social approval, attitudes, and self-efficacy. Inevitably, education and urban living are correlated with the practice, but these take time to change. Some social cognitions such as beliefs, attitudes, and self-efficacy are also commonly associated with the practice. This leads to the design of a program based on communication or education aimed at informing people about what to do and why. The "why" component is usually aimed at changing beliefs and attitudes with the assumption that if these variables are "determinants" of behaviour in a case-control design, then changing the determinants will lead to a change in behaviour. The major flaw in this assumption is that behaviour itself may be determining beliefs, attitudes, and self-efficacy. Furthermore, past behaviour, if habitual, drives future behaviour without much input

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات