
UNIT 1 BEHAVIOUR CHANGE COMMUNICATION SKILLS AND OTHER SOFT SKILLS

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1.0 INTRODUCTION

Behaviour is the range of actions and mannerisms made by humans or any organisms, systems, or artificial entities in conjunction with their environment, which includes the other systems or organisms around as well as the physical environment. It is controlled by a number of factors both internal and external. Sometime particular behaviour can be injurious to health and lead to disorders. Behavioural disorders will contribute to a significant burden of diseases in future. Treatment of behaviour-related diseases like HIV, non-communicable diseases is expensive but the cost of behaviour change interventions is low. Change in behaviour is emerging as an important strategy of prevention and control of many diseases specially non-communicable diseases and addictions.

In this unit we will discuss the communication, how behaviour changes and behaviour change communications process, soft skills which involves interactions in the society would also be discussed.

1.1 OBJECTIVES

After completing this unit, you should be able to:

- explain of communication;
- discuss human behaviour and how it can be changed;
- describe and strategies for behaviour change communication (BCC); and
- discuss skills and their role.

1.2 COMMUNICATION

Communication is the process of sending and receiving messages verbally or in writing. Messages are mainly related to health awareness so that healthy behaviour can be adopted.

Communication is necessary to pave way for desired changes in human behaviour and community participation to achieve predetermined goals. The ultimate goal of all communication is to bring change in the desired direction in one who receives it. These may be at-

- a) Cognitive level - Knowledge
- b) Affective level - Attitude
- c) Psychomotor level - Practice

Communication skills required in health education include– speaking, writing, listening, reading and reasoning. You must recall this process which you studied in your previous training programme. Let us revise it as shown in Fig. 1.1.

Communication process involves a source which can be called as sender or health worker in his/her capacity as a care giver decides to plan and prepare message keeping in mind target group. As shown in Fig.1.1 message is of prime importance from encoding to decoding (receiver), after that feedback from receiver to sender completes the process of communication.

You may recall the communication lecture you must have attended during earlier training programme, however, will review the same. For effective communication always you should remember following points:

- Need based
- Target group oriented
- In simple and clear language and should meet the requirements of the people in need of health related messages.

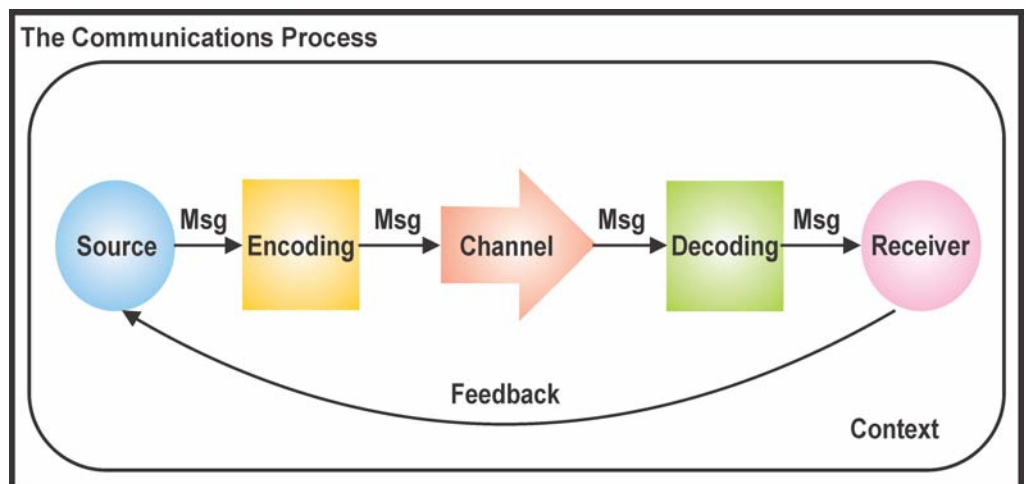


Fig. 1.1: The communication process

1.3 HUMAN BEHAVIOUR

Let us now read about human behaviour. It is not easy to change the behaviour of people. Behaviour is responsible for many health problems and at the same time solution to the health problem. It is not possible to change behaviour at once, or in one time conveying the messages, message has to be enforced many times such as importance of physical activities to prevent non-communicable diseases to be made people adopt this behaviour. (Fig.1.2)

Behaviour is an observable action of an individual often in reaction to specific circumstances or stimuli. It is acquired and liable to change. It is affected by a number of factors like genetic, social norms, culture, attitude, emotions, perceived risk and benefits etc.



Fig. 1.2: Factors affecting behaviour

Human health behaviour

Conner and Norman define health behaviour as any activity undertaken for the purpose of preventing or detecting disease or for improving health and well-being. In simple words it relate to health maintenance, restoration and improvement. Behaviours within this definition include medical service usage (e.g., physician visits, vaccination, screening), compliance with medical regimens (e.g., dietary, diabetic, antihypertensive regimens), and self-directed health behaviours (e.g., diet, exercise, smoking, alcohol consumption). The initiation and maintenance of health behaviours result from an interaction of social, psychological, biological, and environmental factors. Behaviours can be harmful to health like smoking, alcohol, sedentary lifestyle or they can be health promoting like regular exercise, eating habits, compliance to treatment, safe sexual habits etc.

1.4 HEALTH BELIEF MODEL

The Health Belief Model (HBM) shown in Fig.1.3 is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services when social psychologists were asked to explain why people do not participate in health behaviours.

According to the HBM, the following beliefs explain and predict health-related behaviour:

- 1) Perceived personal susceptibility
- 2) Perceived severity
- 3) Perceived benefits
- 4) Perceived barriers
- 5) Cues to action
- 6) Self-efficacy

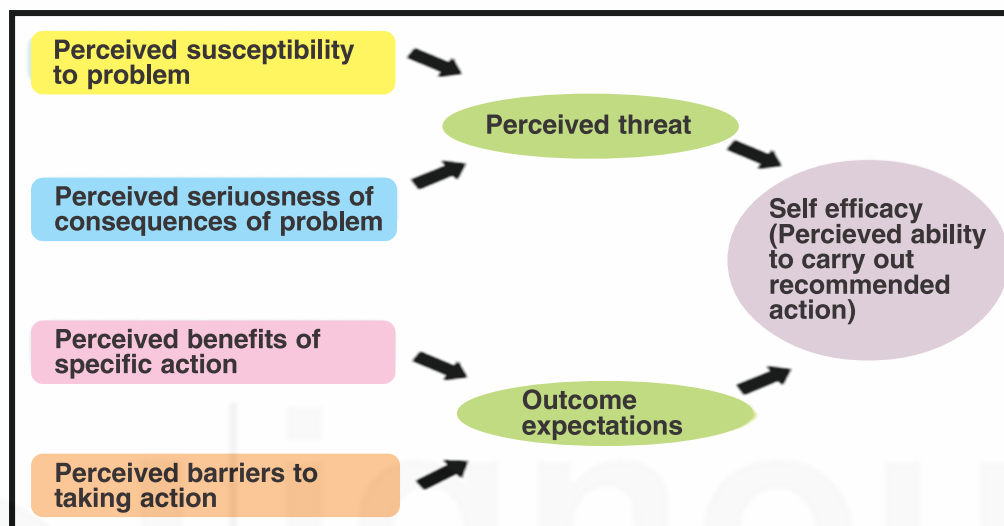


Fig. 1.3: Health Belief Model

1.4.1 Concepts and Definitions in Health Belief Model

Let us read the definition and application of the concepts of health belief as model in brief given in Table 1.1 below:

Table 1.1: Concepts and Definitions in health belief model

| Concept | Definition | Application |
|--------------------------|--|--|
| Perceived Susceptibility | One's opinion of chances of getting a condition | Define population(s) at risk, risk levels; personalise risk based on a person's features or behaviour; heighten perceived susceptibility if too low. |
| Perceived Severity | One's opinion of how serious a condition and its consequences are | Specify consequences of the risk and the condition |
| Perceived Benefits | One's belief in the efficacy of the advised action to reduce risk or seriousness of impact | Define action to take; how, where, when; clarify the positive effects to be expected. |
| Perceived Barriers | One's opinion of the tangible and psychological costs of the advised action | Identify and reduce barriers through reassurance, incentives, assistance |
| Cues to Action | Strategies to activate "readiness" | Provide how-to information, promote awareness, reminders |

| Concept | Definition | Application |
|---------------|--|---|
| Self-Efficacy | Confidence in one's ability to take action | Provide training, guidance in performing action |

HBM has been adapted to explain and predict a variety of long- and short-term health behaviours:

- 1) Preventive behaviour
- 2) Illness behaviour
- 3) Sick role behaviour

1.4.2 Ways to Influence Behaviour

To influence behaviour certain ways may be kept in mind as given :

- 1) **Support:** It is to provide a service support and give people what they need, want, or value. Hence, select message as per their need, availability and in advance.
- 2) **Inform:** Inform, advise, build awareness, educate, encourage, persuade and inspire people to adopt healthy behaviour.
- 3) **Legislation:** Legislate, regulate, enforce with police to force people to adopt health promoting behaviour like following traffic rules.
- 4) **Design:** Set environmental and physical context, design, engineer, availability, distribution of infrastructure in such a way that people are enabled to take action.

1.5 STEPS OF BEHAVIOUR CHANGE

People proceed from lack of knowledge (unawareness) to gain in knowledge which is achieved with efforts on the part of health worker and the receiver of the message. Let us now read important steps of change in behaviour. These are given below:

1) Knowledge

In this step, one first learns about a new behaviour and recalls messages and understands meaning of the messages.

2) Approval

One then approves of the new behaviour and responds favourably to messages. The person discusses the information with personal network (professional, colleagues, family and friends). Later he himself approves of the practices.

3) Intention

One then believes this behaviour is beneficial to them and intends to consult the provider. The person recognises that the strategies can meet a personal need. The person intends to adopt these practices in future.

4) Practice

The person goes to provider of information/supplies/services. One then attempts new behaviour and continues to practice.

5) Advocacy

One can then promote the new behaviour through their social or professional networks as a satisfied practitioner. He experiences and acknowledges personal benefits of adopting behaviours and advocates it to others and supports the programme in the community. E.g. A diabetic person develops habit of regular monitoring of blood sugar which helped him in diabetes control for himself, will tell other diabetic persons to do so.

1.6 TECHNIQUES OF BEHAVIOUR CHANGE

Let us go through techniques of behaviour change as given below:

- **Information-** Used with the belief that audience lacks information. It is source dominated and one way.
- **Education-** It focuses on applying knowledge. Skill building techniques like demonstrations, skill practice, do and learn are useful methods. It build confidence and makes behaviours convenient.
- **Motivation-** It is the driving force to achieve something. It is used when information is established. Different appeals are instrumental for motivation e.g. rationale appeal, emotional appeal, threat/fear appeal, joy/fun appeal
- **Reinforcement-** It is used to sustain behaviour change for repetitive types of behaviours. Need to be used with variations. Community based resources/mechanisms should be established to reinforce the message.
- **Social Pressure-** When person in need of health services not willing to undergo treatment is encouraged by near and dear ones to avail health services.

1.6.1 Guiding Principles in Planning Behaviour Change Communications (BCC) Activity

- 1) BCC should be integrated with programme goals from the start. BCC is an essential element of disease prevention, care and support programmes, providing critical linkages to other programme components, including policy initiatives.
- 2) Formative BCC assessments must be conducted to improve understanding of the needs of target populations, as well as of the barriers to and supports for behaviour change that their members face (along with other populations, such as stakeholders, service providers and community).
- 3) The target population should participate in all phases of BCC development and in much of implementation.
- 4) Stakeholders need to be involved from the design stage.
- 5) Having a variety of linked communication channels is more effective than relying on one specific one.
- 6) Pre-testing is essential for developing effective BCC materials.
- 7) Planning for monitoring and evaluation should be part of the design of any BCC programme.
- 8) **BCC strategies** should be positive and action-oriented.

Check Your Progress 1

- 1) Fill in the blanks.
 - a) Health Belief Model (HBM) was first developed by
 - b) The theme for any BCC campaign should be.....
- 2) State true and false.
 - a) Communication is one way process.
 - b) Formative BCC assessment start by seeking out all available studies, including data from in-depth assessments or rapid ethnographic assessments, behavioural surveillance surveys.
 - c) Population segments are often defined by psychosocial and demographic characteristics in BCC.

1.7 STEPS OF BEHAVIOUR CHANGE COMMUNICATIONS (BCC)

Let us go through the steps of BCC as shown in Fig. 1.4 followed by description:

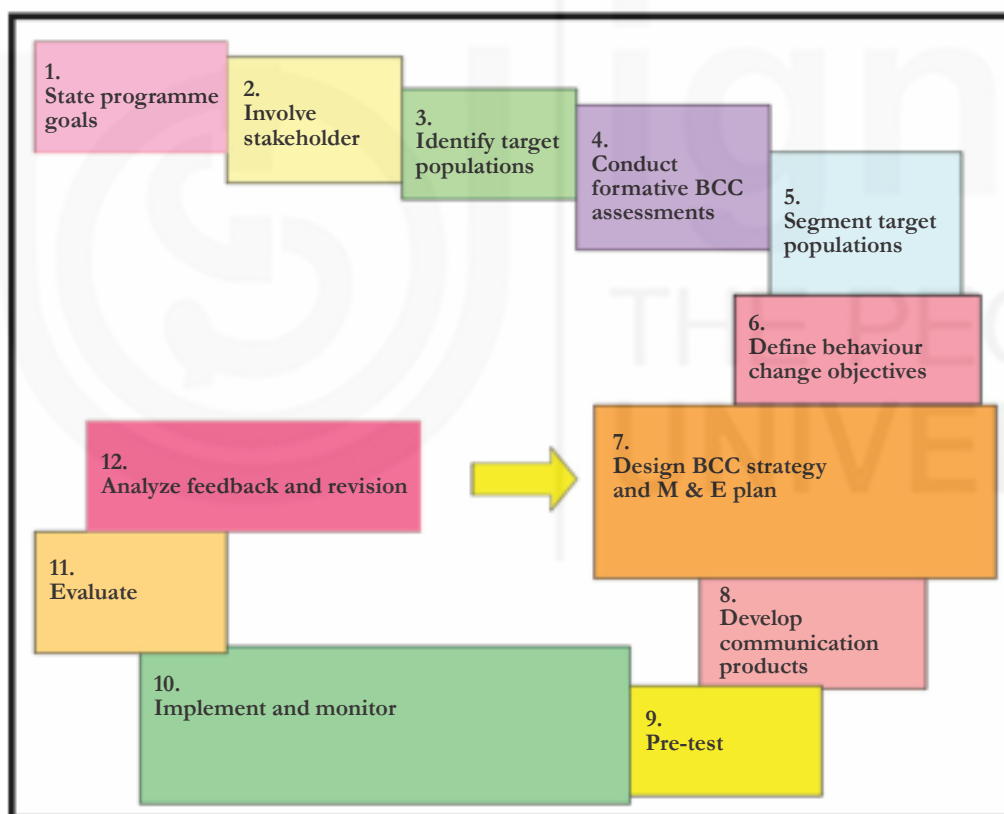


Fig. 1.4: Steps of Behaviour Change Communication (BCC)

- 1) **State programme goals-** Identifying overall programme goals is the first step in developing a BCC strategy. Specific programme goals are established after reviewing existing data, epidemiological information and in-depth programme situation assessments. Please refer Course 1 Block 3 and 4 for Communicable and Non-Communicable Diseases.
- 2) **Involve stakeholders-** Key stakeholders need to be involved early on in every step of the process of developing programmes and their BCC

components. Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of target populations.

- 3) **Identify target populations-** To develop communication, it is important to identify the target populations as clearly as possible. Target populations are defined as primary or secondary. Primary populations are the main groups whose behaviour the programme is intended to influence. Secondary populations are those groups that influence the ability of the primary population to adopt or maintain appropriate behaviours.
- 4) **Conduct formative BCC assessments-** A formative BCC assessment should start by seeking out all available studies, including data from in-depth assessments or rapid ethnographic assessments, behavioural surveillance surveys and other related studies. After synthesising this information, a formative BCC assessment protocol can be developed.

The formative BCC assessment should collect information on:

- 1) Risk situations, showing in detail how decisions are made in different situations, including what influences the decisions and settings for risk
 - 2) Why individuals and groups practice the behaviours they do, and why they might be motivated to change (or unable to change) to the desired behaviours
 - 3) Perceptions of risk and risk behaviours
 - 4) Influences on behaviour, such as barriers or benefits
 - 5) Insights of opinion leaders
 - 6) Patterns of service use and opinions about these services
 - 7) Perceptions of stigma and discrimination
 - 8) Future hopes, fears and goals
 - 9) Media and entertainment habits
 - 10) Health care-seeking behaviours
 - 11) Media resources
- 5) **Segment target populations-** Based on the formative BCC assessment, target populations can then be segmented. Population segments are often defined by psychosocial and demographic characteristics.
 - 6) **Define behaviour change objectives-** What changes in behaviour does the programme intend to achieve? Observable changes in behaviour, as specified in the behaviour change objectives, are a final programme outcome. Such changes include:
 - a) Knowledge change
 - b) Attitude change
 - c) Environmental change
 - 7) **Design BCC strategy and Monitoring and Evaluation (M&E) Plan-** A plan for monitoring and evaluation needs to be drawn up during the initial stage of BCC strategy design. To monitor the course of a BCC strategy properly, it is necessary to establish effective information-gathering systems. These include reports, site visits and reviews of materials. Reporting tools and protocols must be standardised to ensure consistency.

- 8) **Develop communication products and train providers-** It is important to develop an overall theme that will appeal to and attract target populations. The theme should stem from the BCC formative assessment and further consultation.
- The theme should be positive.
 - Avoid blaming or stigmatising.
 - Should call attention to the campaign and link its various elements together, functioning as a sort of umbrella.
 - It should be catchy and devised in such a way that all target populations can relate to it and identify with it.

Steps to develop the overall theme and key messages.

- Step 1.** Develop a profile of the target population from formative BCC assessment.
- Step 2.** Identify desired behaviour change.
- Step 3.** Understand and take into account the varying situations that could affect action and decision-making.
- Step 4.** Identify the information or data that you want to be understood by the target population.
- Step 5.** Develop key benefit statements that take the hopes and aspirations of the target population into account.
- Step 6.** Develop messages from key benefit statements. Messages should be simple, attractive and make clear the benefits of what is being promoted, through words or images.

Choose channels- A channel is the way a message is disseminated. It is important to know which channels can most effectively reach particular target populations. Identifying the range of available channels should be part of every formative BCC assessment.

- mass media—for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics.
 - in-person, by health workers, peer educators, counsellors, or other trained personnel.
 - musical or dramatic performances and community events.
- 9) **Conduct pre-testing-** It is important to pre-test at every stage with all audiences for whom the communication is intended, both primary and secondary. Pre-testing should be done of themes, messages, prototype materials, training packages, support tools and BCC formative assessment instruments. Pre-testing of media, messages and themes should evaluate:
- Comprehension
 - Attraction
 - Persuasion
 - Acceptability
 - Audience members' degree of identification

- 10) **Implement and monitor-** In the implementation phase, all elements of the strategy go into operation. All partners, programmers and channels of the BCC strategy must be closely coordinated. There must be links among critical programme elements, such as supply and demand. It is also necessary during the implementation phase to review the preceding steps in the BCC process to ascertain whether the programme has been addressing the target audiences' previously identified problems and needs. This can also help identify whether behaviour change and communication goals are being achieved, and whether channels are being used as wisely as possible.
- 11) **Evaluate-** Evaluation refers to the assessment of a project's implementation and its success in achieving predetermined objectives of behaviour change. Various research designs are suitable for evaluating the impact of health communication programmes:
 - a) Randomised control group design
 - b) Non-equivalent control group design
 - c) One-group, before after design
 - d) Interrupted time series design
- 12) **Elicit feedback and modify the programme-** As programmes evolve, target populations acquire new knowledge and behaviours, and communication needs may change. The needs of target populations must be periodically reassessed to understand where they stand along the behaviour change continuum. Monitoring and evaluation studies should lead directly to modifications of the overall programme, as well as of the BCC strategies, messages and approaches.

1.8 SOFT SKILLS

Soft skills are a cluster of productive personality traits that characterise one's relationships in a social milieu with other people. These skills can include social graces, communication abilities, language skills, personal habits, cognitive or emotional empathy, time management, teamwork and leadership traits.

1.8.1 Soft Skill Attributes

Following is a list of soft skills important to effectively communicate with patients-

- 1) **Communication** – Oral, speaking capability, written, presenting, listening.
- 2) **Courtesy** – Manners, etiquette, gracious, says please and thank you, be respectful.
- 3) **Flexibility** – Adaptability, willing to change, lifelong learner, accepts new things, adjusts, teachable.
- 4) **Integrity** – Honesty, ethical, high morals, has personal values.
- 5) **Interpersonal skills** – Nice, polite, sense of humor, friendly, nurturing, empathetic, has self-control, patient, sociability, warmth, social skills.
- 6) **Positive attitude** – Optimistic, enthusiastic, encouraging, happy, confident.
- 7) **Professionalism** – Businesslike, well-dressed, appearance, poised.
- 8) **Responsibility** – Accountable, reliable, gets the job done, resourceful, self-disciplined, conscientious, common sense.

- 9) **Teamwork** – Cooperative, gets along with others, agreeable, supportive, helpful
- 10) **Work ethic** – Hard working, willing to work, loyal, initiative, self-motivated, on time, good attendance.

1.8.2 Problem Solving

Problems are encountered every day in our work place. It can occur when a health worker is solving problems for a patient or their families, supporting those who are solving problems, or discovering new problems to solve. The problems can be large or small, simple or complex, and easy or difficult. A fundamental part of every health worker's role is finding ways to solve problems. Problem is a situation one want to change.

Problem-solving process

There are different stages of problem solving process. Every stage has different objectives and activities. Following are the stages of problem solving process:

Stage One

The objectives of stage one are as follows:

- 1) To analyse the facts
- 2) To define the problem

Define the Problem

While defining a problem, various issues has to be kept in mind like:

- 1) What triggers the problem- It includes the precipitating factors which has contributed to the problem
- 2) State the problem
- 3) Question the constraints of the problem statement
- 4) Identify the essential elements that are needed to take into consideration while solving problem
- 5) Scope of the problem in terms of who all will be affected and what processes will be affected
- 6) Gain insights from others
- 7) Restate problem, if necessary

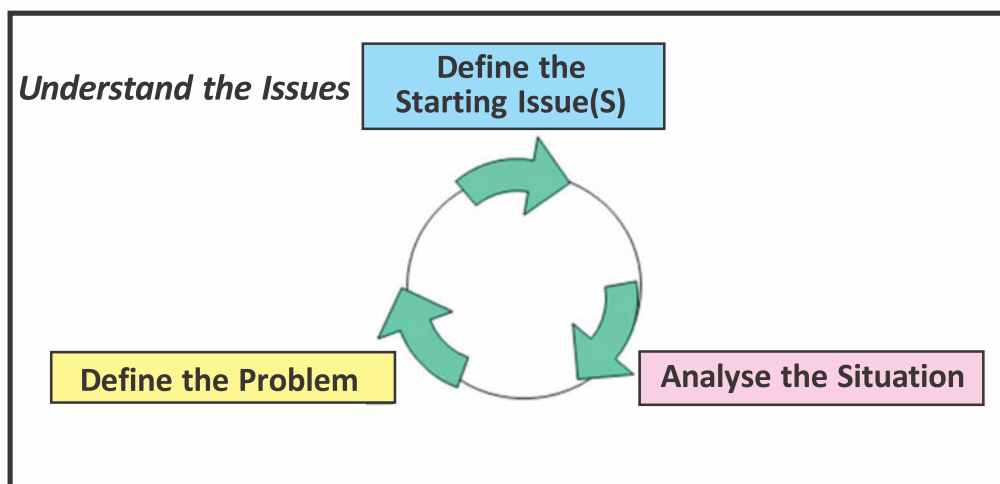


Fig. 1.5: Stage 1 of problem solving process

Stage Two

The objectives of this stage are:

- 1) To generate ideas
- 2) To evaluate ideas
- 3) To decide on the best possible solution

Following are the activities to be done in this stage:

- a) Help determine what information to seek
- b) Explain your choices to others
- c) Determine the importance of time and effort devoted to the problem
- d) List the consequences of each alternative
- e) Assess the future consequences of each alternative
- f) Create a description of the consequences
- g) Eliminate any clearly inferior alternatives
- h) Organise descriptions of remaining alternatives into a table
- i) Try to develop a common scale to measure consequences
- j) Use qualitative and quantitative data
- k) Use experts if necessary
- l) Use scales that reflect appropriate levels of precision

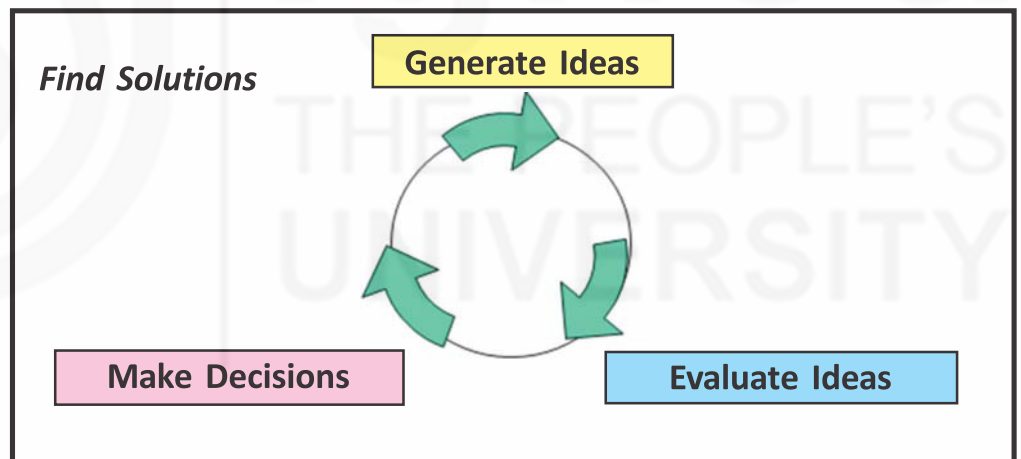


Fig. 1.6: Stage 2 of problem solving process

Stage Three

The objectives of this stage are as follows:

- 1) To determine the impact on people and systems
- 2) To build on action plan
- 3) To decide on follow-through

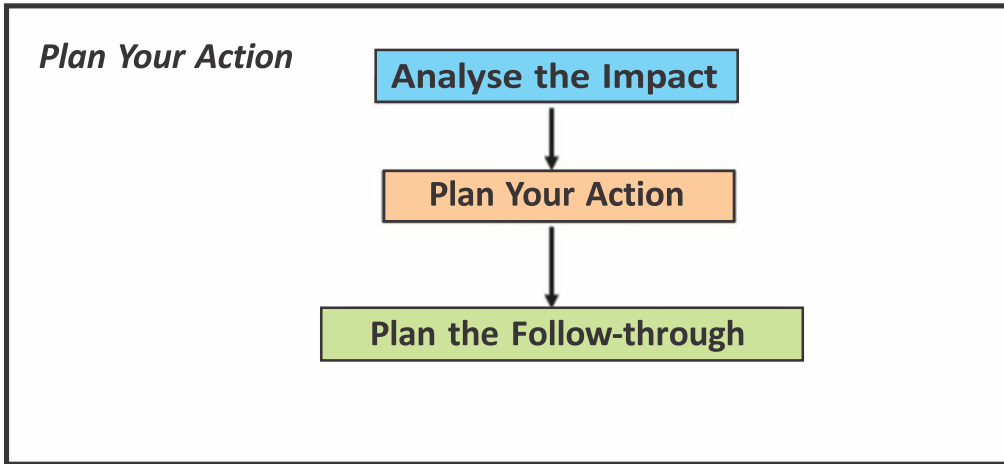


Fig. 1.7: Stage 3 of problem solving process

Steps of problem solving

- 1) State the problem carefully
 - a) Acknowledge complexities
 - b) Avoid assumptions and prejudices
- 2) Specify the objectives
- 3) Create imaginative alternatives
- 4) Understand the consequences of the alternative
- 5) Clarify uncertainties
- 6) Think about risk tolerance and the risks of each alternative
- 7) Consider linked decisions

Check Your Progress 2

- 1) List the steps of behaviour change.

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- 2) Explain the techniques of behaviour change.

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- 3) List characteristics of soft skills.

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1.9 LET US SUM UP

Behaviour is the range of actions and mannerisms made by organisms, systems, or artificial entities in conjunction with their environment, which includes the other systems or organisms around as well as the physical environment. Change in behaviour is emerging as an important strategy of prevention and control of many diseases specially non communicable diseases and addictions. Behaviour change communication (BCC) is an interactive process with an individual or communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours. Communication is necessary to pave way for desired changes in human behaviour and community participation to achieve predetermined goals. The ultimate goal of all communication is to bring change in the desired direction in one who receives it. Techniques of behaviour change are information, education, motivation, reinforcement and social pressure. BCC should be integrated with programme goals from the start. BCC is an essential element of disease prevention, care and support programmes, providing critical linkages to other programme components, including policy initiatives. Soft skills are a cluster of productive personality traits that characterise one's relationships in a social milieu with other people. These skills can include social graces, communication abilities, language skills, personal habits, cognitive or emotional empathy, time management, teamwork and leadership traits.

1.10 KEY WORDS

| | |
|--|--|
| Behaviour | : A behaviour is an observable action of an individual often in reaction to specific circumstances or stimuli. |
| Communication | : Communication is a two way process of exchanging or shaping ideas, feelings, and information. |
| Behaviour Change | : Behaviour change is the modification of an action by an individual in a direction that is intended to be an improvement. |
| Health education | : An process aimed at encouraging people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health, and to seek help when needed. |
| Behaviour change communication | : An interactive process with an individual or communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours. |
| Interpersonal communication (IPC) | : It is a two way communication process and forms an important part of counselling in BCC. |

1.11 MODEL ANSWERS

Check Your Progress 1

- 1) a) Hochbaum, Rosenstock and Kegels
b) positive
- 2) a) False
b) True
c) True

Check Your Progress 2

1) Steps of behaviour change are:

1) **Knowledge**

In this step, one first learns about a new behaviour and recalls messages and understands meaning of the messages.

2) **Approval**

One then approves of the new behaviour and responds favourably to messages. The person discusses the information with personal network (professional, colleagues, family and friends). Later he himself approves of the practices.

3) **Intention**

One then believes this behaviour is beneficial to them and intends to consult the provider. The person recognises that the strategies can meet a personal need. The person intends to adopt these practices in future.

4) **Practice**

The person goes to provider of information/ supplies/ services. One then attempts new behaviour and continues to practice.

5) **Advocacy**

One can then promote the new behaviour through their social or professional networks as a satisfied practitioner. He experiences and acknowledges personal benefits of adopting behaviours and advocates it to others and supports the programme in the community. E.g. A diabetic person develops habit of regular monitoring of blood sugar which helped him in diabetes control for himself, will tell other to do so.

2) Techniques of behaviour change are:

➤ **Information-** Used with the belief that audience lacks information. It is source dominated and one way.

➤ **Education-** It focuses on applying knowledge. Skill building techniques like demonstrations, skill practice, do and learn are useful methods. It build confidence and makes behaviours convenient.

➤ **Motivation-** It is the driving force to achieve something. It is used when information is established. Different appeals are instrumental for motivation e.g. rationale appeal, emotional appeal, threat/fear appeal, joy/fun appeal

➤ **Reinforcement-** It is used to sustain behaviour change for repetitive types of behaviours. Need to be used with variations. Community based resources/mechanisms should be established to reinforce the message.

➤ **Social Pressure tent**

3) Characteristics of soft skills are:

1) **Communication** – Oral, speaking capability, written, presenting, listening.

2) **Courtesy** – Manners, etiquette, gracious, says please and thank you, be respectful.

3) **Flexibility** – Adaptability, willing to change, lifelong learner, accepts new things, adjusts, teachable.

- 4) **Integrity** – Honesty, ethical, high morals, has personal values
- 5) **Interpersonal skills** – Nice, polite, sense of humor, friendly, nurturing, empathetic, has self-control, patient, sociability, warmth, social skills.
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- 9) **Teamwork** – Cooperative, gets along with others, agreeable, supportive, helpful
- 10) **Work ethic** – Hard working, willing to work, loyal, initiative, self-motivated, on time, good attendance.

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