UNIT 2 MODELS OF BEHAVIOUR CHANGE

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Contents

2.0 OBJECTIVES

This Unit discusses the importance of understanding the dimensions of behaviour change in the context of HIV prevention. Various theories have been put forth to understand the context of AIDS. Concepts that are significant in the context of behaviour change, such as perceived susceptibility to harm, self-efficacy and also AIDS decision making are presented. It is well understood that being informed alone is not enough for people to initiate change in their risk-related behaviours. There are many other factors interplay to modify human behaviour. This unit will dwell into some of the most significant theories.

2.1 INTRODUCTION

As it is well known, a number of health problems have linkages with human behaviour. Many are easily linked to illness and disease. For example, consumption of tobacco is linked to many serious problems such as cancer. The behaviour – health link becomes clearer when examining the ten leading risk factors identified by the WHO for preventable death and disease the world over: maternal and child underweight; unsafe sex; high blood pressure; tobacco; alcohol; unsafe water; poor sanitation and hygiene; high cholesterol; indoor smoke from solid fuels; iron deficiency; high body mass index; or overweight. According to WHO, 40 percent deaths are due to these ten risk factors. It is well said that global life expectancy would go up by atleast 5 to 10 years if health promoting decisions would be taken by individuals, families, communities, and governments.

Risk factors translate into disease, disability and death. These then get classified into what is referred to as the 'burden of disease'. One can well understand that addressing risky behaviours rather than specific diseases is more cost effective. One risky behaviour can result in a host of diseases. Under-nutrition is itself a cause of as many as 60 percent of child deaths. In the same way unsafe sex can lead to a multitude of problems such as cervical cancer, unwanted pregnancies, sexually transmitted diseases and HIV. So we can well understand that behaviour has a significant role to play, both in the causation and management of illness.

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The prime question that emerges is that can behaviour be influenced sufficiently to bring about this change and achieve health related goals? Behavioural science suggests that we can and offers evidence based theories of behaviour change.

2.2 UNDERSTANDING AND INFLUENCING HUMAN BEHAVIOUR

Human behaviour is multi-dimensional and complex. Though some generalizations can be made, individuals are unique in their perception of situations and more so in their response. Further individuals vary within groups and each group varies from others. However, considerable amount of research has been undertaken to understand and shed some light on the behaviour of individuals. The theories that have thus been propounded help in having a better insight into human behaviour and hence develop interventions that would guide behaviour in a positive direction.

Why is theory important? Theory is important because it goes beyond trying to explain actions or inactions of specific individuals to provide a unified basis for understanding, predicting to the extent possible, and influencing human behaviour in general. Earlier thinking on behaviour change primarily gave importance to sending messages using appropriate media. The messages were targeted to certain population groups considered vulnerable. For example, sending messages such as 'Use condoms, practice safe sex always' were common for AIDS awareness and safe sex. By and large this communication was unidirectional. Over the years the approach has changed. There is formative audience research on the relevant audience. Planning involves designing the intervention strategy, skill building, multi-chanelled education and advocacy using influential persons, community mobilization. It is now well understood that behaviour does not occur in isolation. The context has to be well understood for effectiveness of the intervention for HIV prevention. To illustrate this, if a young man has been motivated by media outreach programmes and perceives his behaviour as risky and determines to use condoms, he may not be able to put his determination into action. There are many things that may come in his way such as, peer influence, non-availability of condoms at affordable price or even non-availability of condoms at local health clinics. To conclude, behaviour change needs to place in a wider context, where organizations and systems have to play a supportive role.

HIV/AIDS has been extensively studied in the last three decades. Basic research, clinical research, epidemiological research across various countries of the world has contributed towards a better understanding of the virus. A large number of studies have been undertaken on AIDS awareness and prevention looking into the role of mass media and modalities of behaviour change among different population groups.

2.3 MODELS OF BEHAVIOUR CHANGE

In these models of behaviour change the individual is the most basic unit of behaviour change. Individuals can be reached out at any level – groups, organizations, communities and nations. Health professionals spend a large amount of their time in face to face interactions such as in giving instructions and in clients. In most cases of interventions for behaviour change, as also in the case of HIV/AIDS prevention, these efforts have been largely supported with generation of reading and visual materials such as pamphlets, booklets, videos and posters. These apart, mass media reaches out to the masses with the use of print and electronic media. These efforts are now supported by theories that highlight the need to have multi-dimensional

HIV/AIDS prevention and all this based on certain basic research and also on established theories.

In the past three decades AIDS has thrown up several challenges to professionals from diverse disciplines. A major concern for the professionals has been to provide treatment, care and support to the AIDS afflicted and to those who are close to them. The already prevalent health care systems have been burdened and strained. In doing so, the paucity of funds and of trained human resources has always been a major concern. Not only this, the factors that lead to the spread of HIV have entirely different dimensions; risky health related behaviours to name one. Human behaviour is contextual and unpredictable. Social and behavioural sciences have an urgent task to develop effective methods of conveying information that will effect attitudes and belief systems that influence risk behaviours. Towards this considerable research has been conducted. It focuses mainly upon self directed behaviour change that is a function of perception of risk, psychological assessment of costs and benefits, efficacy of change, etc. All these theories are useful when interventions are planned and designed, In light of the fact that in the case of HIV/AIDS, prevention is the best course of action, these theories must guide our interventions.

In AIDS prevention, we are primarily concerned with behaviours and not with populations. It is true that some segments of the population are more prone to be engaged in risk behaviours than others, but it is behaviour that puts a person at risk, and not their affiliation with any group. For this reason, prevention and care would depend upon their ability to influence specific behaviours.

Theory of Reasoned Action

This theory was propounded by Ajzen and Fishbein in the year 1980. The assumption of this theory is that humans are reasonable persons who, in deciding what action to take, systematically process and use whatever information they have. In this theory it has been stated that although substantive specifics are expected to differ from one behaviour to another, and from one population to another, the theory argues that most behaviours can be understood in terms of the same small set of theoretical constructs and psychological processes. The theory links behaviour to intentions, intentions to a combination of norms and attitudes, and attitudes and norms to behavioral and normative beliefs.

Research using the Theory of Reasoned Action (TRA) has explained and predicted a variety of human behaviors since 1967. Based on the premise that humans are rational and that the behaviors being explored are under volitional control, the theory provides a construct that links individual beliefs, attitudes, intentions, and behavior (Fishbein, Middlestadt and Hitchcock, 1994). The theory variables and their definitions, as described by Fishbein et al. (1994), are:

l. **Behaviour:** A specific behaviour is defined by a combination of four components: action, target, context, and time, e.g., implementing a sexual HIV risk reduction strategy (action) by using condoms with commercial sex workers (target) in brothels (context) every time (time).

2. **Intention:** The intent to perform a behavior is the best predictor that a desired behavior will actually occur. In order to measure it accurately and effectively, intent should be defined using the same components used to define behavior: action, target, context, and time. Both attitude and norms, described below, influence one's intention to perform a behavior.

3. **Attitude:** A person's positive or negative feelings toward performing the defined behavior.

When any behaviour is studied, its performance or non-performance depends upon the individual's intention to perform that behaviour. To change behaviour one must change the intentions of the person to perform and sustain that behaviour, and this change in intention has to be in the context of target, action, context and the time. In order to change the behaviour, attitudes and normative beliefs cannot be ignored.

Behavioural Beliefs: Behavioural beliefs are a combination of a person's beliefs regarding the outcomes of a defined behavior and the person's evaluation of potential outcomes. These beliefs will differ from population to population. For instance, married heterosexuals may consider introducing condoms into their relationship an admission of infidelity, while for homosexual males in high prevalence areas it may be viewed as a sign of trust and caring.

Norms: A person's perception of other people's opinions regarding the defined behavior.

Normative Beliefs: Normative beliefs are a combination of a person's beliefs regarding other people's views of a behaviour and the person's willingness to conform to those views. As with behavioural beliefs, normative beliefs regarding other people's opinions and the evaluation of those opinions will vary from population to population. The TRA provides a framework for linking each of the above variables together. Essentially, the behavioural and normative beliefs — referred to as cognitive structures — influence individual attitudes and subjective norms, respectively. In turn, attitudes and norms shape a person's intention to perform a behaviour. Finally, as the authors of the TRA argue, a person's intention remains the best indicator that the desired behavior will occur. Overall, the TRA model supports a linear process in which changes in an individual's behavioural and normative beliefs will ultimately affect the individual's actual behaviour. The attitude and norm variables, and their underlying cognitive structures, often exert different degrees of influence over a person's intention. For example, results from a study of northern Thai males revealed that men's perceptions of peer norms were the best predictor of condom use (VanLandingham, Suprasert, Grandjean and Sittitrai, 1995). To date, behaviours explored using the TRA include smoking, drinking, signing up for treatment programs, using contraceptives, dieting, wearing seatbelts or safety helmets, exercising regularly, voting, and breastfeeding.

Limitations: Some limitations of the TRA include the inability of the theory, due to its individualistic approach, to consider the role of environmental and structural issues and the linearity of the theory components (Kippax and Crawford, 1993). Individuals may first change their behavior and then their beliefs/attitudes about it. For example, studies on the impact of seatbelt laws in the United States revealed that people often changed their negative attitudes about the use of seatbelts as they grew accustomed to the new behaviour.

Stages of Change Theory

Mounting evidence suggests that behaviour change occurs in stages or steps and that movement through these stages is neither unitary or linear, but rather, cyclical, involving a pattern of adoption, maintenance, relapse, and readoption over time. The work of Prochaska and DiClemente (1986) and their colleagues have formally identified the dynamics and structure of staged behaviour change. In attempting to explain these patterns of behaviour, Prochaska and DiClemente developed a

transtheoretical model of behavioural change, which proposes that behaviour change occurs in five distinct stages through which people move in a cyclical or spiral pattern.

The first of these stages is termed **precontemplation**. In this stage, there is no intent on the part of the individual to change his or her behaviour in the foreseeable future. The second stage is called **contemplation**, where people are aware that a problem exists and are seriously considering taking some action to address the problem. However, at this stage, they have not made a commitment to undertake action. The third stage is described as **preparation**, and involves both intention to change and some behaviour change, usually minor, and often meeting with limited success. **Action** is the fourth stage where individuals actually modify their behaviour, experiences, or environment in order to overcome their problems or to meet their goals. The fifth and final stage, **maintenance**, is where people work to prevent relapse and make efforts so as to sustain these changes. The stabilization of behaviour change and the avoidance of relapse are characteristic of the maintenance stage. Prochaska and DiClemente further suggest that behavioural change occurs in a cyclical process that involves both progress and periodic relapse. That is, even with successful behaviour change, people likely will move back and forth between the five stages for some time, experiencing one or more periods of relapse to earlier stages, before moving once again through the stages of contemplation, preparation, action and eventually, maintenance. In successful behavioural change, while relapses to earlier stages inevitably occur, individuals never remain within the earlier stage to which they have regressed, but rather, spiral upwards, until eventually they reach a state where most of their time is spent in the maintenance stage. Further work undertaken and reported by Prochaska et el (1992) suggests that behaviour change can only take place in the context of an enabling or supportive environment. Prochaska's and DiClemente's model has received considerable support in the research literature.

An important aspect of both Prochaska's and DiClemente's approach is that each of the five stages of behaviour change is said to involve different cognitive processes and require different treatments or intervention strategies for the overall change process to be successful. Other researchers also propose that different stages in the change process require different intervention strategies, and generally recommend a multifaceted, community-based approach to intervention in which all stages are addressed so that individuals at all stages of "readiness for change" can potentially be influenced.

Social Cognitive-Behavioural Theories

Social Cognitive Theory explains human behaviour in terms of a triadic, dynamic and reciprocal model in which behaviour, personal factors, and environmental influences interact. It addresses both the psychological dynamics underlying behaviour and their methods for promoting behaviour change. It is a very complex theory and includes many key constructs. Self-efficacy is one of the key concepts.

Self-efficacy refers to one's confidence in the ability to take action and persist in action. It is seen by Bandura (1986) as perhaps the single most important factor in promoting changes in behaviour. Measures of self-efficacy and some of the other key concepts from Social Cognitive Theory have also been identified as key determinants of movement through the stages of change, (Oldenburg, 1999). Self-efficacy expectations have been found repeatedly to be important determinants of:

a. the choice of activities in which people engage

b. how much energy they will expend on such activities and

c. the degree of persistence they demonstrate in the face of failure and/or adversity.

In general, higher levels of self-efficacy for a given activity are associated with higher participation in that activity.

Learning and Behaviour Theories

Learning theorists have demonstrated that behaviour can be changed by providing appropriate rewards, incentives, and/or disincentives. In learning or behaviourist approaches, such rewards and incentives are typically incorporated into structured reinforcement schedules, and the process of behaviour changes is often termed behaviour modification.

While effective in bringing about behaviour change, such approaches require a high level of external control over both the physical and social environment, and the incentives (or disincentives) used to reinforce certain behaviours and discourage others. This kind of control is hard to maintain in real life settings, and thus, strict behaviourist approaches are subject to a number of limitations.

Social Learning Theory

Social learning theory is similar to learning and behaviour theories in that it focuses on specific, measurable aspects of behaviour. Learning theories, however, view behaviour as being shaped primarily by events within the environment, whereas social learning theory views the individual as an active participant in his or her behaviour, interpreting events and selecting courses of action based on past experience. The theory analyses psychosocial influences arising from the interaction of individual factors, the social environment, and experience. While the physical and social environment shapes behaviour, people are not passive in the process, since they in turn can act to change their environments.

According to Murphy (2005) the theory emphasizes behavioural capability: A person needs to know what to do and how to do it. There may be a need for training. She further states that self – efficacy is very important, that is a person's belief and confidence in one's ability to make the desired change. It is very important to bring about health related changes and recommends three ways of bringing about health related behaviours:

(a) Setting small, incremental goals – when one sets small goals and is able to achieve them, his or her self-efficacy increases. Changes targeted or desired then seem attainable.

(b) Behavioural contracting – agreeing to a formal process that specifies goals and rewards. It implies that individuals will receive feedback, guidance and praised for the progress made by them.

(c) Self-monitoring – feedback from self-monitoring or record keeping, such as keeping a journal, can reinforce determination to change and increase confidence in one's ability to achieve the desired action.

One important theory deriving from Social Learning Theory which has had a major impact on many current models of behaviour change is that of self-efficacy. As stated earlier, self-efficacy has to do with a person's beliefs in his or her abilities to successfully execute the actions necessary to meet specific situational demands. Such expectations have been found to be consistently related to behaviour for change or modification across a wide range of situations and population sub-groups.

Social Psychological Theories

Social Psychological theories are concerned with understanding how events and experiences external to a person (i.e. aspects of the social situation and physical environment) influence his or her behaviour. Emphasis is placed on aspects of the social context in which behaviour occurs, including social norms and expectations, cultural mores, social stereotypes, group dynamics, cohesion, attitudes and beliefs. A number of useful concepts have emerged from social psychological theories, including *attribution*, *locus of control*, and *cognitive dissonance*, to name a few.

Social Cognitive Approaches

Social cognitive approaches combine aspects of social psychological theories with components of both social learning theory and cognitive behavioural approaches. Social-cognitive approaches emphasize the person's subjective perceptions and interpretations of a given situation or set of events, and argue that these need to be taken into account if we are to understand adequately both behaviour and the processes of behaviour change.

A number of social psychological concepts have been found to be consistently related to behaviour change across a wide range of situations. For example, the social reality of the group (e.g. peer group, school group, family group etc.) will affect an individual's behaviour. All groups are characterized by certain group norms, beliefs and ways of behaving, and these can strongly affect the behaviour of the group members.

Expectations of significant or respected others can also have a strong influence on a person's behaviour. This phenomenon has been most consistently demonstrated in the early research on self-fulfilling prophecies, which showed that teachers' expectations of their students were consistently related to the students' subsequent performance, even when these expectations were based on falsified information. Thus, support and encouragement, or conversely, low expectations from significant or respected others, can affect and bring about (or not), changes in individual behaviour.

Health Belief Model

The Health Belief Model attempts to explain health-behaviour in terms of individual decision-making, and proposes that the likelihood of a person adopting a given health related behaviour is a function of that individual's perception of a threat to their personal health, and their belief that the recommended behaviour will reduce this threat. The model has been extensively used in studies of compliance in the context of health. In this model it is theorized that people are afraid of getting seriously ill and the health related behaviours (or health seeking behaviour) reflect the level of threat perceived and a person's expected fear reduction potential of taking action. Individuals calculate the net benefits of changing their behaviour. According to Kirscht and Joseph (1989) there are four components in this model: personal susceptibility to a negative heath condition; the perceived severity of the condition; the value of a behaviour; and barriers to action. The summation of all these create a situation where the individual's readiness to act comes forth. With circumstances being conducive, action is enacted and behaviour change may take place. Rosenstock (1974) suggested that a cue was necessary for action to occur. Some others added self-efficacy as an important element for change to occur.

Thus, a person would be more likely to adopt a given behaviour (e.g. walk or cycle regularly) if non-adoption of that behaviour (e.g. unclean air or confused traffic situations) is perceived as a health threat and adoption is seen as reducing that threat. To date, the Health Belief Model has not received consistent or strong support in explaining behaviour change. When the concept of self-efficacy is added to the model, however, prediction of behaviour increases.

AIDS Risk Reduction Model (ARRM)

The Aids Risk Reduction Model has been developed by Catania, Kegeles and Coates (1989). It is a conceptual framework for organizing the factors that may influence the people's abilities to change high risk sexual behaviours. It has built upon the earlier models such as the health belief model, self-efficacy theory, help-seeking behaviour. ARRM organizes the predictors of health behaviour in general and sexual behaviour in particular. As is well known behaviour change is not unidirectional. People may move back to their earlier behaviours. The process of behaviour change is broken into several stages: (a) recognizing and labeling one's behaviour as high risk for contracting HIV, (b) making a commitment to reduce high-risk sexual contacts and increase low risk activities, and (c) seeking and enacting strategies to obtain these goals. ARRM suggests that to avoid HIV infection people exhibiting high–risk activities must first perceive their sexual behaviours as those that place them at risk for HIV infection. They should be willing to make a strong commitment for changing their activities; this may require that they decide if the behaviours can be altered or whether the benefits of change outweigh the costs. Also, they should be willing to seek help by obtaining solutions. Help can be from informal social support or from professionals. Finally, enactment of solutions would require complex negotiations with sexual partners. These three processes are also termed as labelling, commitment and enactment. They are neither unidirectional nor irreversible. Further each state is influenced by a number of extraneous factors such as salience, perception of sexual enjoyment, condom attitudes, negotiation with spouse, peer influence, etc.

Check Your Progress I

Note: Use the space provided for your answer.

1) What is the importance of the theories of behaviour change in the context of HIV Prevention?

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2.4 PERCEIVED SELF-EFFICACY

It goes without saying that prevention from the AIDS virus requires people to take control over their own motivation and behaviour. All social efforts are by and large directed towards spreading awareness on HIV and its modes of transmission. People are educated and the assumption is that once they are aware they will take appropriate self-protective action. Heightened awareness and knowledge of health risks are important pre-conditions for self-directed change. However, information alone does not determine action.

According to Bandura (1989) people need to be given reasons to alter risky habits but also the means and resources to do so. Success requires the skills necessary and also strong belief in one's ability to exercise control. Perceived self-efficacy therefore is the belief held by people that they can have a control over their motivation and behaviour and also their social environment. Self – efficacy determines how much effort people will put in and how long will they withstand all adverse pressures in order to continue and sustain the changes made by them. A number of research studies have been conducted on the influence of self- efficacy on behaviour change. They go to show that every aspect of behaviour change – whether people consider changing their health habits, how hard they try, how much they change, and how well they maintain the changes they have attained. If they perceive themselves as not competent to undertake such changes, it often leads to a feeling of dejection and consequent stress and depression.

It then emerges that information alone is not enough. Some elements determine the translation of knowledge into effective action for harm reduction. These are social skills and a sense of personal power to exercise control over risk situations and these are incremental in nature. Each positive change builds on the perception of self efficacy. Further problems emerge when self protective behaviour comes into conflict with interpersonal relationships. The weaker is the self-efficacy, the more the chance of the person succumbing to outside pressure.

2.5 PERCEPTION OF PERSONAL SUSCEPTIBILITY TO HARM

As researchers have studied human behaviour and the response of people, they have often reported of situations where with precautions certain ailments could have been avoided. Yet people refrain from doing so. According to Weinstein (1989) if the benefits of the preventive measure are uncertain and the burden of change substantial, it is not surprising that few people would respond. This failure to acknowledge personal vulnerability has long been considered to be a barrier to the adoption of prevention measures. A substantial amount of evidence has been put forth to show that people tend to be unrealistically optimistic about their susceptibility to harm. They may not claim they are invulnerable but they do claim that their chances of suffering negative events are smaller than the chances of their peers.

To further explain risk reduction behaviour, Weinstein has explained that there are many motivations governing risk relevant behaviours. For example, use of condoms is an important way of reducing risk of HIV. But use of condoms, is also equated with reduction in sexual pleasure, and demonstrates lack of trust in the sex partner. Similarly, cigarette smoking is well known to result in harm to the body. However, the motivation to continue smoking is related to peer pressure and coping with a stressful situation.

Apart from these motivations, there are some determinants of threat perception. People usually learn about threatful situations from their acquaintances or from mass media. Risk is not an individual judgement but also a social and cultural construct. Many times people have objected to an AIDS care home being set up in their vicinity without actually being aware of the threat to their own health. It is just something they have learnt without actually knowing about it. Salience is another component that may raise the perception of threat. Salient refers to 'vivid images and frequent reminders'. Persons who have seen the suffering of an AIDS afflicted person and his family's struggle to cope may adopt all risk reduction behaviors in order to minimize his risk. It needs to be pointed out that salience influences many social processes so it may not impact hazard response in many cases. Most decisions about hazard response are influenced by the way in which problems are presented.

Perceptions of Personal Vulnerability: Until and unless people believe that they are at risk they will not take precautions. There is a wide variation between objective and subjective risk. When people see data on road accidents, not many of them feel that it would have any meaning for them. The problem is similar in the case of AIDS. 'It cannot happen to me' is the response that most people have when they come across messages in the context of HIV/AIDS. The error on personal susceptibility usually is directional. Mostly people have an optimistic bias; they think that their own vulnerability to harm is less than that of their peers. Why do people show this optimistic bias?

Some researchers report that this bias is because of an attempt by the individual to completely deny that this problem could be related to him. This defense mechanism helps him to avoid the anxiety he would feel upon admitting his vulnerability. A second reason that is given for this optimistic bias, is denying ones risk to enhance or preserve their self esteem. Self esteem is most at risk if the hazards in question are such as are preventable by one's own actions.

2.6 DECISION MAKING ON AIDS

What are decisions? Decisions are a set of choices among alternative courses of action (including inaction). In the context of HIV/AIDS a number of decisions have to be taken which are in no way easy.

1) One of the foremost decisions is related to whether to be tested or not. This outcome of this test would impact the physical and mental health and also the social and economic aspects. A person may respond to a positive result by beginning to take good care of his or her health, or may go into a state of complete self neglect, thinking that whatever he may do, in the end he cannot escape from AIDS. The mental health of the individual depends a lot on the ability of the individual to deal with the result. A person who has received counselling and is in a state where he can cope with the result is on one extreme. The other side is of a person who is unable to handle this situation and denies to be tested. The result would no doubt have an impact on the social relations. Whether the person is ready to share the result with the sex partner and close ones, the person is in a state to cope with the consequences, such as of stigma and discrimination. The economic impact are obviously on the increased health expenditure, the risk of loosing ones job and housing.

2) Another area of decision making in the context of AIDS is reading and developing an understanding of the pandemic. How keen is the person to learn about AIDS and have clarity? Is the information given in that reading material, a brochure may be,

organized or scattered? A quick look over can help the person resolve whether he would like to proceed or not.

3) An area of decision making that is highly contextual, involves a decision to be taken on whether to ask the partner to use a condom or not. Doubtless, it would affect the social relations and the physical health of both. The trust or lack of it between the partners would influence their mental health.

How can one help in the decision making process?

As social workers we have to be very well aware of the social and psychological dimensions of HIV/AIDS. Every aspect of HIV involves decision making that is critical to the client's life. It is important to know how much information can be shared at what stage and also the preparedness of the client to take decisions on his own. Attention needs to be given to the most pressing concerns. Having decided what to communicate, the next concern is how to communicate? Some methods are available in the literature and others need to be developed. Many clients may need help in organizing their decision making process.

Check Your Progress II

Note: Use the space provided for your answer.

1) What kind of decisions have to be made in the context of HIV/AIDS? How can persons be helped in this process?

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2.7 OTHER CONSIDERATIONS RELEVANT TO BEHAVIOUR CHANGE

Behavioural scientists have collaborated and identified eight key variables that account for most of the variance in any given behaviour. These eight key factors identified are potential determinants for intervention and behavioural change. They include an individual's behavioural intention; environmental constraints; skill or ability; attitude or anticipated outcomes of a given behaviour; norms; self standards; emotional reaction and self-efficacy.

The theorists concluded that, generally speaking, for a given behaviour to occur, at least one of these eight factors must be true:

1. The person should have a strong positive intention (or made a commitment) to perform the behaviour
2. There are no environmental constraints that make it impossible for the behaviour to occur
3. The person has the skills necessary to perform the behaviour

4. The person believes that the advantage (benefits, anticipate positive outcomes) outweight the disadvantages (costs, anticipated negative outcomes) of performing a behaviour
5. The person perceives more social (normative) pressure to perform the behaviour than not to perform
6. The person perceives that performance of behaviour is more consistent with his/her self image than inconsistent, or that its performance does not violate personal standards that activate negative self-sanctions
7. The person's emotional reaction to performing the behaviour is more positive than negative
8. The person perceives that he or she has the capabilities to perform the behaviour under a number of different circumstances. That is, they have the perceived self-efficacy to execute the behaviour in question.

The first three factors are viewed as factors "necessary and sufficient" for generating behaviour. That is for a given behaviour to occur, an individual must (a) have strong intentions to perform the behaviour, (b) have the necessary skills to do so and (c) not be restricted by environmental constraints. The remaining factors are viewed as factors that can actively influence the strength and direction of behavioural intention. That is, these dimensions generate a degree of influence on changes in behaviour. In fact, the theorists argued that an individual will not form strong intentions to perform behaviour unless they perceive the positive outcome of performing the behaviour as greater than the negative or that they have the ability necessary to carry out the behaviour.

2.8 LET US SUM UP

In this Unit, you have learnt about the importance of understanding the dimensions of behaviour change in the context of HIV Prevention. Some of the concepts that are significant in the context of behaviour change, such as perceived susceptibility to harm, self efficiency and AIDS decision making have also been discussed under the unit.

2.9 FURTHER READINGS AND REFRENCES

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