HUMAN BEHAVIOUR AND HEALTH PROMOTION LINKAGE

HUMAN HEALTH BEHAVIOUR

Human Health Behaviour -1

- Human behaviour, especially health behaviour, is complex and not always readily understandable
- Health behaviour, like other behaviour, is motivated by stimuli in an individual's environment
- The response to such stimuli may or may not be directly related to health

Human Health Behaviour -2

- Motivation which leads to health influencing behaviour may also not be related to health per se
- Motivation for health behaviour is dynamic and not static

Types Of Health Behaviour

- **Health-directed behaviour**
  - Observable acts that are undertaken with a specific health outcome in mind
- **Health-related behaviour**
  - Those actions that a person does that may have health implications, but are not undertaken with a specific health objective in mind

Types Of Health-related Behaviour -1

- **Preventive Health Behaviour**
  - action taken when a person wants to avoid being ill or having a problem e.g. a mother takes her child for immunisation

- **Illness Behaviour**
  - action taken when a person recognises signs or symptoms that suggest a pending illness e.g. a mother gives her child cough medicine after hearing her wheeze

TYPES OF HEALTH-RELATED BEHAVIOUR -2

- Sick-role Behaviour
  - action taken once an individual has been diagnosed (either self or medical diagnosis) e.g. a mother decides that her child has malaria and takes him to the clinic for treatment

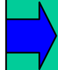
DETERMINANTS OF HEALTH BEHAVIOUR

- Psychological
- Cultural
- Social/Economy
- Environmental

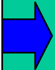
KNOWLEDGE AND BEHAVIOUR

PHASES BETWEEN KNOWLEDGE & BEHAVIOUR

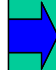
Knowledge of correct health action



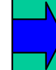
Perception



Interpretation

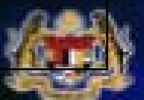


Salience



Putting the knowledge into action

Source: Adapted from Fishbein & Ajzen 1975.)



KNOWLEDGE AND BEHAVIOUR -1

- In some cases, knowledge may be sufficient to elicit changes in behaviour, but in other cases it may be neither necessary nor sufficient
- It should not be assumed that individuals are always knowledgeable about an appropriate health behaviour, but neither should it be assumed that knowledge will guarantee changes in behaviour

KNOWLEDGE AND BEHAVIOUR -2

- Where knowledge is deemed important, this should be expressed in terms that are salient to the target audience
- The transfer of knowledge into action is dependent on a wide range of internal and external factors, including values, attitudes and beliefs

KNOWLEDGE AND BEHAVIOUR -3

- For most individuals, the translation of knowledge into behaviour requires the development of specific skills (enabling factors) which may include interpersonal skills.

ATTITUDES, VALUES AND BEHAVIOUR

ATTITUDES, VALUES AND BEHAVIOUR -1

- An individual's attitude to a specific action and their intention to adopt it is influenced by:
  - beliefs, motivation which comes from the person's values, attitudes and drives (instincts), and
  - the influence from social norms

ATTITUDES, VALUES AND BEHAVIOUR -2

- A belief represents the information a person has about an object or action. It links the object to some attribute.
- Values are acquired through socialization and are those emotionally charged beliefs which make up what a person thinks is important.

ATTITUDES, VALUES AND BEHAVIOUR -3

- Attitudes are value-ladened social judgements which possess a strong evaluative component

- Attitudes have different components - cognitive (belief), emotional (feeling) and behavioural (predispositions to act)

ATTITUDES, VALUES AND BEHAVIOUR -4

- Values and attitudes help to explain the knowledge-action gap in many instances
- Most people are at ease when their knowledge is consistent with their attitude and values
- If discord arises, the facts are often interpreted (or misinterpreted) so that contradiction between knowledge is removed

ATTITUDES, VALUES AND BEHAVIOUR -5

- There is no clear or linear progression from attitudes to behaviour
- Often, attitude change precedes behavioural change
  - Often assumed that changing attitudes to smoking will influence smokers to quit, yet a majority of smokers continue to smoke despite a negative attitude to smoking

ATTITUDES, VALUES AND BEHAVIOUR -6

- But equally, behaviour change may precede and influence attitudes
  - On the other hand, quitting smoking is often a stimulus for indifferent smokers to develop a negative attitude to smoking

MODELS OF BEHAVIOUR CHANGE

1. THE COGNITIVE DISSONANCE MODEL

(Festinger-1957)

COGNITIVE DISSONANCE MODEL -1

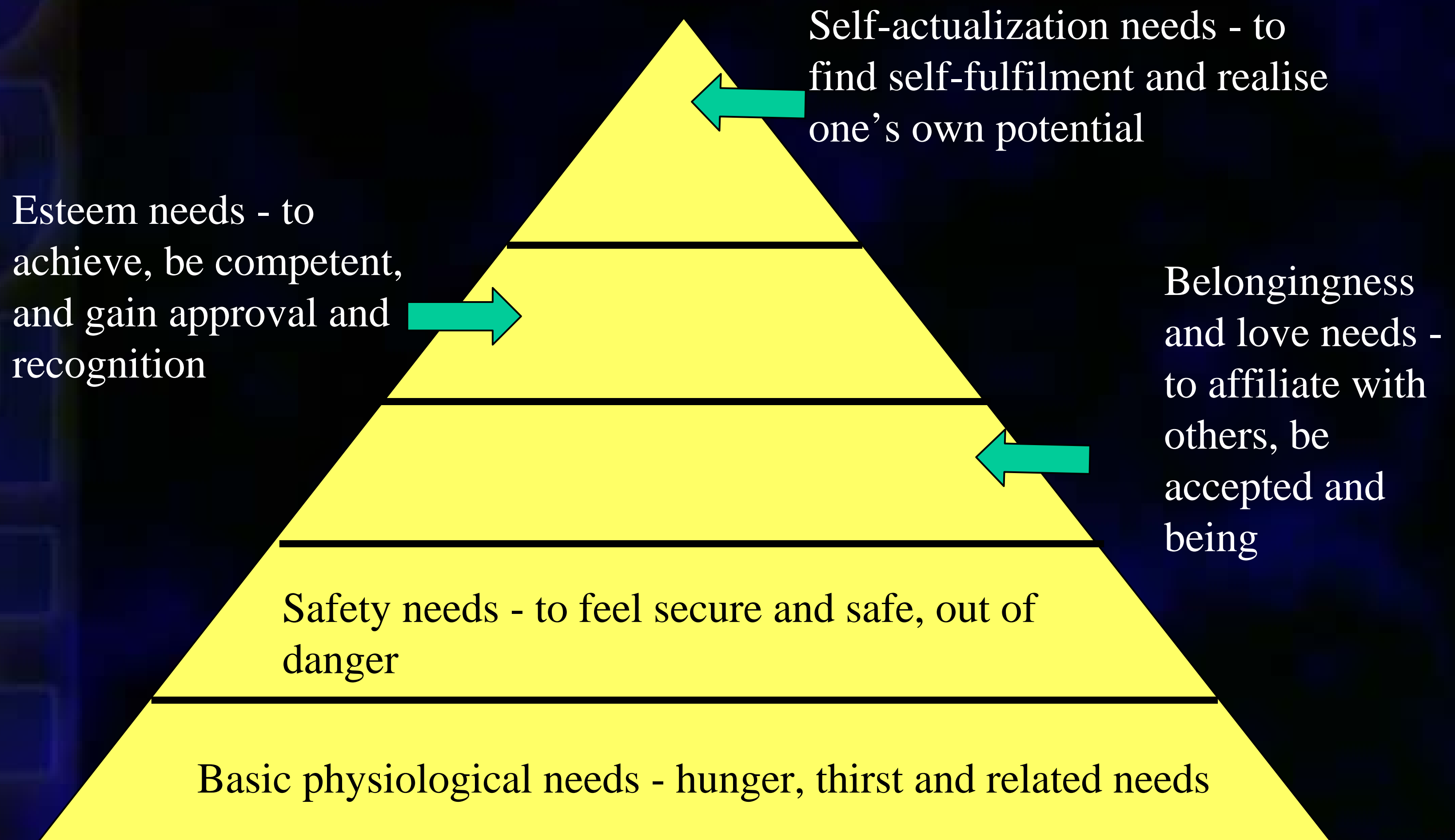
- The model holds that inconsistency is a painful or uncomfortable state
- Since dissonance is psychologically uncomfortable, it will motivate an individual to reduce dissonance to achieve consonance
- In addition, the individual will actively avoid situations and information that are likely to increase the dissonance

COGNITIVE DISSONANCE MODEL -2

- The consequences of this are vital for anyone involved in the process of influence
- For example, if a respected role model with whom an individual identifies makes a statement or declaration with which the individual disagrees, consonance is achieved by either:
  - (a) changing the belief, or
  - (b) changing attitudes to the respected person.

2. MASLOW'S HIERARCHY OF NEEDS (Maslow - 1968)

MASLOW'S HIERARCHY OF NEEDS



MASLOW'S HIERARCHY OF NEEDS

- Behaviour is motivated by a hierarchy of human needs
- Explains why not everybody responds to the obviously beneficial and well-meaning interventions
- Health needs may be compromised for the sake of satisfaction of low-order needs

3. THE HEALTH BELIEF MODEL

(Rosenstock and Becker - 1974)

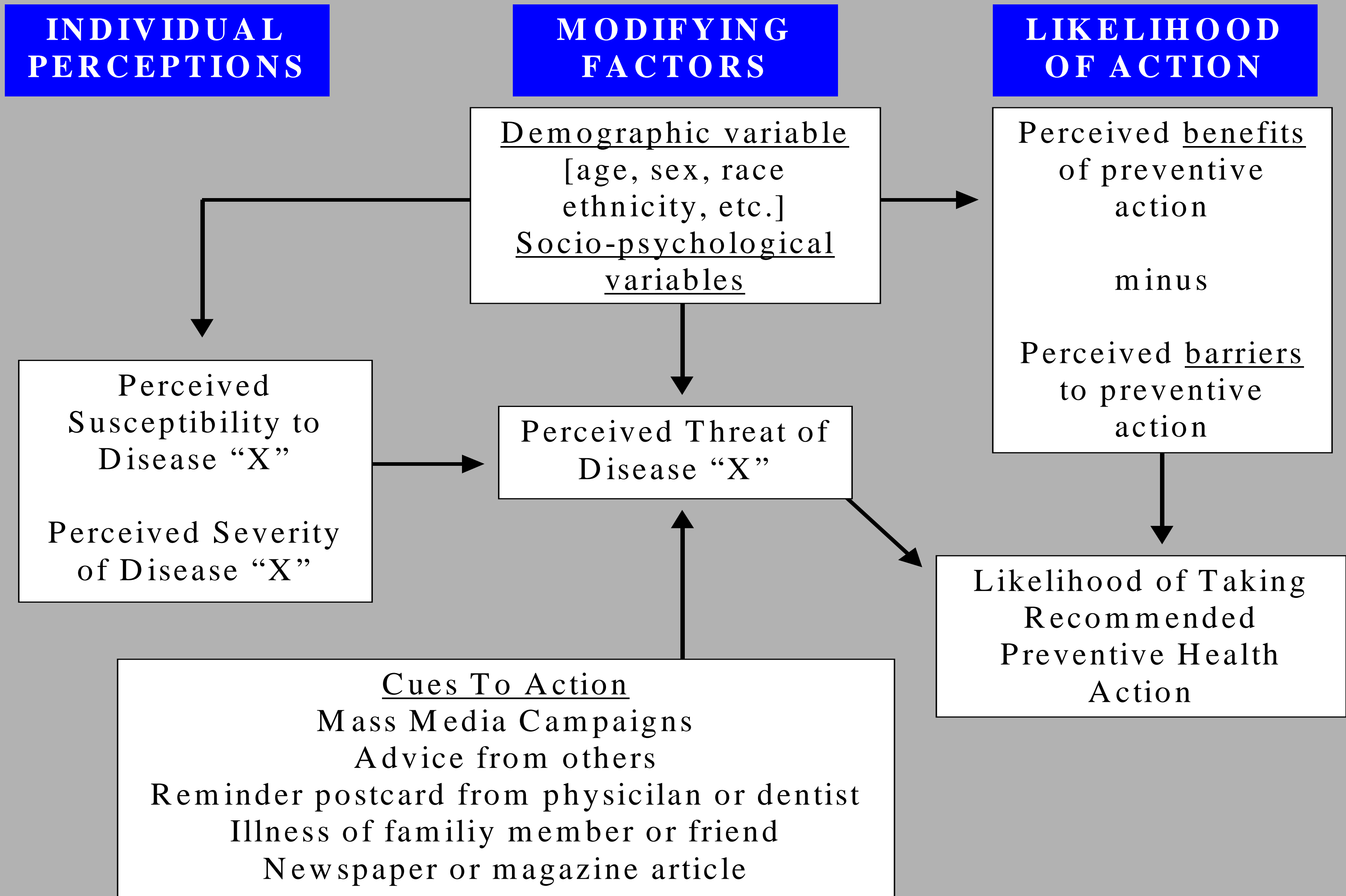
HEALTH BELIEF MODEL

“Two major factors influence the likelihood that a person will adopt a recommended preventive health action

First they must feel personally threatened by disease i.e. they must feel personally susceptible to a disease with serious or severe consequences

Second they must believe that the benefits of taking the preventive action outweigh the perceived barriers to (and/or cost of) preventive action”

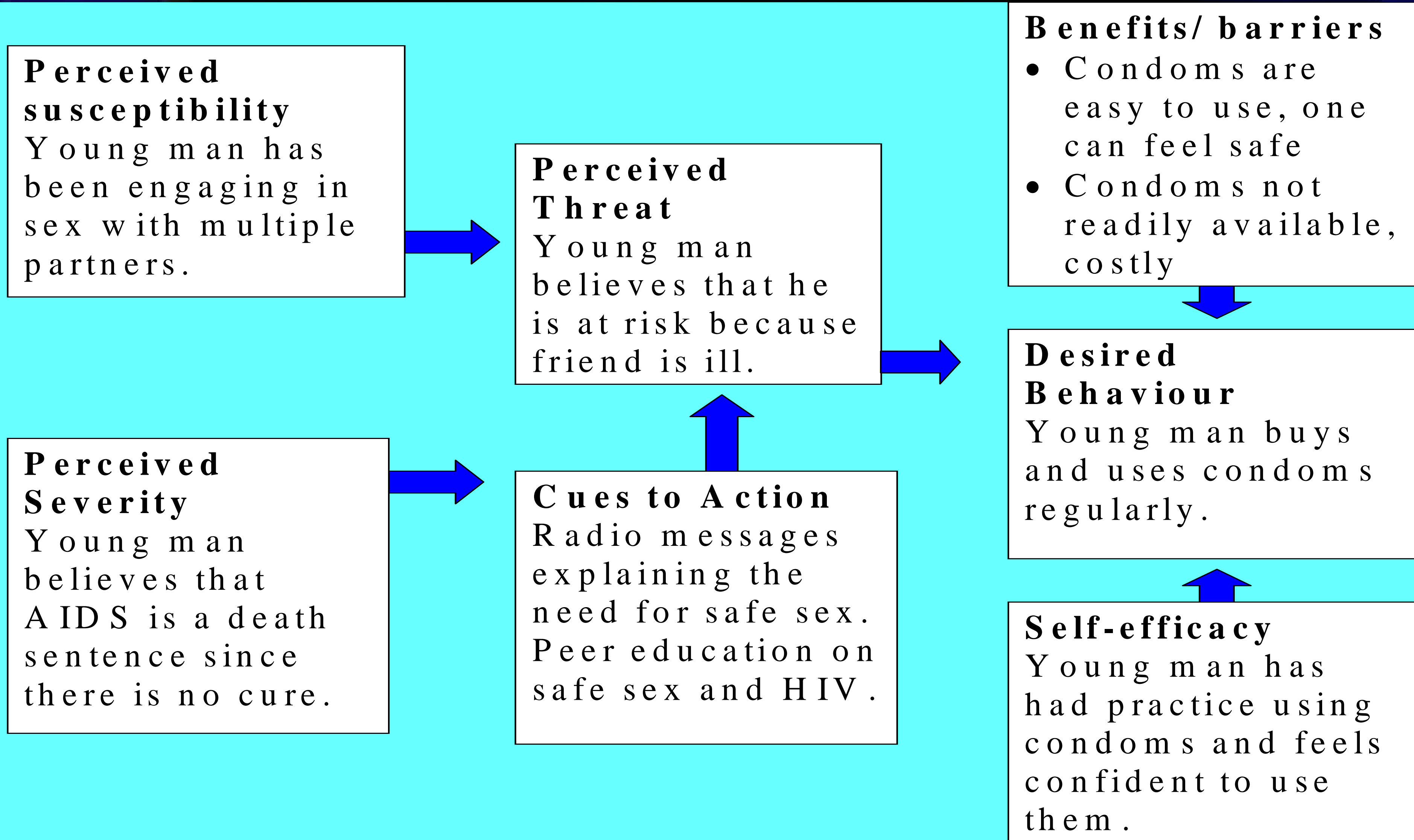
HEALTH BELIEF MODEL (Visual)



HEALTH BELIEF MODEL (Detailed)

Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at 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 sequelae are	Specify consequences of risk and condition
Perceived Benefits	One's opinion of the efficacy of the advised action to reduce risk or seriousness of impact	Define action to talk: how, where, when; clarity 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
Self-Efficacy	Confidence on one's ability to take action	Provide training, guidance in performing action

MODIFIED HEALTH BELIEF MODEL AS APPLIED TO HIV/AIDS PROGRAMME



4. THE SOCIAL LEARNING OR SOCIAL COGNITIVE THEORY

(Bandura - 1977)

SOCIAL LEARNING THEORY -1

- The first theory to introduce the notion of self-efficacy
- Theory is based on the belief that behaviour is determined by expectancies and incentives

SOCIAL LEARNING THEORY -2

- Behaviour is influenced by expectancies about:
  - environmental cues (i.e. beliefs about how events are linked and what leads to what)
  - consequences of one's actions (i.e. how behaviour is likely to influence outcomes)
  - competency to perform the behaviour needed to influence outcomes (i.e. self-efficacy)

SOCIAL LEARING THEORY

Concept	Definition	Application
Reciprocal Determinism	Behaviour changes result from interaction between person and environment; change is bi-directional.	Involve the individual and relevant others; work to change the environment, if warranted.
Behavioural Capability	Knowledge and skills to influence behaviour.	Provide information and training about action.
Expectations	Beliefs about likely results of action.	Incorporate information about likely results of action in advice.
Self-Efficacy	Confidence in ability to take action and persist in action.	Point out strengths; use persuasion and encouragement; approach behaviour change in small steps.
Observational Learning	Beliefs based on observing others like self and/or visible physical results.	Point out others' experience. Physical changes' identity role models to emulate.
Reinforcement	Responses to a person's behaviour that increase or decrease the chances of recurrence.	Provide incentives, rewards, praise; encourage self-reward; decrease possibility of negative responses that deter positive changes.

5. THEORY OF REASONED ACTION

(Fishbein and Atzen - 1975)

THE THEORY OF REASONED ACTION -1

- Proposes that voluntary behaviour is predicted by one's intention to perform the behaviour (e.g. how likely is it that you will take up a quit smoking programme?)

- Intention, in turn, is a function of :
  - attitude towards the impending behaviour (do you feel good or bad about quitting?), and
  - subjective norms (do most people who are important to you think you should quit?)

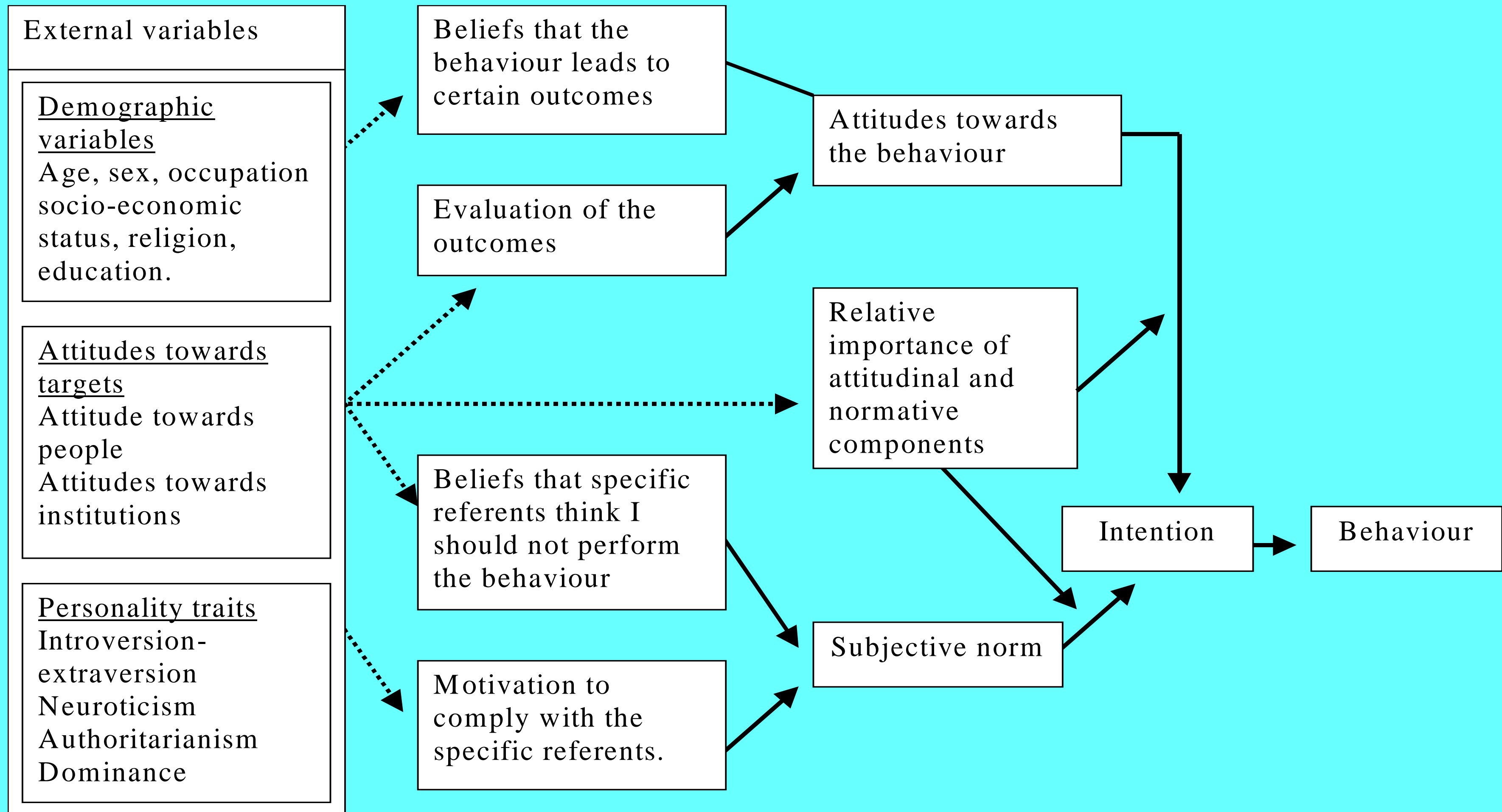
THE THEORY OF REASONED ACTION -2

- Attitude is a function of beliefs about the consequences of the behaviour (how important do you think it is to quit?) weighted by an evaluation of the importance of that outcome (how important is it to you to quit?)
- Subjective norms are a function of expectations of significant others (does your spouse think you should quit?) weighted by the motivation to conform (how important is it to do what your spouse wants?)

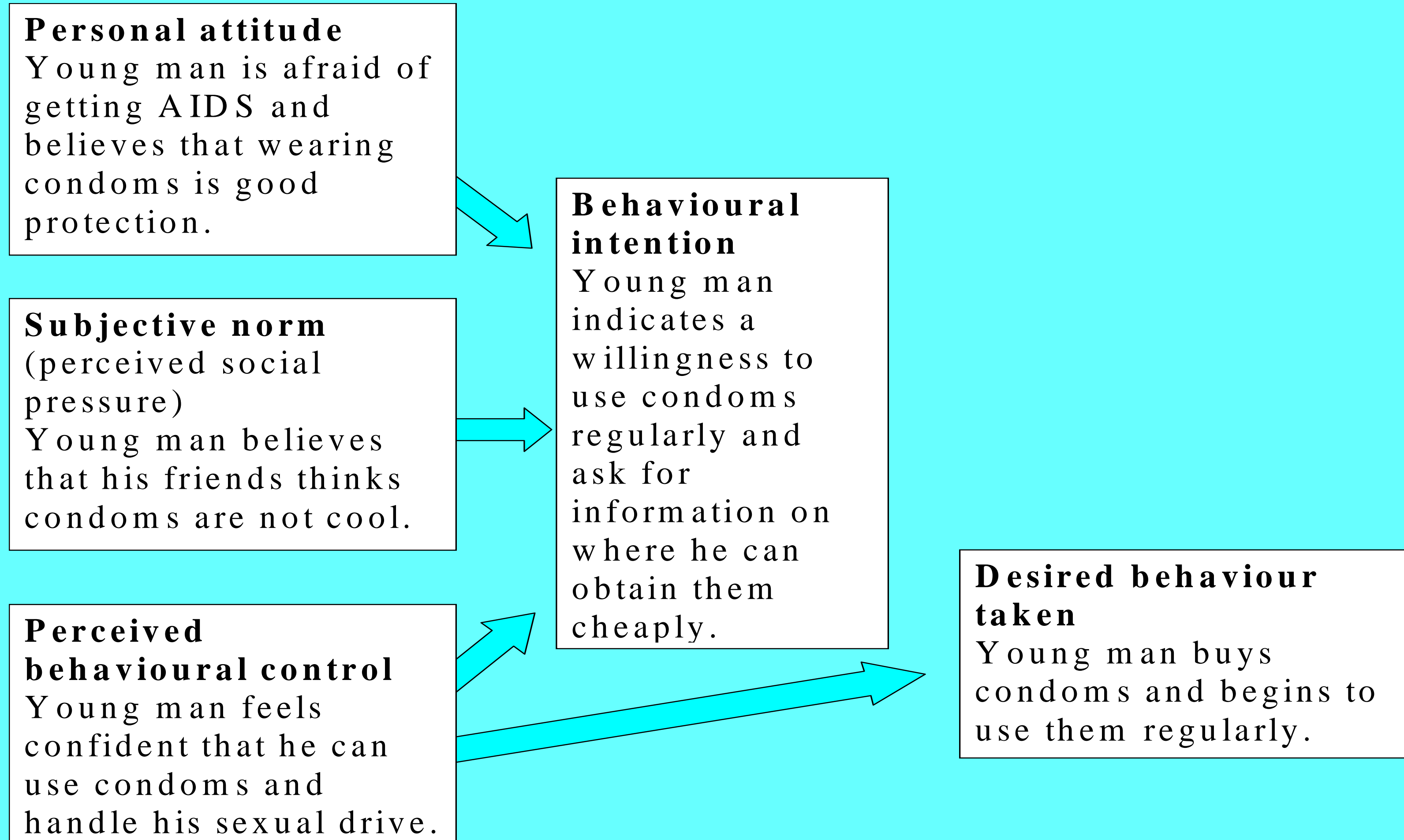
THE THEORY OF REASONED ACTION -3

- Unlike the Health Belief Model and the Social Learning Theory, this model is based on rationality and does not provide explicitly for emotional ‘fear-arousal’ elements such as the perceived susceptibility to illness
- Basically more emphasis is put on intention rather than attitudes.

THEORY OF REASONED ACTION



THEORY OF REASONED ACTION AND PERSONAL BEHAVIOUR APPLIED TO HIV/AIDS PROGRAMME ACTION (Adapted to key focus areas)



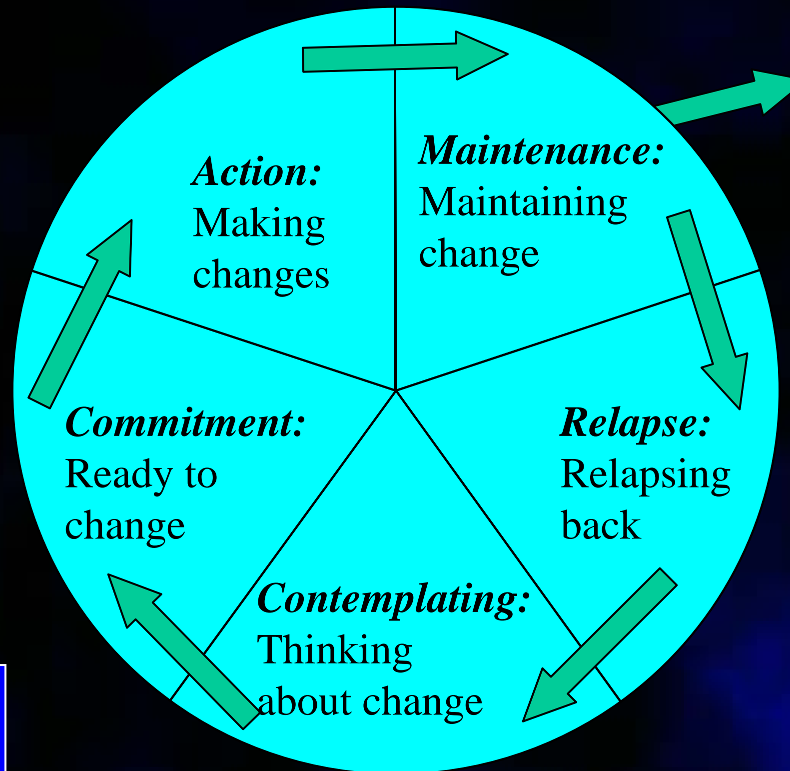
6. STAGES OF CHANGE MODEL

(Prochaska and DiClemente -1984)

STAGES OF CHANGE MODEL

(Prochaska J & DiClemente C, 1984)

Exit:
Maintaining 'safer' lifestyle



Pre-contemplation
Not interested in changing 'risky' lifestyle

STAGES OF CHANGE MODEL -1

- The model identifies a number of stages which a person can go through during the process of behaviour change
- It takes a holistic approach, integrating a range of factors such as the role of personal responsibility and choices, and the impact of social and environmental forces that set very real limits on the individual potential for behaviour change
- It provides a framework for a wide range of potential interventions by health promoters

STAGES OF CHANGE MODEL -2

- **Pre-contemplation stage:** The stage which precedes entry into the change cycle. At this stage the person has not considered changing their lifestyle or become aware of any potential risks in their health behaviour.
- **Contemplation stage:** Although the individual is aware of the benefits of change, they are not yet ready and may be seeking information or help to make the decision. This stage may last a short while or several years.

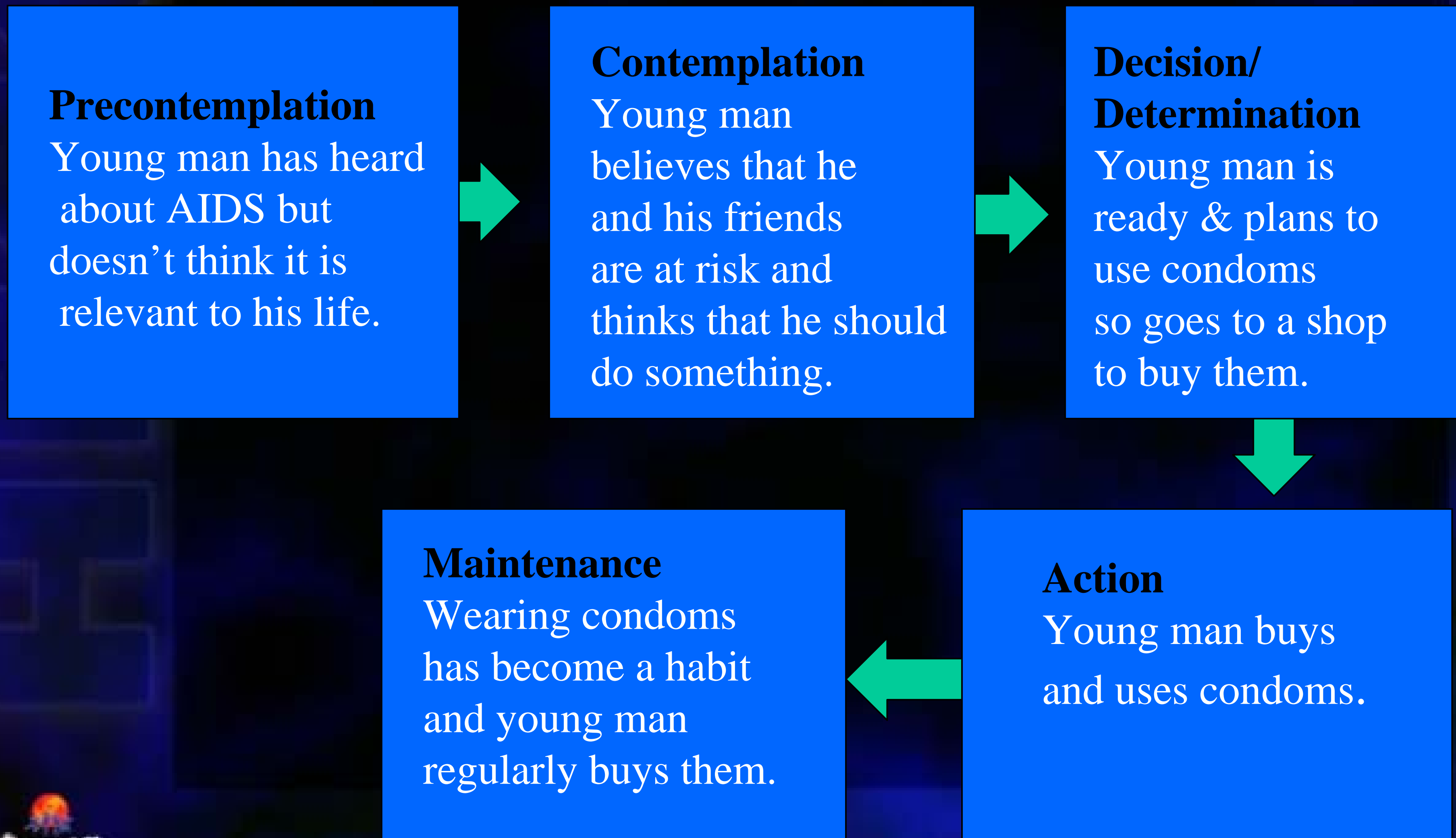
STAGES OF CHANGE MODEL -3

- **Commitment stage:** When the perceived benefits seem to outweigh the costs and when the change seems possible as well as worthwhile, the individual may be ready to change, perhaps seeking some extra support.
- **Action stage:** The early days of change require positive decisions by the individual to do things differently. A clear goal, a realistic plan, support and rewards are features of this stage.

STAGES OF CHANGE MODEL -4

- **Maintenance stage:** The new behaviour is sustained and the person moves into a healthier lifestyle
- **Relapse stage:** Although individuals experience the satisfaction of a changed lifestyle for varying amounts of time, most of them cannot exit from the revolving door first time around. Typically, they relapse back. Of great importance, however, is that they do not stop there, but move back into the contemplation stage.

Stages Of Change Model As Applied To Hiv/Aids Programme



STAGES OF CHANGE MODEL

Concept	Definition	Application
Pre-contemplation	Unaware of the problem hasn't though about change.	Increase awareness of need for change, personalize information on risks and benefits.
Contemplation	Thinking about change, in the near future.	Motivate, encourage to make specific plans.
Commitment	Making a plan to change.	Assist in developing concrete action plans, setting gradual goals.
Action	Implementation of specific action plans.	Assist with feedback, problem solving, social support, reinforcement.
Maintenance	Continuation of desirable actions, or repeating periodic recommended step(s).	Assist in coping, reminders, finding alternatives, avoiding slips/relapses (as applies).

7. THE DIFFUSION OF INNOVATION THEORY

(Rogers - 1962)

DIFFUSION OF INNOVATION PROCESS

Source: Green & MCAlister 1984.

DIFFUSION OF INNOVATION -1

- The adoption of ideas in a community diffuses among individuals in that community at varying rates
- Early in the introduction of a new idea, it is picked up by **'innovators'** (between 2 and 3% of the target population) who are venturesome, independent, risky and daring. They want to be the first to do things and they may not be respected by others in the social system.

DIFFUSION OF INNOVATION -2

- The second group of people, the **'early adopters'** (about 14% of the target population) are very interested in the innovation but they are not the first to sign up. They wait until the innovators are already involved to make sure the innovation is useful. They are respected by others in the social system and looked at as opinion leaders.

DIFFUSION OF INNOVATION -3

- The next group **'early majority'** (about 34% of the target population) may be interested in the innovation but will need external motivation to become involved, They will deliberate for some time before making a decision.
- The **'late majority'** (also about 34% of the target population) are next and it will take more time to get them involved for they are skeptical and will not adopt an innovation until most people in the social system have done so.

DIFFUSION OF INNOVATION -4

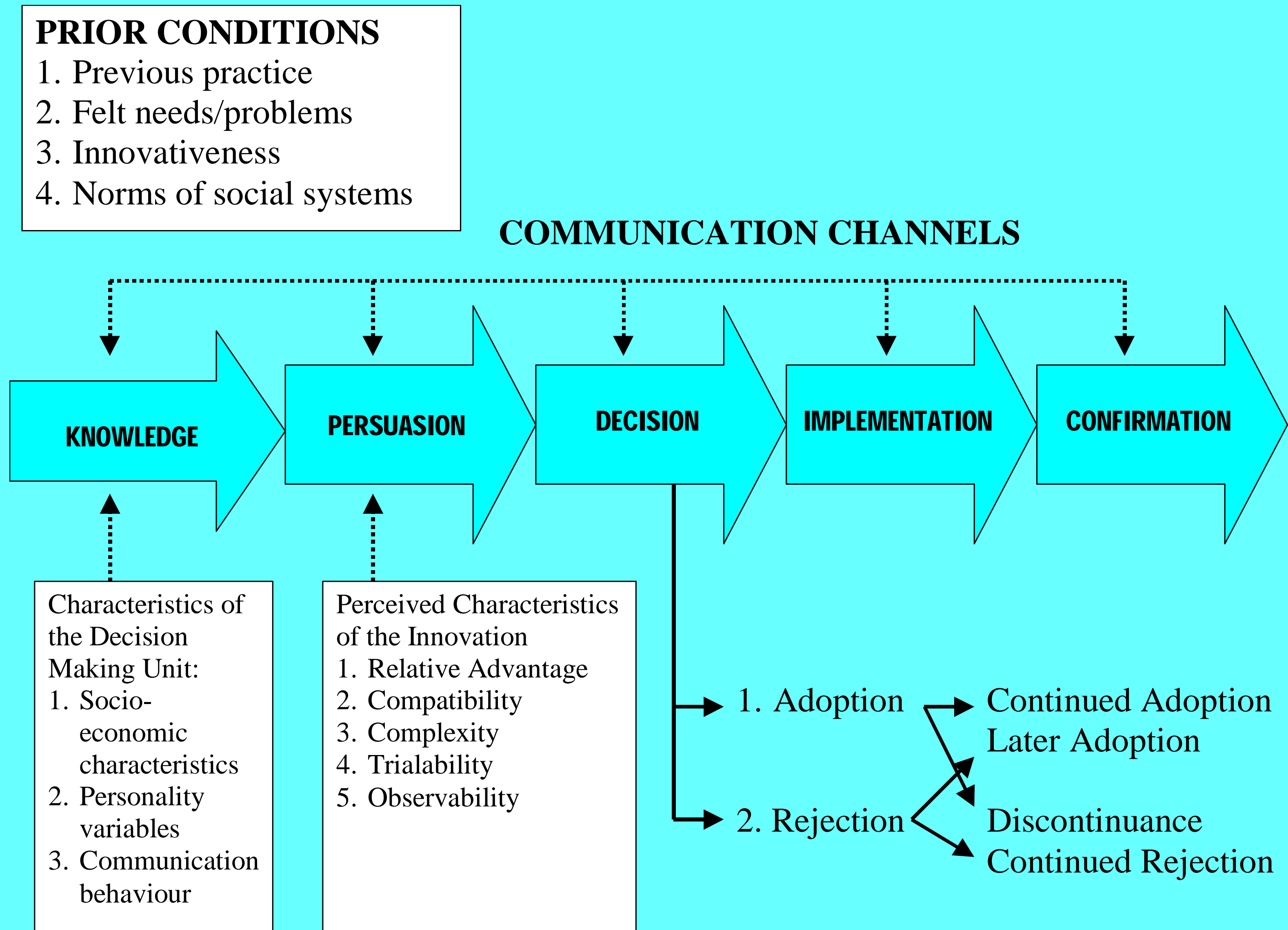
- The last group the **'laggards'** (about 16% of the target population are not very interested in innovation and would be the last to become involved. They are very traditional and are suspicious of innovations. Laggards tend to have limited communication networks, so they really do not know much about new things.
- This situation calls for different strategies for different categories of people and at different stages of the adoption process.

DIFFUSION OF INNOVATION

Time Relapse between awareness, interest, trial and adoption

Source: Green & MCAlister 1984.

DIFFUSION MODEL



VARIABLES UNDERLYING BEHAVIOURAL PERFORMANCE -1

Generally speaking it appears that in order for a person to perform a given behaviour one or more of the following must be true:

1. The person must have formed a strong positive intention (or made a commitment) to perform the behaviour.
2. There are no environmental constraints that will make it impossible to perform the behaviour.

VARIABLES UNDERLYING BEHAVIOURAL PERFORMANCE -2

3. The person has the skills necessary to perform that behaviour.
4. The person believes that the advantages (benefits, anticipated positive outcomes) of performing the behaviour outweigh the disadvantages (costs, anticipated negative outcomes).
5. The person perceives more social (normative) pressure to perform the behaviour than to not perform the behaviour.

VARIABLES UNDERLYING BEHAVIOURAL PERFORMANCE -3

6. The person perceives that performance of the behaviour is more consistent than inconsistent with his or her self image, or that it's performance does not violate personal standards that activate negative self-actions.

7. The persons emotional reaction to performing the behaviour is more positive than negative; and

VARIABLES UNDERLYING BEHAVIOURAL PERFORMANCE -4

8. The person perceives that he or she has the capability to perform the behaviour under a number of different circumstances…"