

# 6

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## Determining Desired Behavior Changes

*“Like slavery and apartheid, poverty is not natural. It is man-made, and it can be overcome and eradicated by the actions of human beings. And overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right—the right to dignity and a decent life. While poverty persists, there is no true freedom.”*

—Nelson Mandela<sup>1</sup>

Assume for a moment that your target audience for a poverty-reduction effort is sitting before you in a room. You have selected them carefully. Of all the possible groups you could have invited, this one seems the most ready for action, representative of a group you can reach, and one that can influence others. Your research and evaluation efforts also indicate that for the poverty issue you are focusing on, they are a good match for your organization’s expertise, resources, and distribution channels.

The question before you now—one the group is eager to hear about as well—is, what do you want to influence them to do? In social marketing, these are the desired behaviors you will focus on—actions that, once taken, will have a positive impact on your target audience and the poverty issue you are addressing.

In this chapter, our poverty issue of focus is family planning. We begin with two case stories from Population Services International

(PSI), one from Pakistan and the other from Romania. Each represents the power of “handpicking” desired behaviors for your target audiences, ones selected based on as rigorous an evaluation as you conducted to find priority target audiences in the first place.

**Family Planning:  
A Poverty-Reduction Solution  
Case Stories from Population Services  
International (PSI)**

“Gulbibi (living in Pakistan) was married at the age of 16. By the time she was 26, she had been pregnant five times, suffered one miscarriage, and given birth to four children. Gulbibi is illiterate, and so are her husband and all their relatives and ancestors as far back as anyone can recall. They migrated to the city two years ago in search of opportunity and better living conditions, yet they could only afford to live in a slum.”<sup>2</sup>

According to the United Nations Family Planning Association (UNFPA), like Gulbibi, at least 200 million women in the world want to use safe and effective family planning methods. But they are unable to do so because they lack access to information and services, or they do not have the support of their husbands and communities.<sup>3</sup> Providing these family planning services is an important poverty-reduction solution. When couples can choose the number, timing, and spacing of their children, they are better able to adequately feed their families, educate their children, reduce healthcare costs, and maintain good jobs.

Although the use of contraceptives by married women worldwide increased from 10% in the 1960s to 60% in 2003, the use of modern contraception has not risen in the past decade, and fertility rates are as high as seven births per woman in some

countries.<sup>4</sup> And, according to the UN, the current trajectory is likely to take us from a worldwide population of 6.6 billion to 9 billion or more by 2050. Almost all of this increase will take place in the less-developed countries, whose populations are expected to reach 7.8 billion in 2050, a 47% increase. By contrast, projections are that the population of the more-developed countries will remain around 1.2 billion.<sup>5</sup>

Improved access to modern and natural family planning options is the goal of all PSI family planning programs. Starting with one condom social marketing project in Kenya in 1973, PSI's family planning programs have expanded to include a range of oral and injectable contraceptives, IUDs, emergency contraceptives, vasectomies, and natural family planning methods, such as the Standard Days Method using CycleBeads. In 2007, PSI programs provided 12.2 million couples years of protection against pregnancy, averting an estimated 2.6 million unintended pregnancies and 13,400 maternal deaths.<sup>6</sup>

The following sections showcase two PSI success stories—one in Pakistan and the other in Romania.

### **PSI Pakistan: Green Star Training, “Lady Doctors,” and Others<sup>7</sup>**

Gulbibi's story, told earlier, does have a happy ending. She eventually convinced her husband that they could not afford to have any more children for a while. He agreed that she should visit a neighborhood health clinic, one with a Green Star on the sign, which she had heard meant they offered quality family planning services (see Figure 6.1). She returned home with an effective method for birth spacing and told others about it—an important and credible social influence, because many couples in Pakistan were poorly informed about family planning.



**FIGURE 6.1** Pakistan: The Green Star Network of clinics provide birth spacing options.

In 1991 PSI established a nonprofit NGO, Social Marketing Pakistan. Together they designed and launched the Green Star Network, with a mission to improve the quality of life among people throughout Pakistan by increasing access to and use of health products, services, and information, particularly in the lower socioeconomic population groups. Contraceptive choices and access to information and services were limited; 76% of women were illiterate, and contraceptive use was low, with fewer than 17% of couples using any modern method at the time (the early 1990s). The Network focuses on existing clinics and pharmacies and works with them to be even more viable for family planning by expanding the number of services they offer

and increasing the numbers of clients. From the beginning, the Green Star social marketing program had five components:

- *Medical training.* The Green Star Network has four types of providers, each receiving unique, targeted training. Green Star #1 is composed of *female doctors* who participate in an intensive 40-hour course on all contraceptive methods. Green Star #2 concentrates a one-day training session on *male physicians* to motivate their male patients to use contraceptives, to talk with their wives about contraception, to take responsibility for family planning, and to support their wives when they choose a method. This addresses the conservative cultural environment in which men typically discuss family planning only with other men. Green Star #3 involves *pharmacists* in a half-day training, increasing their skills in speaking knowledgeably about the contraceptive methods they carry. Green Star #4 focuses on *female health visitors* who make home calls or run small clinics in the poorest neighborhoods. They receive a one-day training in reproductive health, counseling, and nonclinical contraceptive techniques.
- *Reliable supply.* Subsidies from program donors make it possible to provide international-quality contraceptive pills, injectable contraceptives, IUDs, and condoms at prices that are affordable for low-income clients.
- *Public education.* Demand for Green Star reproductive health services and products is created through mass-media promotion of family planning and reproductive health services featuring the Green Star logo. The logo, promoted as the symbol of high-quality, affordable family planning products and services, is placed on signboards of certified clinics and pharmacies and also appears on the packaging of its four contraceptive products. Program staff members also reach directly into communities, organizing neighborhood meetings in which a broad range of reproductive health issues is addressed.
- *Technical support and quality control.* Green Star instructors make regular visits to Green Star clinics to follow up

on service quality and product availability. A medical detailing force also visits Green Star doctors and pharmacists.

- *Program evaluation.* The program has conducted a series of evaluations that assess improvements in quality of care, increases in service delivery, and program impact.

The Green Star Network has achieved concrete results in three very important measures: increased sales of contraceptives, increased number of clients, and improved quality of family planning services. An evaluation early in Green Star's development indicated that among Green Star female doctors, over 90% of clinics had oral contraceptives, injectables, and IUDs available. Doctors discussed three or more birth spacing methods with more than 85% of PSI researchers posing as patients, and over 75% of doctors discussed how to use the contraceptive method chosen.

By 2008, the Green Star Social Marketing Program (the current name for the NGO) was providing 27% of all modern contraception being practiced in Pakistan, making it the largest private source. And government policy requires that Green Star Social Marketing and the Green Star network continue to grow.<sup>8</sup>

### **PSI Romania: Giving Romanian Factory Workers the Facts**

The “Among Us Women” (AUW) initiative is helping the Romanian government educate women of reproductive age by providing them with voluntary family planning and reproductive health information. The program targets factory workers in an effort to influence them to make informed decisions about their choices for contraception. (As will be pointed out later in this chapter, desired behaviors, such as the one illustrated here, may be prevention-related behaviors targeting those at risk for poverty, or poverty-escaping behaviors.)

Since its inception in 2002, the campaign has addressed formative research conducted in 1999 that identified that one of the major barriers to acceptance and consistent use of modern contraceptives was incorrect information. One of the most common myths, for example, was that the birth control pill would cause facial hair and cancer. To address such misperceptions and demystify reproductive health issues, the A UW campaign was launched, funded by the U.S. Agency for International Development (USAID) through John Snow Inc. (JSI) through 2006. The campaign conducts dialogue sessions facilitated by a female health worker, in places that have a high concentration of female workers, including textile and shoe factories, bakeries, technical schools, and other production factories located in urban areas throughout Romania. At the close of the sessions, reproductive health counselors provide referrals to doctors and clinics. Participants are given the “Women’s Health Guide,” which details information on contraceptive methods and other reproductive health issues, and offers condoms and prizes for responding to questions (see Figure 6.2).



**FIGURE 6.2** Female workers listen to a PSI/Romania health worker at an “Among Us Women” session.

Each A UW interpersonal communication facilitator conducts an average of 20 workshops per month, with an average of 17 women in each workshop. It has proven to be a cost-efficient means to target and reach women of reproductive age; with the A UW, program costs are \$3.90 per woman reached. The methodology of reaching groups of women in the workplace has allowed PSI to reach over 180,000 women in 80 factories with interactive sessions. Outcome surveys have shown that these sessions increase participants' overall knowledge of reproductive health choices and modern contraceptive use.

To measure actual impact on contraceptive use, in 2004 JSI and PSI implemented a quantitative survey in Bucharest to determine if the A UW program was effective in increasing the female factory workers' knowledge of modern contraception and changing their behaviors regarding family planning. The study design consisted of 226 women from two factories completing a self-administered questionnaire before the session and then four months after they completed the session. A control group consisting of 258 women from a third factory completed an identical questionnaire that was used for comparison with the intervention group. JSI concluded that "the results of this study suggest that A UW factory sessions have been successful in changing women's knowledge and behavior regarding modern contraceptive methods, with reported use of contraceptives among women who attended the sessions increasing from 60% to 70%."<sup>9</sup>

## What Are Desired Behaviors?

Desired behaviors are ones we want to influence a target audience to "buy"—to *accept*, *reject*, *modify*, or *abandon* (see Table 6.1). Behaviors to accept are ones the target audience is not currently



doing, that you'd like them to start doing. Those to reject are ones the target audience is not currently engaged in, and you want to persuade them to continue “abstaining.” A modification to a behavior is applicable when your target audience is engaged in the desired behavior, but not at the ideal level. Abandoning refers to current (undesirable) behaviors you want your target audience to stop doing.

**TABLE 6.1** Types of Desired Behaviors

Type of Behavior	Poverty Issue	Desired Behavior
Accept	Homelessness	Attend weekly job training workshops.
Reject	Health	Don't start smoking.
Modify	HIV/AIDS	Use condoms with your steady girlfriend, not only with sex workers.
Abandon	Literacy	Eliminate gender inequities by allowing girls to attend school.

In Table 6.1, notice how singular, specific, and measurable the behaviors appear. Notice as well how the behavior, once performed, has the potential to contribute to the poverty-related issue. You probably can imagine multiple additional behaviors that would also contribute to this poverty-related issue. The rationale for calling attention to these three behavior characteristics is strong:

- *Singular*. Even if you have several behaviors you want to influence your target audience to adopt, you will be most effective when you focus on one, or at least present them one at a time. This may be all your target audience can or wants to hear and take on, as with the homeless example in Table 6.1, where you want the target audience to attend job training workshops. After attending the training, you can move on to influencing them to apply for jobs.
- *Specific*. The behavior should be specific, as in the example in Table 6.1, where the desired behavior is to “Use condoms with your steady girlfriend, not only with sex workers.” It could have just said “Use condoms,” but in this case campaign planners know the target audience is using condoms with sex workers on a regular basis, but not with their steady girlfriend.

- *Measurable.* The behavior should be one that the target audience will know they have performed and that you will be able to measure. Target audiences and evaluators, for example, can measure and report on the number of people in a given region or country who are not smoking and can then compare this with the numbers in prior years. They would not, however, be able to measure, track, and report on the number of people who were “protecting their heart.”

Desired behaviors, sometimes also called “calls to action,” vary by target audience (see Table 6.2). They can be illustrated well with our chapter’s focus on family planning, identifying the (next) step you might want a target audience to take. It should be noted that these desired behaviors are not campaign slogans or final copy for messages. They are simply the intended, desired behavior your strategies will be designed to influence.

**TABLE 6.2 Desired Behaviors Vary by Target Audience**

<b>Target Audience</b>	<b>Potential Desired Behavior</b>
Parents of preteen girls	Talk to your daughter about postponing sex.
Young single women	Use condoms with every sexual encounter.
Married women in Pakistan	Visit a health clinic with the Green Star sign.
Married women in the U.S.	Talk with your doctor about using contraceptives.
Private-sector partners	Print family planning messages on your product’s label.
Funders	Provide funding for family planning products in developing countries.
Healthcare visitors	Ask about myths about contraception, and dispel them.
Physicians	Share options available for contraceptives.
Pharmacists	Explain the advantages and disadvantages of contraceptive options.
Policy makers	Allocate funding for family planning services for low-income families.

And thinking again about our intent to move people up and out of poverty, desired behaviors also vary by stage of poverty:

- *Poverty staying behaviors.* These behaviors are ones that most likely contributed to the poverty situation in the first place and, if not abandoned, will likely “keep them there.” Typical ones you will work to eradicate might include those related to domestic violence, drug and alcohol abuse, mismanaging credit, unwanted pregnancies, and nonproductive farming practices.
- *Poverty escaping behaviors.* These behaviors are more typically new ones for the target audience, ones you want them to adopt. For farmers in Africa, desired behaviors might be to start using new fertilizers and irrigation systems to improve crop productivity. For the impoverished fishermen in the Philippines mentioned in Chapter 5, “Evaluating and Choosing Target Market Priorities,” it may be to apply for jobs recently created by the government to begin restoring the habitats that have been degraded by siltation and pollution. For those living in the United States who are non-English-speaking, the behavior would likely be related to attending language classes.
- *Poverty prevention behaviors.* Modification and maintenance-related behaviors are most relevant here, encouraging those diagnosed with tuberculosis to complete their drug regimen, high school youth to stay in school, those engaged in risky sexual behaviors to have an HIV/AIDS test every three to six months, young families to spend within their means, and those who are obese to increase their physical activity and decrease their consumption of high-calorie and high-fat foods.

## Behavior Change Theories

When selecting behaviors for the focus of a campaign or program effort, several models and theories can help guide your decision-making because they help assess how receptive your market will be to the behavior and how much might be required to achieve adoption. Models and theories described in this chapter include the following:

- Stages of Change/Transtheoretical Model
- Theory of Planned Behavior/Reasoned Action

- Health Belief Model
- Social Norms Theory
- Diffusion of Innovations
- Ecological Framework

At the conclusion of this section, we pull together themes from this collection. This can serve as a reference guide when you're trying to decide what behaviors you will be the most successful in persuading your target audience to adopt.

### ***Stages of Change/Transtheoretical Model***

The *stages of change* model, also referred to as the *transtheoretical model*, was presented in depth in Chapter 5. As a brief summary, it was originally developed by Prochaska and DiClemente in the early 1980s, and it identifies six stages that people go through in the behavior change process. A condensed version of the model described earlier includes four of those stages. This time we'll use a family planning effort in Honduras to illustrate the model. The desired behavior is for couples who don't want to use traditional contraceptives to use the Standard Days Method (SDM). SDM was developed by researchers at the Institute for Reproductive Health at Georgetown University School of Medicine. It helps couples recognize when they are most fertile, helping them avoid having unprotected sex during fertile periods. Many women who practice SDM use what are called CycleBeads to help them keep track of the days in their menstrual cycle.<sup>10</sup> Couples could be grouped into one of four stages:

- *Precontemplation* is the stage where people have little or no intention of changing their behavior or don't think their current behavior is a problem. Relative to SDM, these couples are not at all concerned about having another child. In fact, they look forward to it.
- *Contemplation* is the stage where people are considering changing, but they have considerations or concerns and have therefore not acted. These couples have heard about SDM

recently and like the idea, but they are concerned that it sounds complicated and doubt whether they could figure it out. They are also concerned about what their church leader's reaction might be.

- *Preparation/In Action* is the stage where people have decided they have a problem or see a potential benefit in a behavior change and are planning to take action. They may have even taken some initial steps in the desired direction. Relative to SDM, the women have made appointments at a local health clinic to learn more about this method.
- *Maintenance* is the stage where people are performing the desired behavior at the desired level, and the only typical concern is preventing relapses. These couples have been using SDM for several months and are pleased with its results. Once in awhile, they argue that it's hard to abstain for that length of time.

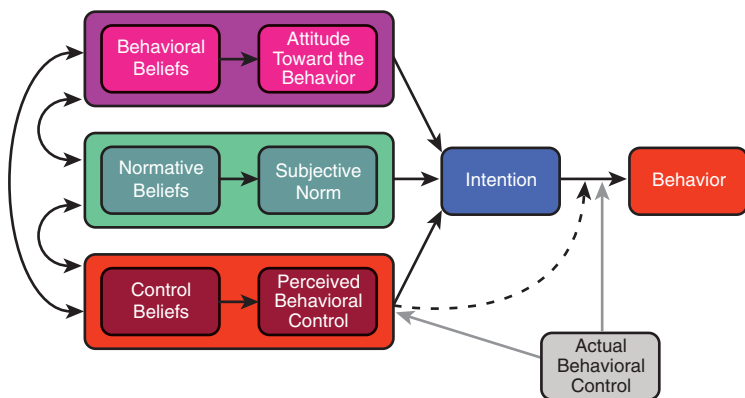
Once the sizes of these groups were estimated, program planners might decide to conduct formative research with the contemplators to learn more about perceptions, barriers, and what might motivate them to take the next step.

This theory will be most useful to you in campaigns where a sizable portion of the market is either contemplating the desired behavior (or at least is open to it) or has decided they will engage in the behavior and are preparing to do so. By contrast, if the vast majority of the “non-doers” are in precontemplation (unaware of and/or uninterested in the behavior), this model is less likely to provide insights that will inspire strategies.

### ***Theory of Planned Behavior/Reasoned Action***

The Theory of Planned Behavior, developed in 1980 by Ajzen and Fishbein, is an extension of the Theory of Reasoned Action, developed in 1975. It suggests that the best predictor of a person's behavior is his or her *intention* to perform the behavior. This intention is determined by three things: the person's attitude toward the behavior, subjective

norms, and perceived behavioral control. As shown in Figure 6.3, this attitude toward the behavior is influenced by behavior beliefs, which refers to the person's favorable (or not) attitude toward the behavior. The second predictor, subjective norm, refers to the perceived social pressure to perform the behavior, determined by the extent to which "important others" for the target audience would approve (or disapprove) of performing a given behavior. And the third antecedent of intention, the degree of perceived behavioral control, refers to the perceived ease (or difficulty) of performing the behavior.<sup>11</sup>



**FIGURE 6.3 The Theory of Planned Behavior**

Source: Ajzen, I. <http://people.umass.edu/ajzen/>

Stated simply, a target audience is most likely to adopt a behavior when they have a positive attitude toward it, perceive that "important others" would approve, and believe they will be successful in performing it.

**Illustrative example:** Launched in India in 1995, the Small Family by Choice Project was designed by the Family Planning Association of India (FPAI) and funded by the International Planned Parenthood Foundation. The Project covered three districts in Madhya and a fourth in Raisen, with a population of nearly four million people in 3,900 villages. The thrust of the Project was to impact the acceptance of family planning, with a focus on increasing the use of contraceptives.

In line with the Theory of Planned Behavior, the project clearly targeted existing beliefs regarding family planning, created new norms for where babies were born, and increased perceived control by increasing access to and improving quality of health services. The project was launched at a meeting of 500 women in Bhopal, where women were encouraged to postpone marriage until after the age of 18 and to think about planning to have their babies in a hospital or health center rather than at home. (At the time, 80% of deliveries in the region were taking place at home.) They were also encouraged to demand better health care service from their government. An evaluation in 2004 showed that contraceptive prevalence rates increased from 36% at the start of the project to 61% ten years later. This had a tremendous catalytic effect on influencing the state government to establish community delivery rooms.<sup>12</sup>

This theory will be most useful in guiding your selection of behaviors when, as illustrated in this example, the following points are true:

- You have research on or insights into your target audience that indicate they have a positive attitude or feelings about the desired behavior.
- They believe they have the resources and skills to perform the behavior.
- Important others in their lives are also positive about the behavior.

You will eventually develop strategies that capitalize on these influential factors. By contrast, a behavior that your target audience is uninterested in, or perceives they don't have the resources or skills to perform, has little chance of success. This is especially true when social networks are also negatively inclined.

### ***The Health Belief Model***

The Health Belief Model (HBM), described in Table 6.3, is a psychological-emphasis model that attempts to explain as well as predict

health behaviors. Developed by social psychologists at the U.S. Public Health Service in the 1950s, the model postulates that several conditions will impact the likelihood that a target audience will adopt a behavior. Since then, the HBM has evolved, with key variables identified by Rosenstock, Strecher, and Becker in the early 1990s. Some cite two limitations to the model. First, it relates largely to cognitive factors, predisposing a person to a health behavior, and it does not take into consideration other environmental or economic barriers that may influence their adoption. Secondly, it does not specifically incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviors.<sup>13</sup>

**TABLE 6.3 Health Belief Model**

<b>Concept</b>	<b>Definition</b>	<b>Family Planning Application</b>
Perceived susceptibility	What are the chances that I am at risk?	What are the chances I'll get pregnant?
Perceived severity	Even if I am at risk, how concerned am I with the potential health condition?	How concerned am I about having (another) baby?
Perceived benefits	How effective do I believe the desired behavior would be in reducing the threat of the illness?	Do the contraceptives work?
Perceived barriers	Do I believe that potential negative consequences might result from taking the action?	Will the contraceptives cause cancer? Will my husband be angry?
Cues to action	Do I notice any physical symptoms? Do I see anything in my environment that encourages me to take action?	Does my village have any health clinics with the Green Star logo that tells me family planning services are offered there?
Self efficacy	How confident am I that I can perform the desired behavior?	Will I be able to follow the instructions accurately?



As shown in Table 6.3, this theory “forces” the development of a rich description of what your target audience is probably thinking and feeling about the behavior you have in mind. By investigating their position on each of these factors, you can know what you are up against, as well as what you need to do to successfully influence them. By contrast, as noted, it does not focus on external factors that may also be critical to behavior adoption—factors such as resources, access, and the influence of important others.

### ***Social Norms Theory***

The social norms approach, first suggested by H. Wesley Perkins and Alan Berkowitz in 1986, states that our behavior is influenced greatly by incorrect perceptions of how other members of our social groups think and act. For example, college freshmen often overestimate the extent to which students on campus drink and smoke. The social norms theory predicts that these overestimations of problem behavior increase the likelihood that these students will then engage in these risky behaviors. Similarly, underestimations of healthy behaviors discourage individuals from engaging in them. Thus, a focus on correcting misperceptions of group norms is likely to result in decreased problem behavior or increased prevalence of healthy behaviors. According to Berkowitz and Perkins, “these peer influences are based more on what we think others believe and do (the *perceived norm*) than on their real beliefs and actions (the *actual norm*). This gap between ‘perceived’ and ‘actual’ is called a *misperception*, and its effect on behavior provides the basis for the social norms approach. Presenting correct information about peer group norms in a believable fashion is hypothesized to reduce perceived peer pressure and increase the likelihood that individuals will express preexisting attitudes and beliefs that are health-promoting.”<sup>14</sup>

**Illustrative example:** In 2004, Planned Parenthood of New York City launched a community campaign targeting parents of teens ages 11 to 17, intending to help young people avoid sexual risk-taking, including early intercourse. Focus groups with parents in the target community were conducted to identify specific practices that parents were currently using to help protect their teens from sexual risk-taking. This information then informed the development of a parent survey, which was conducted with a randomly selected sample of parents to determine actual and perceived norms for each of the identified parenting practices. As shown in Table 6.4, the survey identified large and pervasive misperceptions about parenting-related norms. For example, respondents guessed that only about a third of parents had talked with their teens about STDs, when in fact the vast majority (80%) indicated they had done this. This then informed the development of social norms marketing campaigns promoting positive parenting practices. At the core of the campaign were messages intended to establish with parents who were not engaged in these conversations with their children that these practices were “okay” to have. In fact, they are “the norm.”<sup>15</sup>

**TABLE 6.4 Parent Survey to Determine Actual Versus Perceived Norms**

“What percent of parents do you think always...”	Perceived	Actual
Meet their teen’s closest friends	20%	65%
Don’t allow their teen to go to parties at homes where they know there won’t be any parents	25%	78%
Talk to their teen about the dangers of sexually transmitted diseases	33%	80%
Talk to their teen about what might happen if she got pregnant/he got someone pregnant	30%	70%
Praise their teen when he or she makes good choices	37%	87%
Tell their teen how much they care about him or her	37%	90%

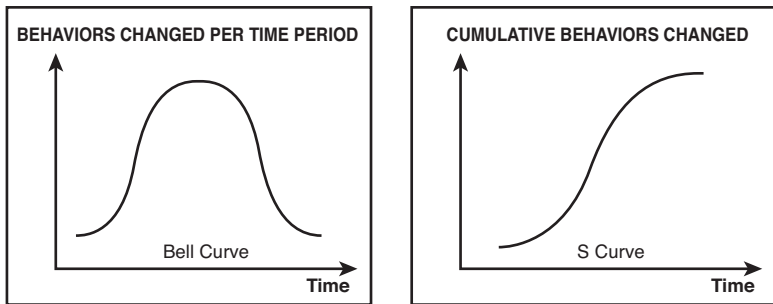
This theory is clearly most applicable when your target market is in the “minority”—when the majority of others within this population of focus are engaged in the desired behavior. This then naturally leads to a strategy that corrects misperceptions of the norm and capitalizes on its popularity. By contrast, when a behavior you are considering is not yet “popular,” this theory will not provide significant inspiration when you’re developing your campaign strategy.

### ***Diffusion of Innovations Model***

In his comprehensive book *Diffusion of Innovations, 5th Edition* (2003), Everett Rogers defines diffusion as the process by which (1) an innovation (2) is communicated through certain channels (3) over time (4) among the members of a social system. Innovation diffusion research suggests that different types of adopters accept an innovation at different points in time. Five groups have been identified:

- *Innovators* are motivated by a need for novelty and a need to be different.
- *Early adopters* are drawn by the product’s intrinsic value.
- *Early majority* perceive the spread of a product and decide to go along with it, out of their need to match and imitate.
- *Late majority* jump on the bandwagon after realizing that “most” are doing it.
- *Laggards* finally follow suit as the product attains popularity and broad acceptance.

As illustrated by the bell curve shown in Figure 6.4, adoption begins with the (typically) small group of innovators, is picked up by the early adopters, and then by the larger early majority group, followed by the late majority, and, eventually, over time, the laggards. The adoption curve becomes an S curve when cumulative adoption over time is plotted.<sup>16</sup>

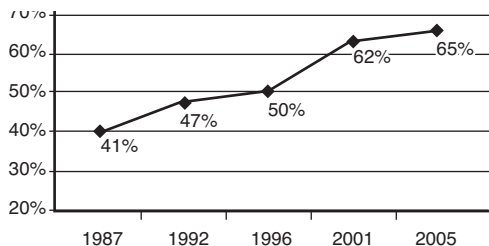


**FIGURE 6.4** Diffusion of Innovations adoption curves

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**Illustrative example:** Honduras, the second-largest country in Central America, has steadily and significantly decreased its total fertility rate in recent years, from an average of 5.6 children per woman in 1987 to 3.3 in 2005. Honduras has also made impressive gains in its contraceptive prevalence rate, increasing from 41% in 1987 to 65% in 2005, creating an S curve, as shown in Figure 6.5. These historic gains resulted from successful interventions, including increasing access to IUDs, innovative information, education and communication strategies, training in contraception eligibility criteria, and appropriate counseling. And according to USAID, political will has contributed to this adoption, acknowledging the government of Honduras for its commitment to comply with a series of international conventions and treaties.<sup>17</sup>

This model, like the Stages of Change Model, is useful when a significant portion of the population of focus is in groups that you can influence—the early adopters and the early majority in this model. On the other hand, if the largest or dominant segments are the late majority and laggards, your success in getting this behavior adopted further in the near term is diminished. Therefore, using this model to guide the development of strategies will be less inspiring.



**FIGURE 6.5** Contraceptive prevalence rate (all methods)

Source: USAID Demographic and Health Surveys

### *Ecological Model*

A criticism of many theories and models of behavior change is that they emphasize the individual behavior change process and pay little attention to sociocultural and physical environmental influences on behavior—an ecological perspective. This approach places the importance and role of supportive environments on par with the development of personal skills.<sup>18</sup> Although several versions of ecological models exist, most have at least four major levels of behavior influence in common: *individual factors* (demographics, personality, genetics, skills, religious beliefs), *relationship factors* (friends, families, colleagues), *community factors* (schools, work sites, healthcare organizations, media), and *societal factors* (cultural norms, laws, governance). These models argue that the most powerful interventions are those that simultaneously influence these multiple levels, expected to lead to greater and longer-lasting behavioral changes. The key is to assess each of these levels of influence and determine what is needed that will provide the greatest influence on the desired behaviors.

**Illustrative example:** In the article “Ending Africa’s Poverty Trap,” Jeffrey Sachs and his coauthors outline a theory on Africa’s poverty trap and point, in part, to structural conditions and history that have led to the trap (community and societal factors from the ecological model). These include “very high transport costs, small market size, low productivity agriculture, very high disease burden, adverse geopolitics and slow diffusion of technology from abroad.” They then argue that what is needed is “a big push in public investments to produce a rapid step increase in Africa’s underlying productivity, both rural and urban.” They also urge that those African countries that are well-governed should be provided substantial increases in assistance to enable them to achieve the Millennium Goals for poverty reduction by the year 2015. The paper then lays out an investment strategy that focuses on *interventions*, broadly defined as the provision of goods, services, and infrastructure, “ones that could make enormous changes in productivity at rather low cost.” Ones, we would add, that will support desired individual poverty-reduction behaviors (such as accessing family planning services).<sup>19</sup>

The advantage of using this ecological model for guidance is that it is so comprehensive that it forces you to explore multiple strategies to eventually influence the desired behavior. The potential bad news is that it may require you to implement these multiple strategies. These may be out of the normal purview of the social marketer’s direct influence (such as the need for new roads to reach remote villages).

### ***Themes from All Models***<sup>20</sup>

To summarize behavior change interventions, Fishbein combined themes from most of the models presented in this chapter, providing a quick reference of options for understanding your target audience and then selecting the most appropriate behaviors for program focus. Generally speaking, it appears that behaviors that have

the best chance of adoption are those that best meet the following criteria:

- The behavior is one that the target audience has a strong *positive intention* (or commitment) to perform (such as getting an IUD).
- There are *few or no environmental constraints* that make it impossible to perform the behavior (for example, affordable and accessible family planning services are available).
- The target audience has the *skills* necessary to perform the behavior (such as negotiating with their spouse regarding contraception).
- The target audience believes that the *advantages* (benefits, anticipated positive outcomes) of performing the behavior *outweigh the disadvantages* (costs, anticipated negative outcomes).
- The target audience believes there is more *social (normative) pressure* to perform the behavior than to not perform it (such as increasing the timing between the births of children).
- The target audience perceives that the behavior is more consistent than inconsistent with their *self-image* or that its performance does not violate personal standards (such as religious beliefs).
- The target audience's *emotional reaction* to performing the behavior is more positive than negative (such as condom use).
- The person perceives that he or she has the *ability* to perform the behavior under a number of different circumstances (such as using the natural Standard Days Method of contraception tied to menstrual cycles).

## An Analytical Model for Selecting Behaviors

As you develop and consider potential behaviors to influence, the following five criteria will help you choose one(s) with the greatest potential for meaningful change, or at least assist you in prioritizing among those you have placed on your “short list”:

- *Impact.* Assuming that target audiences adopt the behavior, what potential impact will it have on the poverty-reduction issue that your plan is focusing on (such as reducing unwanted pregnancies)? How does it compare with other potential behaviors under consideration for resource allocation? To determine this impact, we often rely on the expertise of scientists, sociologists, epidemiologists, and other technical experts regarding the effectiveness that this specific behavior will have (such as abstinence as a way to reduce teen pregnancies).
- *Demand.* How ready, willing, and able is your target audience to perform this behavior? Do any major internal or external barriers exist, either perceived or real? Do target audiences seem eager to do this? Do they have the skills and any required resources to perform the behavior (such as money to buy emergency contraceptives)?
- *Supply.* This criterion considers the extent to which other programs or organizations are already working to influence your target audience to adopt this behavior. If the market is “saturated” with others already doing “all that can be done” to influence this behavior, perhaps your support for a different behavior would be more beneficial to the poverty issue.
- *Support.* What level of support exists for this behavior from your key public? If it doesn’t currently exist, will it be hard to build? This includes potential funders, policy makers, administrators, the media, and others who could influence your success. This criterion is distinct from demand, which is the extent to which your target audience is anticipated to support the behavior.
- *Organizational match.* Do you have the expertise and resources to influence this behavior? Is it compatible with your organization’s mission and consistent with your organization’s values and brand? Have you attempted something similar to this in the past and therefore have experience that you can leverage?

As illustrated in Table 6.5, each potential behavior being considered is evaluated on five factors, and then bottom-line scores are compared. This particular hypothetical example uses a rather subjective scale, with High, Medium, and Low and a corresponding score of



3, 2, or 1, respectively. As indicated, efforts to influence abstinence behaviors look most favorable for this school district, and emergency contraceptives are the least favorable.

**TABLE 6.5 Hypothetical School District Evaluation of Potential Teen Pregnancy Prevention Behaviors to Support at Middle Schools**

	<b>Abstinence</b>	<b>Condoms</b>	<b>Contra- ceptives</b>	<b>Emergency Contra- ceptives</b>
<b>Impact</b> (Preventing pregnancies)	High	Medium	High	Medium
<b>Demand</b> (Teen interest)	Low	High	Medium	Low
<b>Supply</b> (Whether other programs or organizations are already supporting the behavior)	Medium	Low	High	High
<b>Support</b> (From parents, school administrators, elected officials, community leaders)	High	Medium	Low	Low
<b>Organizational Match</b> (Ability of high schools to deliver or disseminate)	High	Medium	Low	Low
<b>Overall Score</b>	<b>12 points</b>	<b>10 points</b>	<b>10 points</b>	<b>8 points</b>

When more quantifiable data is available, you might be able to use a more objective rating such as an index or a more differentiating scale. To add even more rigor, you might want to weight one or more of the criteria. Referring to the middle school program to prevent teen pregnancies, for example, it would be most realistic to rate potential target audience demand as twice as important to you as support from others. In Table 6.5, this would increase the appeal of the condom behavior and significantly decrease the viability of the abstinence strategy.

In the end, we are most interested in choosing behaviors that will have a *positive impact* on the poverty issue, ones that our target audience is (*most*) *ready to adopt*, that are *not currently being handled* by other organizations, that our key public will *support*, and that are a good *match* for our organization. Consider the positive impact that the “Condom King” from Thailand, highlighted in Chapter 4, “Segmenting the Poverty Marketplace,” had on influencing specific behaviors relative to family planning, as described in the following sidebar.

### Gates Foundation Honors “The Condom King”

On May 29, 2007, the Bill & Melinda Gates Foundation announced that Thailand’s Population and Community Development Association (PDA) had received the 2007 Gates Award for Global Health, in recognition of its pioneering work in family planning and HIV/AIDS prevention. This is the world’s largest prize for international health. It aims to honor extraordinary efforts to improve health in developing countries. The prize honored Mechai Viravaidya, founder and chairman of the PDA. His organization has helped millions of Thais to live healthier lives by demonstrating that effective HIV prevention and family planning are possible in even the poorest communities.

In 1974, the average Thai family had seven children. Each child borne made the family poorer. Viravaidya saw too many births keeping Thailand stuck in poverty. He saw the answer as convincing mothers to use the Pill, and he developed innovative social marketing solutions:

- He renamed and publicized the birth control pill as “the family welfare pill.”
- The Pill had to be prescribed by a doctor, but Thailand had too few doctors per hundred thousand people. So Viravaidya convinced the medical community that nurses should also be allowed to explain and prescribe the Pill.

- He used the Buddhist principle that life is suffering and said that the Pill would prevent a lot of suffering.

His whole premise was to make birth control popular and comfortable. Sex is a part of every living creature, and society has to acknowledge this.

Then Viravaidya recognized the condom as another potent solution. But condoms were not publicly discussed in Thailand. He decided to bring them into the open and discuss them everywhere. He turned to “edutainment” methods. To popularize the condom, he did the following:

- He held condom “balloon-blowing” contests with prizes for kids and adults, and he made sure that the media would take photos that he hoped would end up on page 1.
- He distributed condoms to shopkeepers, hairdressers, taxi drivers (many of whom were women), and hotels, and he recruited 320,000 rural teachers to talk about condoms and sex.
- Condoms were passed out or made available at tollbooths, in banks, and in hotels.
- One campaign featured a Captain Condom (looking like Superman) and Miss Condom.
- Publicity was given to a Cops and Rubbers program.
- An ad showed da Vinci’s famous Mona Lisa with a condom on her arm.
- Fashion shows were run showing condoms in different colors.
- A special ad showing three condoms in three colors was prepared for the 2008 Olympics in China.
- Viravaidya showed other uses for condoms, such as putting them over the barrel of a gun to prevent sand from getting into the barrel. Each novel event supplied further publicity for the condom.
- He had monks bless condoms so that Thais would know there would be no ill effects from using them.

Then Viravaidya and the PDA turned to a third solution besides pills and condoms: vasectomies. He ran events to publicize the positive effects of having a vasectomy: that it was painless and would not produce children.

- The PDA ran a vasectomy contest, with the winner getting a million dollars.
- The PDA sponsored a Fourth of July vasectomy event held in a luxury hotel ballroom. The man could choose the music to hear during the procedure and afterwards had a choice of food to eat.
- The PDA ran a Father's Day Vasectomy event.
- The PDA purchased a tour bus. Those who could give evidence that they had had a vasectomy could ride the bus for free.

The PDA then turned to a fourth solution—motivating women not to get pregnant. The PDA offered nonpregnancy microcredits (to purchase pigs, chickens, and so on). The number of microcredits would increase each year that the woman remained unpregnant. The impact of all these efforts—the Pill, condoms, vasectomies, and nonpregnancy microcredits—was that the average number of children per family in Thailand went from 7 in 1974 to 3.3 in 2005. Thailand's population growth went from 3.2% a year in the 1970s to 1.2% in the mid-'90s (now it is 0.7%).

## Summary

Desired behaviors, sometimes also referred to as “calls to action,” are ones we want to influence a target audience to “buy”—to *accept*, *reject*, *modify*, or *abandon*. Those that are most effective are ones that are singular and specific in nature, making it easier for your target audience to perform and for you to then measure.

When you're selecting behaviors for the focus of a campaign or program effort, several models and theories can help guide your decision-making. They help you assess how receptive your market will be

to the behavior and how much might be required to achieve adoption. These models and theories were described in this chapter:

- Stages of Change/Transtheoretical Model
- Theory of Planned Behavior/Reasoned Action
- Health Belief Model
- Social Norms Theory
- Diffusion of Innovations
- Ecological Framework

Behaviors that have the best chance of adoption are ones that the target audience has a strong *positive intention* to perform and that have *few or no environmental constraints*. The target audience has the *skills* necessary to perform the behavior, believes that the advantages outweigh the disadvantages, and believes that there is more *social (normative) pressure* to perform the behavior than to not perform it. They perceive that the behavior is more consistent than inconsistent with their *self-image*, and the *emotional reaction* to performing the behavior is more positive than negative. The person also perceives that he or she has the *ability* to perform the behavior under a number of different circumstances.

In the end, we are most interested in choosing behaviors that will have a *positive impact* on the poverty issue—ones that our target audience is (*most*) *ready to adopt* and that are *not currently being handled* by other organizations. They are also behaviors that our key public will *support* and are a good *match* for your organization.

## Endnotes

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