

Participatory Approaches and Health Behavior Change – Part 2

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Overview:



“Nothing new under the Sun”



Health Behavior Change and Social Marketing



Community-Based Participatory Research (and Practice)



Behavior Change Myths and Examples

Jeni Cross TEDx Talk: Three Myths of Behavior Change

Myth #1:

Education will change behavior.

Two Approaches

Which Will Reduce Littering?

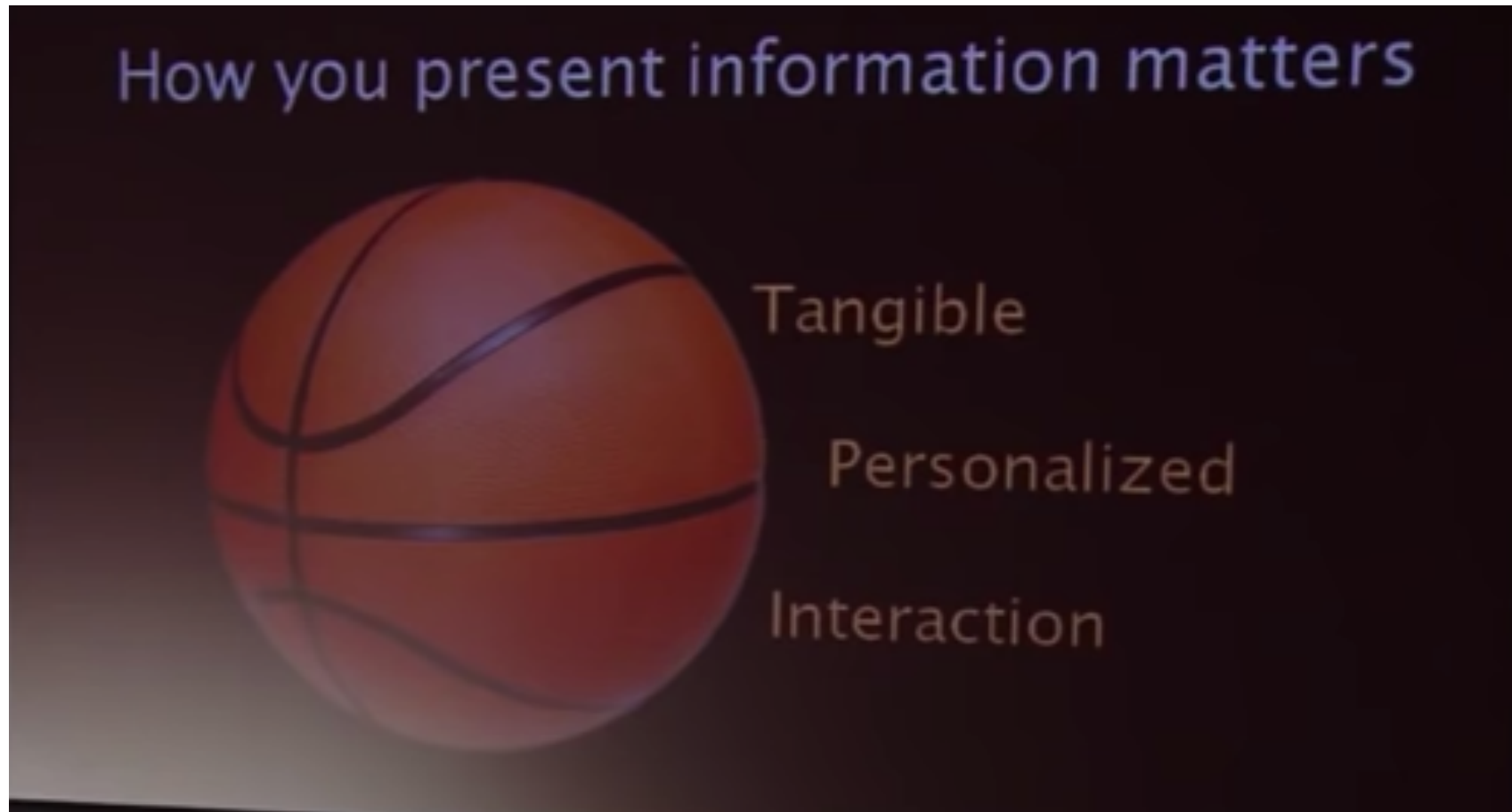
A



B



Presentation matters



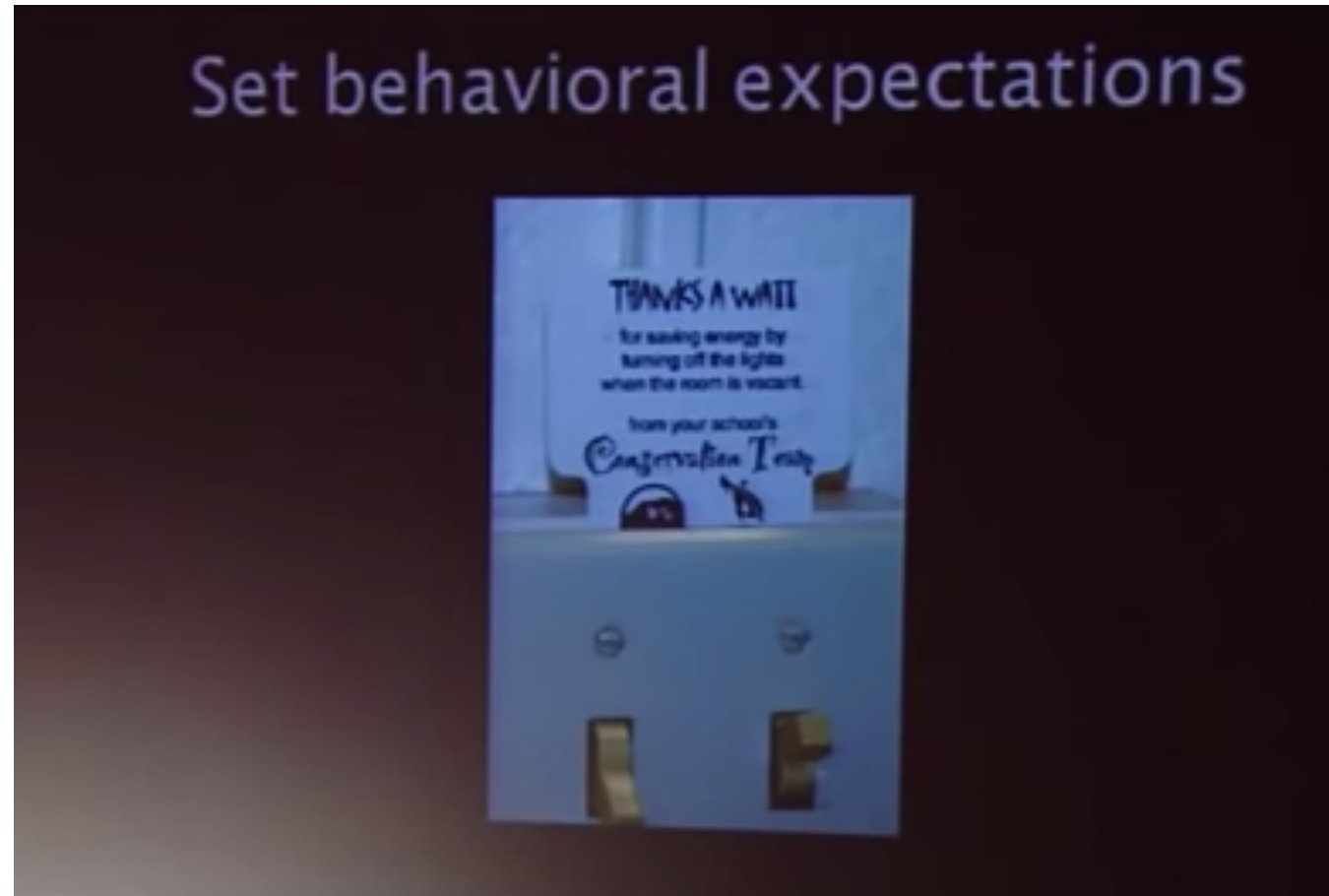
Myth #2:

You need to change attitudes
to change behavior.

Behavior comes first



Expectations matter



Values matter



Myth #3:

People know what motivates them
to take action.

Social norms matter



Two Approaches

Which Will Reduce Littering?

A



B



WASH United (NGO)



WASH United

Non-profit organization

WASH United is a non-profit organization that works to end the global sanitation and hygiene crisis by making toilets and good hygiene "cool" and "sexy". [Wikipedia](#)

Founded: 2010

Awards: [Shorty Social Good Award for Best Use of a Hashtag](#)

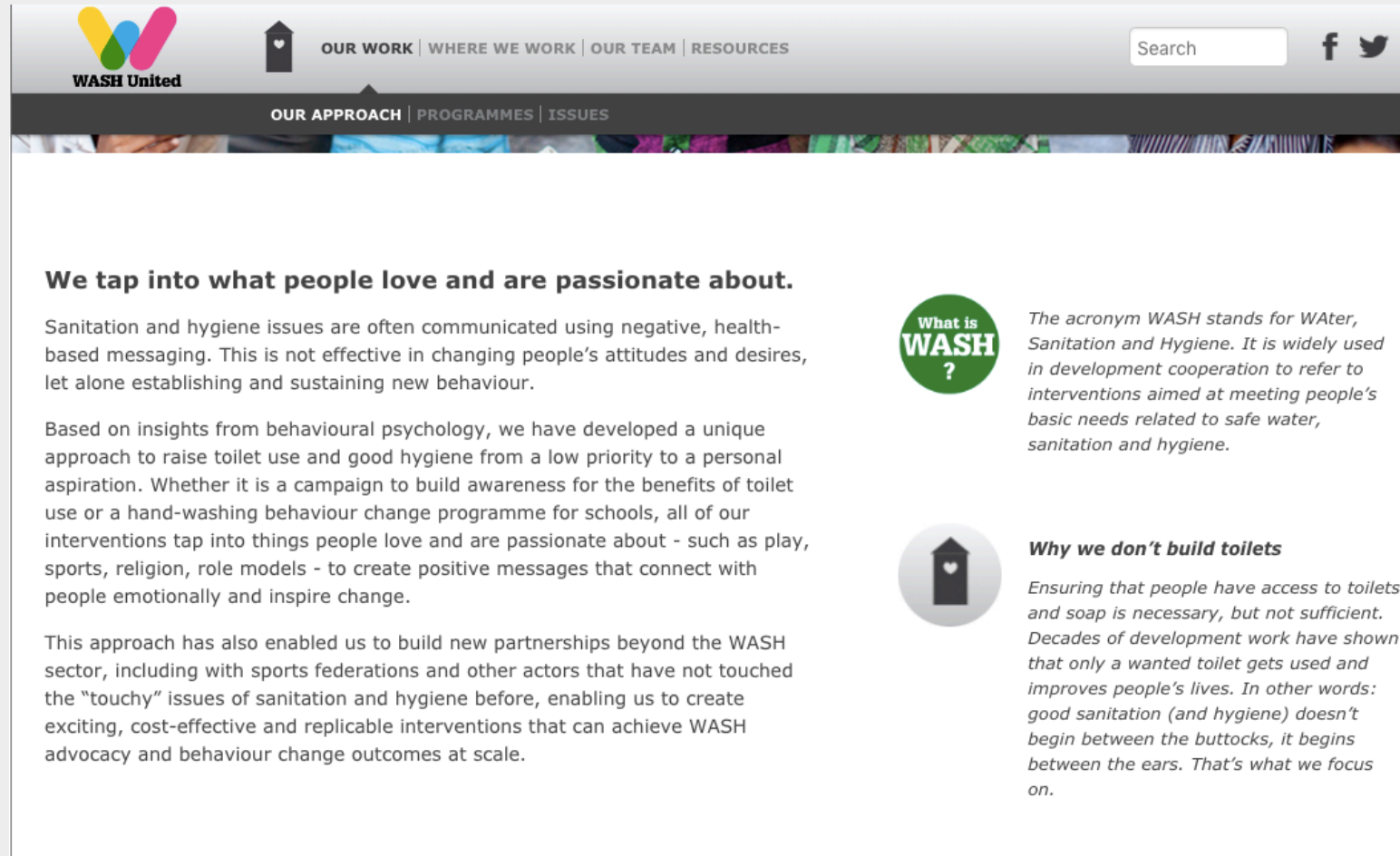
Type of business: [Non-Governmental Organisation](#)

Areas served: [Sub-Saharan Africa](#), [Southern Asia](#)

Nominations: [Shorty Social Good Award for Best Use of Music & Dance](#)

<http://wash-united.org/>

“Good sanitation begins...between the ears.”



The screenshot shows the WASH United website. The top navigation bar includes the WASH United logo, a home icon, and links for 'OUR WORK', 'WHERE WE WORK', 'OUR TEAM', and 'RESOURCES'. A search bar and social media icons for Facebook and Twitter are also present. A secondary navigation bar below features 'OUR APPROACH', 'PROGRAMMES', and 'ISSUES'. The main content area is divided into two columns. The left column has a heading 'We tap into what people love and are passionate about.' followed by three paragraphs of text. The right column contains two circular icons: a green one with 'What is WASH?' and a grey one with a house icon. Each icon is followed by a bold heading and a paragraph of text.

WASH United

OUR WORK | WHERE WE WORK | OUR TEAM | RESOURCES

Search

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OUR APPROACH | PROGRAMMES | ISSUES

We tap into what people love and are passionate about.

Sanitation and hygiene issues are often communicated using negative, health-based messaging. This is not effective in changing people’s attitudes and desires, let alone establishing and sustaining new behaviour.

Based on insights from behavioural psychology, we have developed a unique approach to raise toilet use and good hygiene from a low priority to a personal aspiration. Whether it is a campaign to build awareness for the benefits of toilet use or a hand-washing behaviour change programme for schools, all of our interventions tap into things people love and are passionate about - such as play, sports, religion, role models - to create positive messages that connect with people emotionally and inspire change.

This approach has also enabled us to build new partnerships beyond the WASH sector, including with sports federations and other actors that have not touched the “touchy” issues of sanitation and hygiene before, enabling us to create exciting, cost-effective and replicable interventions that can achieve WASH advocacy and behaviour change outcomes at scale.

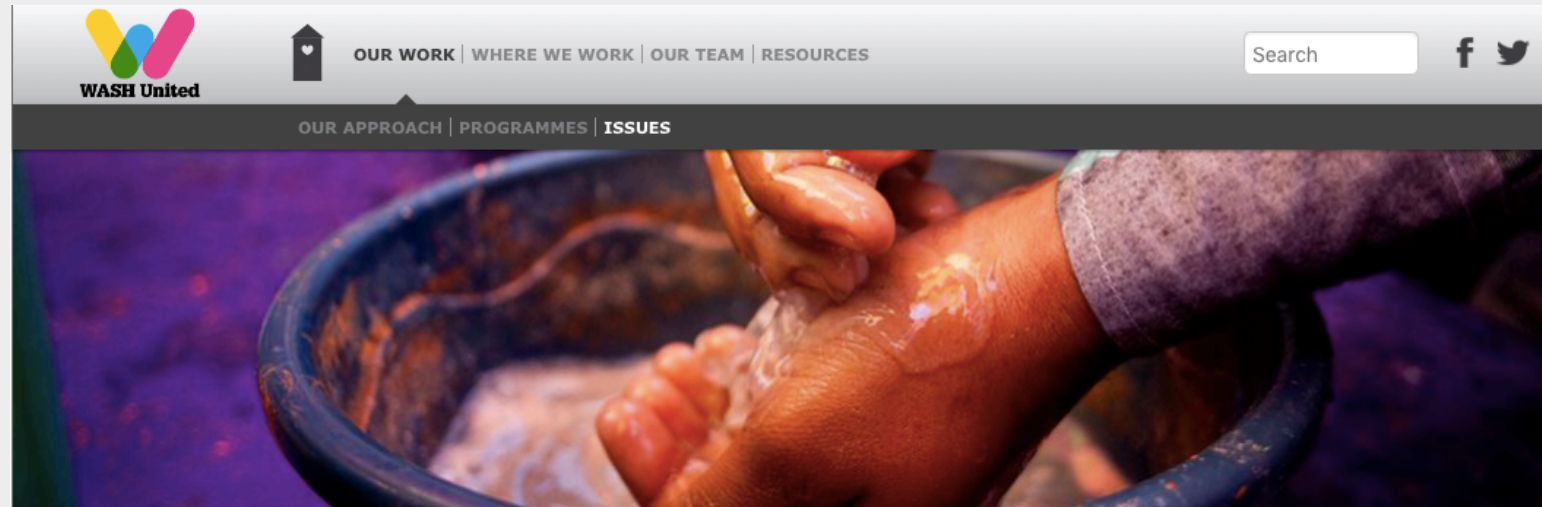
What is WASH ?

The acronym WASH stands for WATER, Sanitation and Hygiene. It is widely used in development cooperation to refer to interventions aimed at meeting people’s basic needs related to safe water, sanitation and hygiene.

Why we don’t build toilets

Ensuring that people have access to toilets and soap is necessary, but not sufficient. Decades of development work have shown that only a wanted toilet gets used and improves people’s lives. In other words: good sanitation (and hygiene) doesn’t begin between the buttocks, it begins between the ears. That’s what we focus on.

“Because only a used toilet is a good toilet....”



WASH United


OUR WORK | WHERE WE WORK | OUR TEAM | RESOURCES

Search

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OUR APPROACH | PROGRAMMES | ISSUES



Sanitation

Still today, 2.5 billion people don't have access to a safe and hygienic toilet. 1.1 billion people have nothing at all. They are forced to use railroad tracks, roadside ditches and open places in and around their communities for want of a toilet. But building toilets alone does not solve the problem. In South Asia and Sub-Saharan Africa, there are tens of thousands of toilets that are unused, abandoned or have been converted into bicycle sheds, chicken stalls or even temples. WASH United develops innovative tools that help to change attitudes around sanitation and create demand for toilets. Because only a used toilet is a good toilet is a toilet that changes the world – one poop at a time.

DBC

Designing for Behaviour Change (DBC)

DBC is a relatively quick and simple to use, 5-step process that assists behaviour change agents to organize existing information and to gather new information needed to design effective behaviour change strategies. The DBC Framework can be used to design behaviour change strategies in any sector e.g. health, nutrition, food, security, water and sanitation, agriculture, natural resource management, civil society and gender equity and for any audience e.g. mothers, youth, farmers, pastoralists.

DBC Steps

Five Steps of DBC

- Step 1: Formulation of a clear and unambiguous behaviour statement which includes the priority group
- Step 2: Specification and description of the priority group
- Step 3: Formative research using BA survey (Barrier Analysis) to discover from a set of up to 12 common behavioural determinants, which are critical ones for selected behaviour and priority group, and the specific setting
- Step 4: Formulation of the Bridges to Activities
- Step 5: Formulation of Activities linked to the key determinant(s) through the Bridges Activities

World Vision also partners with *Essence Workshop*, the non-profit organisation behind the

DBC Resources

[About](#)[Resources](#)[Map](#)[Consultants](#)[FAQs](#)[Contact](#)

Designing for Behaviour Change (DBC)

[Home](#) / [Resources](#) / [Designing for Behaviour Change \(DBC\)](#)

On this site you can find guidance on and examples of using the Designing for Behaviour Change (DBC) framework, a **field-tested approach for designing effective behaviour change strategies**. It enables you to identify the reasons why people are not practicing the desired behaviours and to design a behaviour change strategy that effectively addresses the barriers.

[GUIDANCE ON DBC APPROACH](#)

[PRACTITIONERS' DBC FRAMEWORKS](#)

Barrier Analysis (BA)



Barrier Analysis (BA)

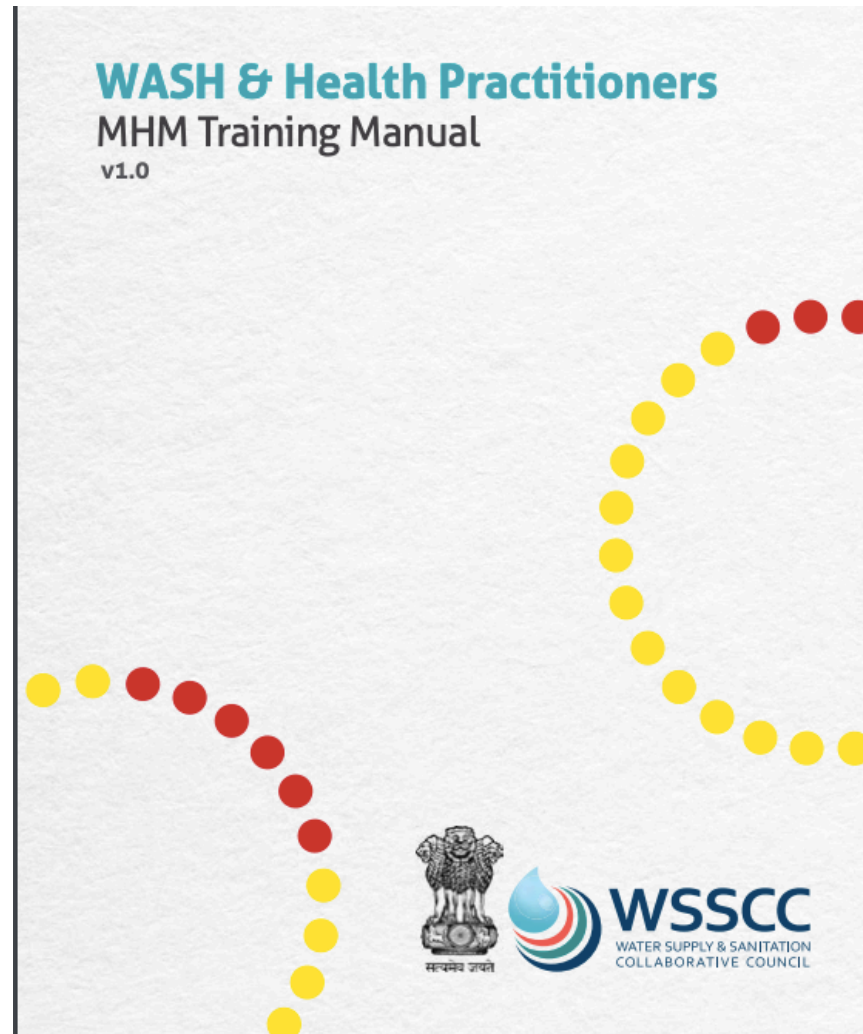
The Barrier Analysis study asks people a series of questions aiming to **identify which barriers and motivators have the biggest influence** on whether they (do not) practice the desired behaviour. The Barrier Analysis study uses the Doer/Non-Doer methodology that consists of interviewing 45 people who already do the behaviour (Doers) and 45 people who have not adopted the behaviour yet (Non-Doers). The differences between their answers are what matters most as they reveal the barriers and motivators to practicing the studied behaviour. The Barrier Analysis has been used by more than twenty relief and development organisations in about **50 countries**. It is most useful when used as a part of the Designing for Behaviour Change (DBC) Framework.

[GUIDANCE ON BA](#)

[BA QUESTIONNAIRE TEMPLATES](#)

[BA QUESTIONNAIRES ON COMMON BEHAVIOURS](#)

Overcoming Stigma



So what have we learned?

Sanitation and Public Health: A Heritage to Remember and Continue

Carolini's research article about public vulnerabilities to unsanitary conditions in Maputo, Mozambique reminds us that more than a billion people lack basic sanitary services that North Americans and most Europeans have taken for granted for more than a century.¹ She focuses on variations in public understanding of sanitation's four A's (adequacy; accessibility; affordability of water, sanitation facilities, and waste management; and awareness of disease outcomes and hygiene practices) as contributors to sanitation-related mortality and morbidity. Unsanitary conditions in Maputo—caused by inadequate infrastructure and staff to manage the systems, as well of a lack of public knowledge—are mirrored in poor neighborhoods and rural areas in much of the global south. In this editorial, I revisit the commendable contribution of the *American Journal of Public Health*® (*AJPH*) to the sanitary movement and describe today's international challenges.

SUCCESS IN SANITARY PRACTICE IN THE UNITED STATES

AJPH published more than 230 articles, editorials, and book reviews about sanitary practices during the 1911–1960 period, and that effort was needed. The last cholera epidemic in the United States started more than a century ago in Asia. In 1911, the steamship *Moltke* (Hamburg, Germany, to New York City) brought infected people to New York City. The small public health community responded quickly,



During a hygiene promotion campaign, residents of Cap-Haitien, Haiti, are taught proper hand washing to avoid cholera infection. Printed with permission of Corbis.

isolating the population on Swinburne Island (a tiny island just east of Staten Island in the New York Bay).² Eleven people died, including a health care worker. This episode should be distinguished from others in which quarantine was used as an instrument to reinforce xenophobic values.³ It comes as no surprise that the first article in the first issue of *AJPH* in 1911 was about controlling the spread of cholera,⁴ and the first decade of the *Journal* was marked by 90 publications about the rapid development of industrial hygiene and sanitary practices associated with industrialization, urbanization, and internationalization, and more specifically the demands of the First World War,⁵ the newly opened Panama Canal Zone, and rural areas.

The 1920s and 1930s saw a decrease in the number of articles about sanitation and a shift in focus from battlefields and barracks to recreation (tourist camps,

resorts, summer camps, swimming pools, playgrounds) and schools. Articles focused on foods and beverages of every variety (ice cream, fruits and vegetables, bottled beverages, oysters, fish, livestock) and the places that served them (kitchens, bakeries and restaurants). The 1940s and 1950s included 2 wars, an economic depression that gave way to unprecedented economic growth, and the beginning of postwar suburban-oriented America. Sanitary-related war issues temporarily returned, including special problems associated with sanitary conditions in South Pacific. With the end of the war, restaurants, schools, hospitals, and rural areas reappeared as the focus. The *Journal* emphasized the need for training to inspect and record data about sanitary conditions.

By 1960, the US sanitary movement was institutionalized. In 1949, Wolman summarized key accomplishments.⁶ He reported that 85 million US

So what have we learned?



Build on what we (and others) know



Build on strengths and values



Engage community in as many aspects as possible



Expand our team



Reflect on our practice



UNIVERSITY *of* ALASKA
ANCHORAGE