
# PREVENTING GENDER-BASED VIOLENCE THROUGH BEHAVIOR CHANGE COMMUNICATION

# EXPERIENCES FROM THE EASTERN DEMOCRATIC REPUBLIC OF CONGO

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**Table 2: Factors Influencing Individual Behavior and their Programmatic Implications**

| Factor Influencing Individual Behavior | Explanation | Programmatic Implications |
|---|---|---|
| Knowledge | A person will be more likely to change a behavior if he or she knows the negative consequences of the current behavior, what alternative behaviors exist, and the benefits associated with engaging in the desired behavior. At this stage, provision of clear, factual information is more appropriate. | Assessing the knowledge of the target population in regards to both current and desired behaviors so as to tailor interventions and messaging. The BCC program, targeted audiences at this stage with information on what GBV is, causes & consequences, and the law. |
| Attitudes | A person's attitude toward a particular behavior, or the object of that behavior, will affect whether an undesired behavior is sustained or changed. In GBV prevention, the most common example of attitudes affecting behavior negatively is the perception of women and their role in society. Negative attitudes toward women perpetuate forms of violence against them. | Programmatically, assess the prevalent attitudes of the target group towards current and desired behaviors, as well as generating an understanding of where such attitudes originate. Such information will help inform messaging and activities that are culturally appropriate. |
| Self-Image | At times, certain behaviors reinforce our own self-image. For example, young people may smoke because it makes them feel "cool". Similarly, a man could reinforce a "macho" image he has of himself by being aggressive toward his wife. | Behaviors that contribute to a person's self-image will require interventions to associate positive images of self-worth with the desired behavior. The BCC program promoted images of men displaying positive behaviors. |
| Perceived Risk | Before a person will consider changing a behavior, he or she will need to perceive the dangers associated with continuing the current behavior. A person therefore, is more likely to consider using condoms for example, if he or she perceives the risks and fear of contracting HIV. Similarly, men are more likely to abstain from raping if they perceive the fear going of to prison. | In some interventions it is important to highlight the risks and to play on the emotion of fear through messaging in order to trigger a desire for change. In the BCC program, we attempted to promote a sense of fear, emphasizing the sentence for rape. With the challenges in places like DRC where impunity is common, partnerships with the media to report on cases that were convicted proved helpful. |
| Self-Efficacy | At times, wanting to change is not enough. We may be aware of all the risks associated with a current behavior but feel unable to make the change. This is commonly seen in smoking where people often know the dangers of smoking and want to stop, but do not feel they have the self-efficacy, that is, the capabilities and belief that they can change. As a result, they do not engage in attempting to change. | It is important that BCC programs which want to stimulate a change in behavior also provide the necessary support to make the change possible. This can include tailored messaging suggesting steps on how to change, help-lines, support groups, discussions on alternative behaviors, or providing props that may aid change (eg. nicotine patches for smoking cessation or condoms for sexual health promotion). |
| Norms | Norms are shared expectations of specific individuals or groups regarding how people should behave (Paluck and Ball, 2010). Although different people will be influenced by norms in different ways, these can be powerful motivators for or against certain behaviors because people who deviate from group expectations are often subjected to shaming and disapproval. | Desired behaviors which deviate from the norm (for example a husband who includes his wife in all household decisions) need to be praised and valued through communication interventions. This can be done through positive messaging, events which publicly celebrate those exhibiting the desired behavior, or by providing some from of reward like a certificate of accomplishment for example. |
| Social Influences | As per the ecological framework, our peer network and family can influence whether we maintain or change a behavior. | Programmatically this reinforces the importance of an ecological approach and highlights the need for considering the peer networks of the target group in a behavior change intervention. |
| Emotions | We know that emotions have an effect on our behavior. Previously, when looking at perception of risk, we saw how fear may trigger behavior change. Similarly, positive and inspirational emotions may also stimulate change. | Inspiring certain emotions in the target group may reinforce or change behaviors. The BCC program for example, found that men responded very positively to messages which inspired feelings of family harmony and happiness. |

### 3.2 Theories that Explain Behavior

Behavior is the result of a complex interaction between internal and external factors. It is generally accepted that behavior change interventions be guided by a series of hypothesis and theories which attempt to explain behavior. Some theories explain behavior by focusing more on the individual, while others place greater emphasis on social and structural change. Table 3 provides a list of some of the most commonly used theories in behavior change interventions and an indication of where the emphasis lies. A more detailed description of each theory can be found in Appendix 1.

**Table 3: Main Theories that Explain Behavior**

| Theory | Basis for the theory | Individual vs Social Focus |
|---|---|---|
| ○ Health Belief Model<br>○ Theory of Reasoned Action<br>○ Stages of Change (Transtheoretical Model) | Cognitive thinking and rational decision making | Individual  Structural & Social Change |
| ○ Extended Parallel Processing (Fear Management) | Interaction between cognitive thinking and emotions | |
| ○ Social Learning | Social comparison and social influence | |
| ○ Diffusion of Innovation | Social structures and social networks | |

*Source: Johns Hopkins University, Center for Communications Programs*

As behavior is affected by a range of individual, cultural and contextual factor, it is not always appropriate to rely on a single theory to design interventions. Most often, greater benefits are obtained from drawing upon more than one theory to guide program development based on situation analysis and needs assessment.

The implementation of the BCC program for example, was guided by two main theories: the extended parallel model and the theory of reasoned action. In the case of the former, it was believed necessary to create awareness of the reality and consequences of rape, thus motivating change through personal fear of the consequences. In the case of the latter, social and peer influences on individual behavior, particularly normative actions, were taken into account by targeting what was referred to as secondary audience (those who had a direct influence on the primary audience/primary target group).

## Appendix 1: Brief overview of key behavior change theories

Not all behavior change programs are equally successful in achieving their aims and objectives. Although not many projects are implemented with overt reference to theory, there is evidence to suggest that the use of theory can significantly improve the chances of success in achieving program objectives (Glanz et al, 1997; Nutbeam and Harris, 2002). The use of theory can help better understand the nature of the problem being addressed and the needs and motivations of the target group to guide programming and obtain a better fit between problem and intervention.

The paragraphs below aim to provide a brief overview of six of the most influential theories and models which have been used to guide health promotion and behavior change practice**.** The six theories discussed are:

1) The health belief model
2) The theory of reasoned action and planned behavior
3) The stages of change (transtheoretical) model
4) The extended parallel processing model
5) Social learning theory
6) Diffusion of innovation theory

### 1) Health Belief Model

At the core, this model suggests that the likelihood of an individual taking action to change behavior relating to a given issue is based on the interaction between four different types of beliefs:

1. The individual's belief of his or her vulnerability to the issue being addressed
2. The individual's belief that not changing a behavior will have serious consequences
3. The individual's belief that a course of action is available and feasible and it will reduce his or her susceptibility to the problem or minimize the consequences
4. The individual's belief that the benefits of taking action will outweigh the costs or barriers

Later versions of the model also acknowledged the importance of other influencing factors, including immediate cues for action, such as publicity or personal experience, and the concept of self-efficacy, that is, the person's belief that they are able to take appropriate, corrective action. Thus, for example, if this model were applied to HIV, for individuals to adopt positive behaviors which minimize the risk of infection, they would need to:

- → Believe that they are at risk of HIV infection
- → Believe that the consequences of infection are serious
- → Receive supportive cues for action, such as targeted messaging
- → Believe that the suggested alternative behavior greatly reduces the risk of infection
- → Believe that the benefits of changing behavior will outweigh the potential costs and barriers, such as reduced enjoyment or negative reactions from the partners
- → Believe that they are able to take effective action and adopt the desired behavior

**In summary:**

Traditionally the health belief model has been used mostly as a planning tool for health education programs intended to promote compliance with preventive behaviors such as immunization, condom use or attendance to routine health check-ups. The model is deemed more appropriate for

these types of behavior and has been found to be less useful for longer term and more complex, socially determined behaviors such as smoking or alcohol consumption.

The main limitation of the model is that it only considers attitudes and beliefs as influencing behaviors. There are, of course, other forces that can affect behavior, including social, economic, structural and environmental factors which can deter or promote change.

Overall the health belief model is useful in providing a simple way of illustrating the importance of considering individual beliefs about a problem and about the costs and barriers to change.

**2) Theory of Reasoned Action and Planned Behavior**

The theory of reasoned action was developed by Ajzen and Fishbein (1980) and is based on the assumption that intention to act is the most immediate determinant of behavior, and that all other factors influencing behavior are mediated through behavioral intention.

According to this theory, behavioral intention is influenced by two elements:

1. Attitudes toward the behavior
2. Subjective norms

**Attitudes** toward the behavior are determined by the belief that a desired outcome will occur if a particular behavior is followed (the desired behavior) and that the outcome will be beneficial to the individual.

**Subjective norms** relate to the individual's belief about what other people (peers, family, social network) think he or she should do, and by the individual's motivation to comply or not with other people's wishes. Thus, if an individual is aggressive toward his wife for example, and feels that most of his family and friends do not engage in such behaviors and would like him to stop, it is more likely for that individual to consider changing his behavior toward his wife. In general, subjective norms are affected most by significant others, like partners, parents, family members and very close friends.

Ajzen and Fishbein later added an element to this theory to indicate that short-term consequences of a behavior are the most powerful predictor of behavior change, denoting the importance of emphasizing short-term benefits of the desired behavior in interventions.

Over time, the theory of reasoned has been further refined, to add the individual's perceived behavioral control as a third influence on behavioral intention, and thus action. This recognized that intention to change is more likely if an individual perceives he or she is has the ability and efficacy to take action. This modified theory was name the theory of planned behavior.

One limitation of both theories is that they are based on the assumption that individual behavior is rational.

**In summary**

The theory of reasoned action and the theory of planned behavior can be useful in thinking about what information to collect about a target group to develop an intervention. They highlight the need to understand the beliefs of the audience about the issue being addressed, whom the audience sees as significant others affecting their beliefs, and what they perceive as barriers to change. The theories provide valuable insight into the factors that influence behavior and

highlight the importance of considering perceived social norms and of understanding the short-term consequences which shape behaviors. The models have been applied to programs aimed at reducing the uptake of smoking among young people in the 1980s, and they emphasized the importance of the short-term negative consequences of smoking (such as bad breath, or financial costs) to trigger behavioral intention. Such programs also recognized the role of significant others in shaping decisions to smoke, and this led to the development of peer education programs.

**3) The Stages of Change (Transtheoretical) Model**

This model was developed by Prochaska and DiClemente (1984) to try and explain the different stages that individuals go through when changing behaviors. The model is based on the premise that behavior change is a process, not a one-off event, and that individuals have varying degrees of motivation and readiness to change. The model identifies five steps to behavior change:

1. **Pre-contemplation –** this describes people who are unaware and not considering changing behavior, either consciously or unconsciously.
2. **Contemplation –** this indicates the point at which an individual starts considering making a change.
3. **Preparation –** this is when a person makes a serious commitment to change, for example starts developing strategies for adopting the change.
4. **Action –** this stage is when behavior change is initiated.
5. **Maintenance –** this is when the change is sustained. At this fifth stage, relapse may occur and the individual may fall into any of the previous stages.

People appear to move in a predictable way through the above stages, although some may move fast, while others may get stuck at particular stages or regress to a previous stage. The model should be viewed in a circular way to indicate that people may enter or exit this process at any point.

The model has useful implications for interventions both at the individual and broader community levels. At the individual level, this model has proved useful to health practitioners in thinking about the type of advice and support to give their patients who want to change a behavior (for example stop smoking) depending on where they are placed along the stages of change model.

From a broader program perspective, the stages of change model highlights the importance of audience segmentation and researching the characteristics of the target audience, as not all people will be at the same stage. It also provides guidance to develop interventions that can move the audience along the stages of change.

**In summary:**

The stages of change model provides an understanding of the steps individuals go through when changing behaviors. The model emphasizes the different and changing needs of individuals and target populations, indicating the importance of assessing the segmenting the audience according to their behavior change stage rather than assuming that all individuals are the same.

**4) Extended Parallel Processing Model (Fear Management)**

The extended parallel processing model acknowledges how rational considerations and emotional reactions combine to determine behavioral decisions and thus behavior. In particular it emphasizes the role of perceived threat and perceived control or efficacy. The degree to which an individual feels threatened by an issue related to his or her behavior will determine motivation to

act, while his or her self-efficacy, that is, self-confidence to effectively reduce threat, will determine whether the individual engages in behavior change. As illustrated in the table below, there are four key variables to the extended parallel processing model, two related to threat and two related to efficacy.

| Threat Variable | Efficacy Variable |
|---|---|
| ○ Perceived severity of threat (eg. the consequences contracting HIV are very serious) | ○ Response efficacy (eg. the belief that the proposed solution, such as use of condoms, is effective in preventing HIV infection) |
| ○ Perceived susceptibility (eg. I am at risk of contracting HIV) | ○ Self-efficacy (eg. belief that the proposed solution is feasible for the individual) |

According to this model, fear of risks associated with a certain behavior can create protective actions or self-defeating actions depending on the individual's perceived self-efficacy. When perceptions of threat are strong for example, and perceived levels of efficacy are high, it is more likely that the individual will engage in behavior change and self-protective action. When perceptions of threat are strong but perceived levels of efficacy are low, self-defeating behaviors such as denial or rejection are more likely. The different behaviors resulting from the interaction of perceived threat and perceived efficacy can be seen in the model below:

| | **High Efficacy**<br>*Belief that one is able to avert a threat* | **Low Efficacy**<br>*Belief that one cannot avert a threat, or that averting it would have no effect* |
|---|---|---|
| **High Threat**<br>*Belief that one is at risk of a significantly harmful threat* | **Danger Control:** People take protective action against the threat | **Fear Control:** People are in denial of the threat and react against it |
| **Low Threat**<br>*Belief that a threat is irrelevant and/or trivial* | **Less Danger Control:** People take some protective action but are not significantly motivated | **No Response:** People do not consider the threat to be real or relevant. People may even be unaware that the threat exists |

*Source: Research 101, Health Communication Partnership*

The extended parallel processing model has been successfully used in HIV prevention, particularly with young people by increasing knowledge of risk factors while also educating them about effective ways to reduce threat.

**In Summary**
The extended parallel processing model acknowledges the interaction between the perceived threat linked to a current behavior and perceived efficacy of engaging in an alternative behavior. It emphasizes the importance of increasing knowledge among the target group about the severity and likelihood of the risks associated with a particular behavior, while also educating them about alternative behaviors and how best to adopt them.

## 5) Social Learning Theory

Social learning theory is considered a very complete theory as it addresses the underlying determinants of behavior and suggests different methods to promote change. It has evolved over 50 years with input from several scholars, the most influential being Albert Bandura.

Social learning theory is built on an understanding of the interaction which occurs between an individual and their environment. It recognizes that this interaction is subtle and complex and can be influenced both by structural or social factors. A smoker, for example, is less likely to smoke in an environment where there are regulations against smoking; in this case, behavior would be influenced by a structural factor. Social factors can also affect behavior, and a smoker may be less likely to smoke if surrounded by complaining non-smokers even when no regulations against smoking are in place. In acknowledging the influence of social factors, Bandura pointed to the how environment and behavior constantly interact, highlighting the importance of addressing social norms to promote behavior change.

A further element of social learning theory is that behavior is also influenced by personal cognitive factors which are themselves affected by the environment. Three cognitive factors are considered particularly significant:

1. **Observational learning** indicates the ability to learn by observing others and the rewards received from engaging in different patterns of behavior.
2. **Expectations** refers to the capacity of the individual to anticipate and value the outcome resulting from engaging in a different behavior. For example if a man believes that including his wife in financial decisions of the household will benefit him economically, he is more likely to start discussing financial matters with his wife.
3. **Self-efficacy** is a concept which can be found in other theories and refers to the individual's perception of his or her ability to make the desired change. The promotion of self-efficacy, that is, increasing an individual's belief that they can change, is an important element of behavior change.

The explicit recognition of the dynamic and reciprocal relationship between individual, behavior and environment in the social learning theory avoids the development of simple interventions which focus on individual behavior in isolation from the environment. According to this theory, interventions ought to alter knowledge, understanding, beliefs and skills which affect observational learning, outcome expectations and self-efficacy.

**In Summary**
Overall, social learning theory provides insight into approaches that can be used to improve knowledge and skills for behavior change. It acknowledges the importance of social norms and environmental influences while also providing guidance on how to modify these influences through individual cognitive factors. Social learning theory supports interventions that facilitate change by adapting the environment and developing personal competencies to enable individuals to change their behaviors. Because of the completeness of this theory, it has been used to guide numerous health promotion and behavior change interventions.

### 6) Diffusion of Innovation Theory

Diffusion of innovation refers to the spread of new ideas and has its origins in the examination of how new agricultural technologies were introduced into different settings. Research into the diffusion process in relation to health is mostly attributed to Everett Rogers (1983)who developed the diffusion of innovation theory .

Diffusion is defined as the process by which an innovation is communicated over time and among members of a social system. Innovation refers to an idea, practice or object which is perceived to

be new by an individual. The concept of *perceived* newness is important, as something may be considered an innovation regardless of its first use or discovery.

Diffusion of innovation refers to the processes by which innovations are communicated and adopted. Some individuals and groups in society are quicker to pick up new ideas than others. Young people for example, are typically associated with adopting new trends such as fashion or technology. Rogers developed a classification to categorize adopters according to the speed at which adoption occurs. The following five categories are identified:

- **Innovators –** these represent 2 to 3% of the population and are the quickest to adopt an innovation. However, these may be regarded as fickle by other community members and are less likely to be trusted and thus copied.
- **Early Adopters –** these represent between 10 and 15% of the population. They are more mainstream within the community than innovators, but are characterized by acceptance of innovation and some personal or financial resources which allows them to adopt the innovation.
- **Early Majority –** these represent between 30 and 35% of the population. They are amenable to change and have become persuaded of the benefits of adopting the innovation.
- **Late Majority –** these represent 30 to 35% of the population who are skeptics and reluctant to adopt new ideas until the benefits have been clearly established.
- **Laggards –** these represent 10 to 20% of the population who are seen as most conservative and resistant to change. In some instances they may never change.

Factors that can influence adoption include exposure to the media, age, dominant norms, culture and perceived benefits. Knowing the target community and what is likely to influence their response to an innovation is highlighted by this theory.

Analysis of programs based on the diffusion of innovation theory identified characteristics of innovations which have been consistently associated with successful adoption. These include:

- **Compatibility** of the innovation with prevailing socio-economic and cultural values.
- Presence and clarity of a **relative advantage** of the innovation compared to current practices.
- **Simplicity and flexibility** of the innovation. If the new idea or behavior requires simple actions or can be adapted to different circumstances it will be adopted more easily, for example a nutrition program which does not require the use of new cooking instruments is more likely to succeed than one that requires a change in cooking tools.
- **Reversibility** of the innovation and the **perceived risk** if adopted. Innovations which are perceived as risky (for example myths which associate contraception with in fertility) or innovations which are irreversible (for example vasectomy) are less likely to be adopted.
- **Observability** of the benefits resulting from adoption of the innovation. Testimonials, photographs and accounts of before and after the adoption of a new behavior are all ways of making the benefits of the innovation visible and thus encourage further adoption.

Although it is rare that an innovation meets all the above criteria, an understanding of these elements can help develop behavior change programs.

Finally, the theory of innovation recognizes the importance of an agent of change in the process of diffusion of innovation. Agents of change can be people working in the community or community members who have adopted the new behavior and can act as role models for other

potential adopters. Selection of effective agents of change, such as local leaders, influential individuals and peers can accelerate the adoption of an innovation.

**In Summary**

Diffusion of innovation theory has been tested in a range of settings. It acknowledges that new ideas, objects or practices are adopted gradually by different members of a community depending on their personal characteristics and on the characteristics of the innovation itself. Diffusion of innovation highlights the importance of assessing how and why populations respond to the introduction of new ideas and it acknowledges the important role that can be played by agents of change and positive role models.

# 5. Key Elements and Approaches of the BCC Program

While the challenges from proposal to execution were substantial, this section outlines the key elements and approaches that were found helpful in taking the program through its first two years of implementation.

## 5.1 Root Cause Analysis

As discussed, the original BCC proposal lacked focus, with suggested activities ranging in scope. To address this issue and ensure proper targeting of the intervention, a root cause analysis was carried out at the end of Year 1 which was then used to guide future programming.

Root cause analysis involves asking why a problem exists, and then asking why to the answer or answers generated. Each answer is questioned until no more "whys" can be asked, and the final answer is considered the root cause of the problem.

Root cause analysis proved very helpful to the BCC program in focusing activities and messaging. It was carried out in an interactive workshop where BCC staff and partners SFCG, analyzed the root cause together using their knowledge of the realities on the ground, information from relevant literature and the findings from JHU/CCP's formative research. In this way, the root cause analysis was informed both by practical knowledge of the field and by evidence-based research.

Figure 4 shows the root cause analysis process. The starting question was "why does GBV happen in our communities?" and several answers were suggested, including impunity, lack of education, traditional belief systems and socio-economic challenges. Each of these answers was then questioned further until no more questions could be asked, eventually uncovering the root cause. According to this analysis, it was found that GBV exists in our communities because "men feel valued through behaviors that encourage GBV". As a result, we understood that the focus of our intervention and of our messaging needed to be placed on shifting values around masculinity and around what behaviors are considered worthy of respect.

The BCC program found it very helpful to keep the root cause in mind as this informed both messaging and interventions, all of which aimed to produce environments and attitudes that addressed the root cause. It was also useful when engaging with stakeholders and partners as focusing on the root cause provided guidance for collaborations.

**Figure 4: Root Cause Analysis:**

**Why does GBV happen in our community?**

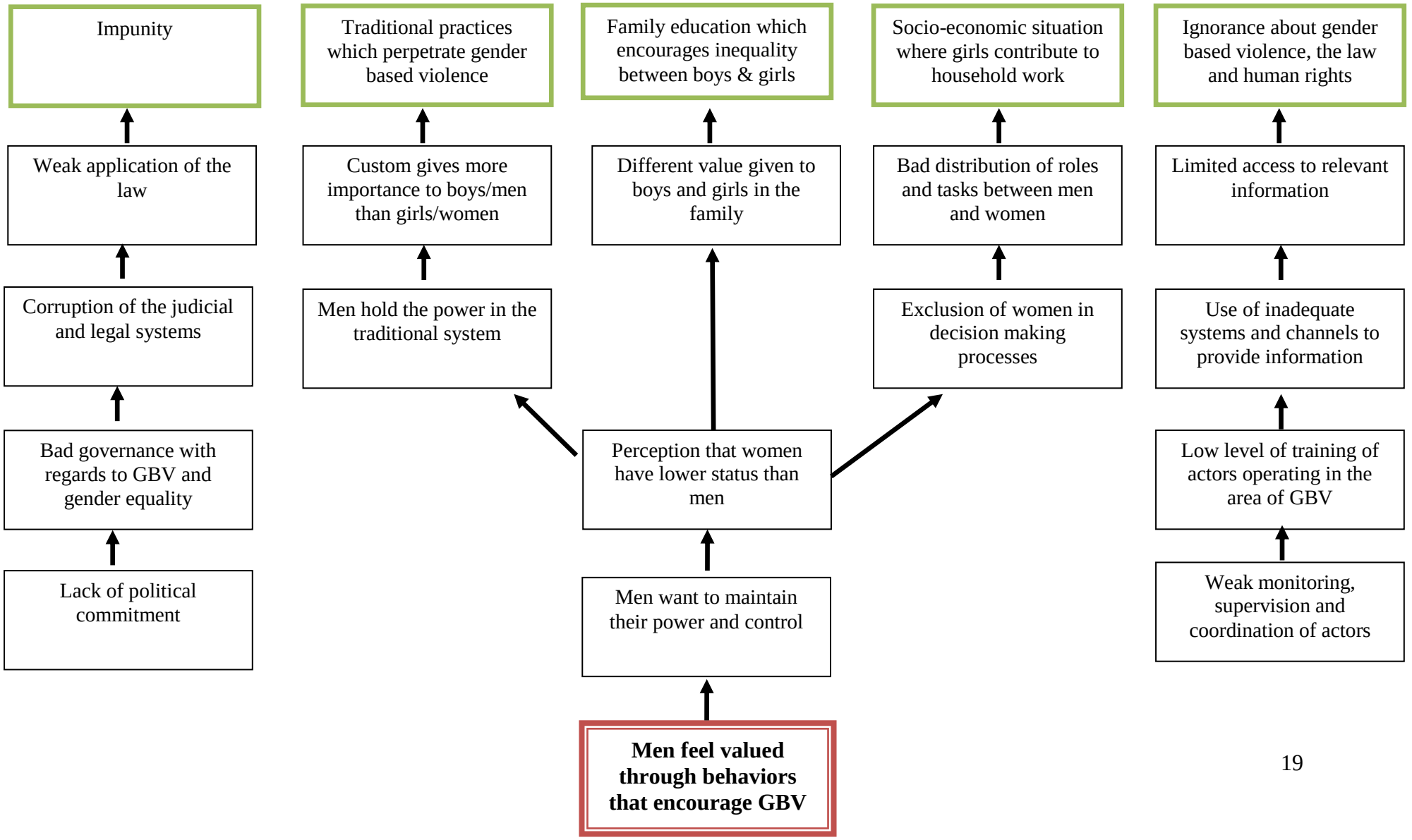

**Table 6: Channels of Communication used in the BCC Program for Different Audience Segments**

| | Primary Audiences | | | | Secondary Audiences | | | | | | | | | | Tertiary Audiences | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Individual | | | | Relations | | | | | | Community | | | | Society | | | | |
| **Communication Channel** | **Young People** | **Adult Men** | **Men in Uniform** | **Survivors of GBV** | **Peers** | **Couples** | **Local Groups** | **Leaders** | **School Community** | **Teachers** | **CBOs** | **Community Facilitators** | **Health Providers** | **Police** | **Military Commanders** | **Local Radio** | **Journalists** | **National Radio** | **Government Partners** | **Advocacy Networks** |
| Small group activities | ■ | ■ | ■ | | | ■ | ■ | ■ | | ■ | ■ | | | ■ | ■ | | | | | |
| Peer education/facilitation | | | | | ■ | | | ■ | | | ■ | ■ | | ■ | ■ | | | | | |
| Development of action plans/activities | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | |
| Participatory theater | ■ | ■ | | | | ■ | | | | | | | | | | | | | | |
| Film screenings | ■ | ■ | ■ | ■ | | ■ | | ■ | | | | | | ■ | ■ | | | | | |
| Other Edutainment | ■ | ■ | ■ | ■ | | ■ | | ■ | | | | | | ■ | ■ | | | | | |
| Celebration of positive role models | ■ | ■ | ■ | | | ■ | | ■ | | | | | | ■ | ■ | | | | | |
| Training | | | ■ | | | | ■ | ■ | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | ■ | ■ |
| Tribunal for Popular Expression | ■ | ■ | | | | ■ | | | | | | | | | | ■ | ■ | | | ■ |
| Local radio programming | ■ | ■ | ■ | ■ | | ■ | ■ | ■ | | | ■ | ■ | | ■ | ■ | ■ | ■ | | | |
| IEC materials | ■ | ■ | ■ | ■ | | | | ■ | | ■ | | | | | ■ | | | | | |
| Radio Spots | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Advocacy partnerships | | | | | | | | | | | ■ | | | | | | | | ■ | ■ |