SOCIAL COGNITIVE THEORY

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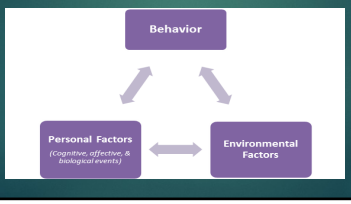
INTRODUCTION

Social Cognitive Theory (SCT) started as the social learning theory (SLT) in the 1960s by Albert bandura. it developed into the SCT in 1986 and posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior.



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Personal factors: knowledge, expectations, attitudes etc.

Environmental factors: social norms, influence on others(ability to change own environment) etc.

Behavioural factors: skills, practice, self-efficacy etc.

- The unique feature of SCT is the emphasis on social influence and its emphasis on external and internal social reinforcement. SCT considers the unique way in which individuals acquire and maintain behavior, while also considering the social environment in which individuals perform the behavior
- The goal of SCT is to explain how people regulate their behavior through control and reinforcement to achieve goal-directed behavior that can be maintained over time.

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DEFINITION OF SOCIAL COGNITIVE THEORY

- According to Bandura (1991), the social cognitive theory is based on the concept that learning is affected by cognitive, behavioral, and environmental factors in contrast to the traditional psychological theories that emphasized learning through direct experience.
- Bandura (1986) posited that virtually all learning phenomena can occur by observing other people's behavior and consequence of it. Looking at what Bandura posited, two forms of social cognitive theory of learning can be deduced. Namely; Enactive and Vicarious learning.
- **Enactive learning** refers to learning which occurs by doing and experiencing the consequences of your actions
- **Vicarious Learning** refers to learning which occurs as a result of observing other person's experience or consequences.

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- Based on the above discussion SCT is a learning theory which has come out on the ideas that people learn by watching what others do, and that human thought processes are central to understanding personality

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CONSTRUCTS OF SOCIAL COGNITIVE THEORY

The first five constructs were developed as part of the SLT; Bandura (1986) added the construct of self-efficacy when the theory evolved into SCT.

- **Reciprocal Determinism** - This is the central concept of SCT. This refers to the dynamic and reciprocal interaction of person (individual with a set of learned experiences), environment (external social context), and behavior (responses to stimuli to achieve goals).
- **Behavioral Capability** - This refers to a person's actual ability to perform a behavior through essential knowledge and skills. In order to successfully perform a behavior, a person must know what to do and how to do it. People learn from the consequences of their behavior, which also affects the environment in which they live.

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- **Observational Learning** - This asserts that people can witness and observe a behavior conducted by others, and then reproduce those actions. This is often exhibited through "modeling" of behaviors. If individuals see successful demonstration of a behavior, they can also complete the behavior successfully.
- **Reinforcements** - This refers to the internal or external responses to a person's behavior that affect the likelihood of continuing or discontinuing the behavior. Reinforcements can be self-initiated or in the environment, and reinforcements can be positive or negative. This is the construct of SCT that most closely ties to the reciprocal relationship between behavior and environment.

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- **Expectations** - This refers to the anticipated consequences of a person's behavior. Outcome expectations can be health-related or not health-related. People anticipate the consequences of their actions before engaging in the behavior, and these anticipated consequences can influence successful completion of the behavior. Expectations derive largely from previous experience. While expectancies also derive from previous experience, expectancies focus on the value that is placed on the outcome and are subjective to the individual.
- **Self-efficacy** - This refers to the level of a person's confidence in his or her ability to successfully perform a behavior. According to Bandura (1986), self-efficacy is the belief in one's capabilities to organize and execute sources of action required to manage prospective situations. Self-efficacy is unique to SCT although other theories have added this construct at later dates, such as the Theory of Planned Behavior. Self-efficacy is influenced by a person's specific capabilities and other individual factors, as well as by environmental factors (barriers and facilitators).

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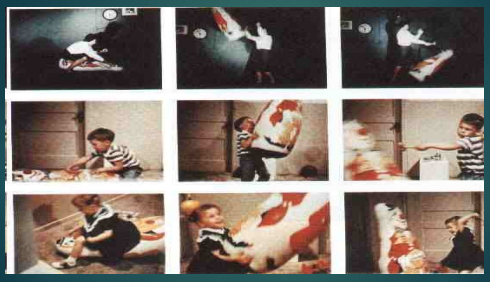
THE BOBO DOLL EXPERIMENT



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- The Bobo Doll Experiment according to Bandura (1988) explains how modelling teaches general rules and strategies for dealing with different situations.
- To illustrate that people, learn from watching others, Bandura, Ross and Ross (1961) constructed a series of experiments using a Bodo doll (inflated toy). They used 72 students from Stanford University Nursery School varying in age 3 to 6 years and divided them into two groups namely; experimental group and the control group. The experimental group was made up of 48 students in which 24 students were exposed to an aggressive model and 24 students exposed to a non-aggressive model. The control group was also made up of 24 students.

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CONT'D OF THE EXPERIMENT

MODELING:

- Stage 1. 24 students (12 boys and 12 girls) watched a male or female model behaving aggressively towards a Bobo doll for 10 minutes. The adults attacked the Bobo doll in a distinctive manner-they used hammer in some cases, and in others threw the Bobo doll in the air
- Stage 2. Another 24 students (12 boys and 12 girls) were exposed to a non-aggressive model that played with the doll in a quiet and subdued manner for 10 minutes.
- Stage 3. The final 24 students (12 boys and 12 girls) were used as a control group and not exposed to any model at all.

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STOP AND THINK

Does the violence that children observe on television, movies and videos games lead them to behave aggressively?

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CONT'D OF THE EXPERIMENT.

RESULTS:

Bandura, Ross and Ross (1961) found out that, at the absence of the models:

- Children who were exposed to the aggressive model performed aggressive behaviours towards the Bobo doll while those in the non-aggressive model played with the doll.
- The girls in the aggressive model showed more physical aggressive responses if the model was a male but more verbal aggressive response if the model was female.
- Boys imitated more physical aggressive acts than girls

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STRENGTHS OF SOCIAL COGNITIVE THEORY

According to Hurst (2014), the following are the strengths of the social cognitive theory:

- A great deal of learning occurs from watching.
- People have considerable control over beaviour of learning.

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LIMITATIONS OF SOCIAL COGNITIVE THEORY

According to Flamand (2014), the following are the limitations of the social cognitive theory:

- The theory is loosely organized, based solely on the dynamic interplay between person, behavior, and environment. It is unclear the extent to which each of these factors into actual behavior and if one is more influential than another.
- The theory heavily focuses on processes of learning and in doing so disregards biological and hormonal predispositions that may influence behaviors, regardless of past experience and expectations.

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- The theory does not focus on emotion or motivation, other than through reference to past experience. There is minimal attention on these factors.
- The theory assumes that changes in the environment will automatically lead to changes in the person, when this may not always be true.
- Assumes that all behaviour is as a results of modeling not genetic, illness or other influences.

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CLASSROOM IMPLICATION OF SOCIAL COGNITVE THEORY

- Teachers must set goals for students to accomplish and help them to take records of these accomplishments. Once a while, take the record and celebrate their hard work. For example: Pictures made by students can be pasted in the classroom so that once a while teacher refer to them when teaching.
- As teachers we must be cautious of how we react to situations in the classroom since students learn from what they see and imitate accordingly.

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- There can be many forms of non-verbal communication in the classroom
  - Students can learn from the teachers and peers that certain symbols mean certain things. For example: thumbs up means "good job" and holding two figures in the air may be the teacher's symbol for "quiet".
  - Students learn that stress, intonation, body movement, personal space issues and eye contact are all part of non-verbal communication.
- Teacher can apply this theory using technology by having students watch a step by step how to video. For example: they can observe how to create a paper flower and then after watching the video create one themselves using the information that was provided for them on the video.

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- Teaching and learning should be more of practical for students to view and appreciate various concepts taught.

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OPINION

We agree with Bandura, that social cognitive theory is a way in which children learn how to behave thus: By observing what elders do or peers we tend to imitate them. For this reason, when children are young we try not to expose them to people who may say or do inappropriate things around them because they may pick up on them and repeat them.

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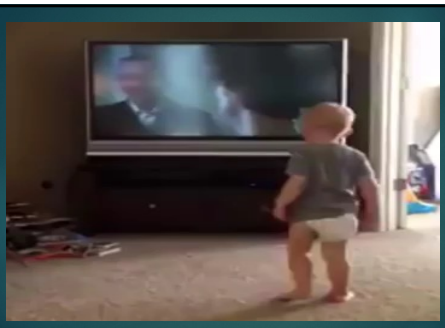

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THANK YOU!

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REFERENCES

Bandura, A., Ross, D., & Ross, S. (1961). Transmission of aggression through imitation of aggressive models. *Journal of Abnormal and Social Psychology, 63*(12), 575–582.

Bandura, A. (1986). *Social foundations of thought and action*. Upper Saddle River, NJ: Prentice Hall

Bandura, A. (1988). Organizational application of social cognitive theory. *Australian Journal of Management, 13* (2): 275–302

Bandura, A. (1991). Social cognitive theory of self-regulation. *Organizational Behavior and Human Decision Processes, 50*(2), 248-287

Flamand, L. (2014). *Limitations of social cognitive theory*. Retrieved from http://www.ehow.com/about_5421206_limitations-social-cognitive-theory.html

Hurst, M. (2014). *Social-cognitive learning theory: Definition and examples*. Retrieved from http://education-portal.com/academy/lesson/social-cognitive-learning-theory-definition-and-examples.html#lesson

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Theory of Planned Behavior

The Theory of Planned Behavior (TPB) started as the Theory of Reasoned Action in 1980 to predict an individual's intention to engage in a behavior at a specific time and place.

The theory was intended to explain all behaviors over which people have the ability to exert self-control.

The key component to this model is behavioral intent; behavioral intentions are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome.

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The TPB has been used successfully to predict and explain a wide range of health behaviors and intentions including smoking, drinking, health services utilization, breastfeeding, and substance use, among others.

The TPB states that behavioral achievement depends on both motivation (intention) and ability (behavioral control). It distinguishes between three types of beliefs - behavioral, normative, and control.

The TPB is comprised of six constructs that collectively represent a person's actual control over the behavior.

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- Attitudes - This refers to the degree to which a person has a favorable or unfavorable evaluation of the behavior of interest. It entails a consideration of the outcomes of performing the behavior.
- Behavioral intention - This refers to the motivational factors that influence a given behavior where the stronger the intention to perform the behavior, the more likely the behavior will be performed.
- Subjective norms - This refers to the belief about whether most people approve or disapprove of the behavior. It relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behavior.

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- Social norms - This refers to the customary codes of behavior in a group or people or larger cultural context. Social norms are considered normative, or standard, in a group of people.
- Perceived power - This refers to the perceived presence of factors that may facilitate or impede performance of a behavior. Perceived power contributes to a person's perceived behavioral control over each of those factors.
- Perceived behavioral control - This refers to a person's perception of the ease or difficulty of performing the behavior of interest. Perceived behavioral control varies across situations and actions, which results in a person having varying perceptions of behavioral control depending on the situation. This construct of the theory was added later, and created the shift from the Theory of Reasoned Action to the Theory of Planned Behavior.

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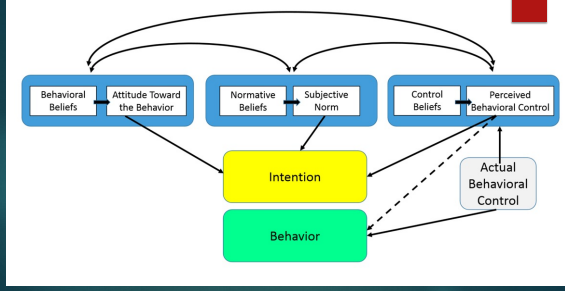

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Limitations of the Theory of Planned Behavior

- It assumes the person has acquired the opportunities and resources to be successful in performing the desired behavior, regardless of the intention.
- It does not account for other variables that factor into behavioral intention and motivation, such as fear, threat, mood, or past experience.
- While it does consider normative influences, it still does not take into account environmental or economic factors that may influence a person's intention to perform a behavior.
- It assumes that behavior is the result of a linear decision-making process, and does not consider that it can change over time.

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- While the added construct of perceived behavioral control was an important addition to the theory, it doesn't say anything about actual control over behavior.
- The time frame between "intent" and "behavioral action" is not addressed by the theory.

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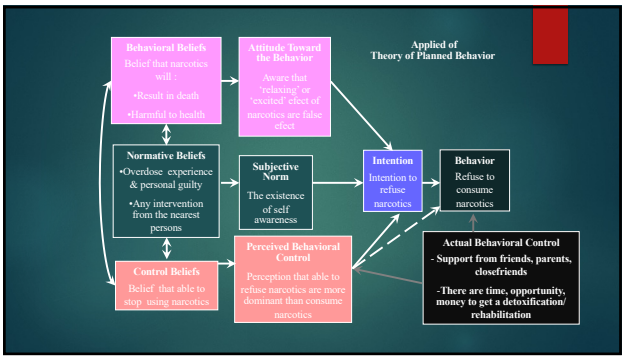

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Diffusion of Innovation Theory

- Diffusion of Innovation (DOI) Theory, developed by E.M. Rogers in 1962, is one of the oldest social science theories. It originated in communication to explain how, over time, an idea or product gains momentum and diffuses (or spreads) through a specific population or social system.
- The end result of this diffusion is that people, as part of a social system, adopt a new idea, behavior, or product.
- Adoption means that a person does something differently than what they had previously (i.e., purchase or use a new product, acquire and perform a new behavior, etc.). The key to adoption is that the person must perceive the idea, behavior, or product as new or innovative. It is through this that diffusion is possible.

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- Adoption of a new idea, behavior, or product (i.e., "innovation") does not happen simultaneously in a social system; rather it is a process whereby some people are more apt to adopt the innovation than others.
- Researchers have found that people who adopt an innovation early have different characteristics than people who adopt an innovation later.
- When promoting an innovation to a target population, it is important to understand the characteristics of the target population that will help or hinder adoption of the innovation.
- There are **five established adopter categories**, and while the majority of the general population tends to fall in the middle categories, it is still necessary to understand the characteristics of the target population. When promoting an innovation, there are different strategies used to appeal to the different adopter categories.

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1. Innovators - These are people who want to be the first to try the innovation. They are venturesome and interested in new ideas. These people are very willing to take risks, and are often the first to develop new ideas. Very little, if anything, needs to be done to appeal to this population.
2. Early Adopters - These are people who represent opinion leaders. They enjoy leadership roles, and embrace change opportunities. They are already aware of the need to change and so are very comfortable adopting new ideas. Strategies to appeal to this population include how-to manuals and information sheets on implementation. They do not need information to convince them to change.
3. Early Majority - These people are rarely leaders, but they do adopt new ideas before the average person. That said, they typically need to see evidence that the innovation works before they are willing to adopt it. Strategies to appeal to this population include success stories and evidence of the innovation's effectiveness.
4. Late Majority - These people are skeptical of change, and will only adopt an innovation after it has been tried by the majority. Strategies to appeal to this population include information on how many other people have tried the innovation and have adopted it successfully.
5. Laggards - These people are bound by tradition and very conservative. They are very skeptical of change and are the hardest group to bring on board. Strategies to appeal to this population include statistics, fear appeals, and pressure from people in the other adopter groups.

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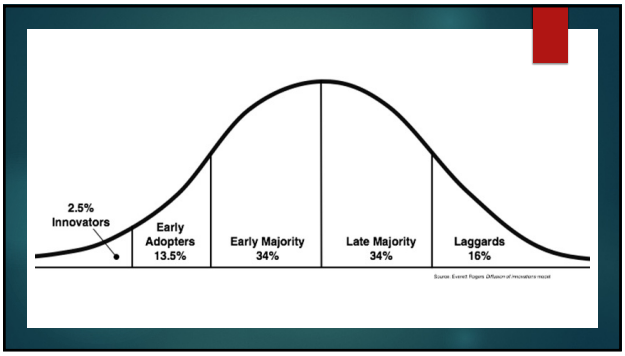

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- The stages by which a person adopts an innovation, and whereby diffusion is accomplished, include awareness of the need for an innovation, decision to adopt (or reject) the innovation, initial use of the innovation to test it, and continued use of the innovation. There are **five main factors that influence adoption of an innovation**, and each of these factors is at play to a different extent in the five adopter categories.

1. Relative Advantage - The degree to which an innovation is seen as better than the idea, program, or product it replaces.
2. Compatibility - How consistent the innovation is with the values, experiences, and needs of the potential adopters.
3. Complexity - How difficult the innovation is to understand and/or use.
4. Triability - The extent to which the innovation can be tested or experimented with before a commitment to adopt is made.
5. Observability - The extent to which the innovation provides tangible results.

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Limitations of Diffusion of Innovation Theory

- Much of the evidence for this theory, including the adopter categories, did not originate in public health and it was not developed to explicitly apply to adoption of new behaviors or health innovations.
- It does not foster a participatory approach to adoption of a public health program.
- It works better with adoption of behaviors rather than cessation or prevention of behaviors.
- It doesn't take into account an individual's resources or social support to adopt the new behavior (or innovation).

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- This theory has been used successfully in many fields including communication, agriculture, public health, criminal justice, social work, and marketing.
- In public health, Diffusion of Innovation Theory is used to accelerate the adoption of important public health programs that typically aim to change the behavior of a social system. For example, an intervention to address a public health problem is developed, and the intervention is promoted to people in a social system with the goal of adoption (based on Diffusion of Innovation Theory). The most successful adoption of a public health program results from understanding the target population and the factors influencing their rate of adoption.

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Cognitive Dissonance Theory (Festinger)

DEFINATION

- *Cognitive dissonance* refers to a situation involving *conflicting attitudes*, beliefs or behaviors.
- This produces a *feeling of discomfort* leading to an alteration in one of the attitudes, beliefs or behaviors to reduce the discomfort and restore balance etc.
- For example, when people smoke (behavior) and they know that smoking causes cancer (cognition).

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Festinger's (1957)

- cognitive dissonance theory suggests that we have an inner drive to hold all our attitudes and beliefs in harmony and avoid disharmony (or dissonance).
- Attitudes may change because of factors within the person.
- An important factor here is the principle of cognitive consistency, the focus of Festinger's (1957) theory of cognitive dissonance.
- This theory starts from the idea that we seek consistency in our beliefs and attitudes in any situation where two cognitions are inconsistent.

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Leon Festinger (1957)

- Proposed cognitive dissonance theory, which states that a powerful motive to maintain cognitive consistency can give rise to irrational and sometimes maladaptive behavior.
- According to Festinger, we hold many cognitions about the world and ourselves; when they clash, a discrepancy is evoked, resulting in a state of tension known as cognitive dissonance. As the experience of dissonance is unpleasant, we are motivated to reduce or eliminate it, and achieve consonance (i.e. agreement).
- Cognitive dissonance was first investigated by Leon Festinger, arising out of a participant observation study of a cult which believed that the earth was going to be destroyed by a flood, and what happened to its members — particularly the really committed ones who had given up their homes and jobs to work for the cult — when the flood did not happen.
- While fringe members were more inclined to recognize that they had made fools of themselves and to "put it down to experience", committed members were more likely to re-interpret the evidence to show that they were right all along (the earth was not destroyed because of the faithfulness of the cult members).

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Eliminate Dissonance

- 1) Reduce the importance of the dissonant beliefs,
- 2) Add more consonant beliefs that outweigh the dissonant beliefs,
- 3) Change the dissonant beliefs so that they are no longer inconsistent.
- Dissonance occurs most often in situations where an individual must choose between two incompatible beliefs or actions.
- The greatest dissonance is created when the two alternatives are equally attractive. Furthermore, attitude change is more likely in the direction of less incentive since this results in lower dissonance.
- In this respect, dissonance theory is contradictory to most behavioral theories which would predict greater attitude change with increased incentive.

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Example

- Consider someone who buys an expensive car but discovers that it is not comfortable on long drives.
- Dissonance exists between their beliefs that they have bought a good car and that a good car should be comfortable.
- Dissonance could be eliminated by deciding that it does not matter since the car is mainly used for short trips (reducing the importance of the dissonant belief) or focusing on the cars strengths such as safety, appearance, handling (thereby adding more consonant beliefs).
- The dissonance could also be eliminated by getting rid of the car, but this behavior is a lot harder to achieve than changing beliefs.

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Principles

- Dissonance results when an individual must choose between attitudes and behaviors that are contradictory.
- Dissonance can be eliminated by reducing the importance of the conflicting beliefs, acquiring new beliefs that change the balance, or removing the conflicting attitude or behavior.

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- **Example 1:** Knowing that smoking is harmful (First cognition) while liking to smoke (second cognition). The Cognitive dissonance theory's conditions were met because those cognitions are dissonant
- **Example 2:** Believing that lying is bad (First cognition) and being forced to lie (second cognition)
- **Example 3:** Liking a friend (first cognition) while knowing that he hates your brother (second cognition)

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Cognitive Dissonance Theory And Adaption

- People adapt to Cognitive dissonance in different ways.
- For example a person might adapt by creating a new cognition, a second may adapt by changing his attitude and a third may adapt by changing his behavior.
- In the next few lines I will give some examples for adaptation according to the Cognitive dissonance theory based on the previous three examples.
- **Example 1:** In such a case a person could create a new cognition by claiming that lots of old people smoke since they were young and they are still healthy
- **Example 2:** In this case the person might change his behavior by not lying or even change his attitude by claiming that he believes in the lie
- **Example 3:** In such a case the person can claim that his friend doesn't like his brother because he didn't have time to know him well.

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ASSUMPTIONS

1. Humans are sensitive to inconsistencies between actions and beliefs.
2. Recognition of this inconsistency will cause dissonance, and will motivate an individual to resolve the dissonance.
3. Dissonance will be resolved in one of three basic ways:
   a. Change beliefs
   b. Change actions
   c. Change perception of action

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1) Dissonance will be resolved in one of three basic ways:

- *Change beliefs*
  - Perhaps the simplest way to resolve dissonance between actions and beliefs is simply to change your beliefs.
  - You could, of course, just decide that cheating is o.k.
  - This would take care of any dissonance.
  - However, if the belief is fundamental and important to you such a course of action is unlikely.
  - Moreover, our basic beliefs and attitudes are pretty stable, and people don't just go around changing basic beliefs/attitudes/opinions all the time, since we rely a lot on our world view in predicting events and organizing our thoughts.
  - Therefore, though this is the simplest option for resolving dissonance it's probably not the most common.

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- *Change actions*
  - A second option would be to make sure that you never do this action again.
  - Lord knows that guilt and anxiety can be motivators for changing behavior. So, you may say to yourself that you will never cheat on a test again, and this may aid in resolving the dissonance.
  - However, aversive conditioning (i.e., guilt/anxiety) can often be a pretty poor way of learning, especially if you can train yourself not to feel these things. Plus, you may really benefit in some way from the action that's inconsistent with your beliefs.
  - So, the trick would be to get rid of this feeling without changing your beliefs or your actions, and this leads us to the third, and probably most common, method of resolution.

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- *Change perception of action*
  - A third and more complex method of resolution is to change the way you view/remember/perceive your action.
  - In more colloquial terms, you would "rationalize" your actions. For example, you might decide that the test you cheated on was for a dumb class that you didn't need anyway.
  - Or you may say to yourself that everyone cheats so why not you? In other words, you think about your action in a different manner or context so that it no longer appears to be inconsistent with your beliefs.
  - If you reflect on this series of mental gymnastics for a moment you will probably recognize why cognitive dissonance has come to be so popular.
  - If you're like me, you notice such post-hoc reconceptualization's (rationalizations) of behavior on the part of others all the time, though it's not so common to see it in one's self.

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Force field Theory (Kurt Lewin)

KURT LEWIN
(German psychologist)

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Field

- A Field is a psychological concept.
- Every individual has his own field of ***perception*** and ***field forces***.
- Field consist of a person and his psychological environment.
- Psychological environment implies the mental world in which a person lives at a defined moment of his life.

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Important concepts in field theory

- ✓ **Life space**
- ✓ **Foreign Hull**
- ✓ **Topology**
- ✓ **Vector**
- ✓ **Valence**
- ✓ **Conflict**
- ✓ **Locomotion**
- ✓ **Barriers**

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LIFE SPACE

- **Life space is a psychological representation of individual's environment**.
- The life space includes the person himself and everything in his environment that influence his behavior.
- It includes both the things of which he is consciously aware and the factors which influence him even though he is unconscious of them .

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✓It includes the persons , his drives, motives, believes, tensions, thoughts, feelings and his physical environment which consist of perceived objects and events.

✓ The life spaces of two persons in an identical situation maybe entirely different .

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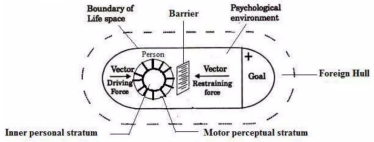
A Person in Life Space



The person is often represented as a points moving about in his life. Psychologically a person is composed of two components

- Motor perceptual stratum(abilities)
- Inner personal stratum(needs)

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Foreign Hull

• The life space is surrounded by a non psychological boundary called ***foreign hull.***

Topology

• Topology is non-metrical geometry which includes concepts such as inside, outside and boundary.

Vector

• ***In field psychology, a vector means a force that is influencing psychological movement towards or away from a goal***

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Valences

• Valences are the attracting or repelling powers of regions.

➢ Objects may have either positive or negative valence. The movement of person is decided by the valence of the goal.

• ***POSITIVE VALENCE:*** *The object or goal which satisfy needs or are attractive to the person.*

• ***NEGATIVE VALENCE:*** *The object or goal which threatens the individual or are repulsive to the person.*

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Conflicts

It is the state of tensions brought in by the presence of two opposing desires in the individual .

- If only one vector impelling upon the individual, he will move in the direction indicated by the vector .
- If two equally balanced vectors are operating , the result is a conflict.
- As the person is influenced by several valences at a time, these give rise to conflicts.

• There are three types of conflicts

✓Approach- approach conflict

✓Approach – avoidance conflict

✓Avoidance- avoidance conflict

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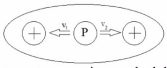
Approach- Approach conflict

• It arises when the person is caught in between two goals both having positive valences.

• ***It is a conflict between two positive goals which are equally attractive.***



• Eg: 1. A Person who wants to go two marriages scheduled at the same time.
2. A person who wants to choose a course after completing degree.

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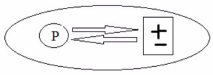
Approach-Avoidance conflict

- It arises when the person is caught in between a positive and a negative goal.
- ***The same object has strong positive valence as well as negative valence.***



- Eg: Smoking, alcohol consumption etc. is enjoyable, but they are threat to health.

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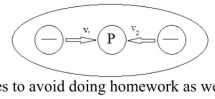
Avoidance-Avoidance conflict

- It arises when a person is caught in between two goals both having negative valences. The person is like ***"caught in between devil and sea".***



- Eg: A student who desires to avoid doing homework as well as the punishment from the teacher.

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Locomotion

- Locomotion in life space is delineated by a geometrical representation of the selection of alternative, the examining of possibilities , the setting out towards the goal.
- ***"Learning takes place as a result of locomotion from one region of life space to another. When a person moves from one region to another, the structure of life space undergoes change".***

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BARRIERS

A barrier is a psychological obstruction.

- They restrict the person's movement towards the goal, and the path he must follow to reach his goal.
- It may be objects, people, social codes anything which threatens the motivated individual as he is moving towards a goal.

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According to the field theory proposed by Kurt Lewin,

"Learning is a process of perceptual organization or reorganization of one's life space involving insight and emphasizes on behavior and motivation in learning".

According to this theory, the behavior(B) of an individual is a function of interacting person(P) in the total psychological environmental situation(E)

i.e. B = f(P,E)

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Maslow's Need Hierarchy

- Maslow's theory assumes that a person attempts to satisfy the more basic needs before directing behavior toward satisfying upper-level needs.
- Lower-order needs must be satisfied before a higher-order need begins to control a person's behavior.
- A satisfied need ceases to motivate.

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Physiological Needs

Physiological needs are those required to sustain life, such as:

- *Air*
- *Water*
- *Food*
- *Sleep*

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Safety Needs

Once physiological needs are met, one's attention turns to safety and security in order to be free from the threat of physical and emotional harm. Such needs might be fulfilled by:

- *Living in a safe area*
- *Medical insurance*
- *Job security*
- *Financial reserves*

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Social Needs

Once a person has met the lower level physiological and safety needs, higher level needs awaken. The first level of higher level needs are social needs.

Social needs are those related to interaction with others and may include:

- *Friendship*
- *Belonging to a group*
- *Giving and receiving love*

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Esteem Needs

Once a person feels a sense of "belonging", the need to feel important arises. Esteem needs may be classified as internal or external.

Internal esteem needs are those related to self-esteem such as self respect and achievement

External esteem needs are those such as social status and recognition. Some esteem needs are:

- *Self-respect*
- *Achievement*
- *Attention*
- *Recognition*
- *Reputation*

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Self-Actualization

Self-actualization is the summit of Maslow's hierarchy of needs. It is the quest of reaching one's full potential as a person.

Self-actualized people tend to have needs such as:

- Truth
- Justice
- Wisdom
- Meaning

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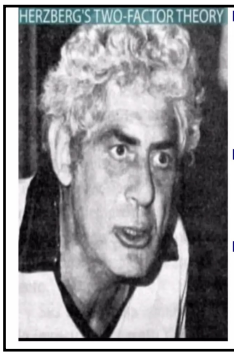
The Criticisms of the theory include the following

- The needs may not follow a definite hierarchical order. For example, even if safety need is not satisfied, the social need may emerge.
- The need priority model may not apply at all times in all places.
- The level of motivation may be permanently lower for some people. For example, a person suffering from chronic unemployment may remain satisfied for the rest of his life if only he get enough food.

77



- The two-factors theory (also known as Herzberg's motivation-hygiene factors theory)
- It was developed by American Psychologist -behavioural scientist- **Frederick Herzberg**
- He was interested in helping managers find out how to offer that **balance** between employee satisfaction and motivation .

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Cont' Introduction

- Herzberg's was interested in the relation between employee attitude and workplace motivation.
- He want to find out what make people satisfied and un-satisfied when they came to the workplace .
- Theory explored the factors that make employees feel satisfied or dissatisfied in the workplace.
- In 1959, he published his conclusions in a Book called the motivation to work

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Cont' Introduction

- The theory consists of two factors:

1. **Hygiene factors** - (also called dissatisfiers) and also can create job dissatisfaction . Herzberg described hygiene factors as **extrinsic** to the job . Examples pay quality company rules and worker relationships .
2. **Motivators factor** - can create job satisfaction . Herzberg described motivation factors as **intrinsic** to the job .Examples promotion, personal growth , responsibility acknowledgement and achievement

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Origins of the theory

- Was influenced by Maslow's hierarchy of needs.
- Herzberg produced a two dimensional model of factors influencing people's attitudes towards job.
- In the beginning Herzberg developed a hypothesis that satisfaction and dissatisfaction with a work were affected by two different sets of factors.
- Researches on job satisfaction were implemented to select which factors in an employee's **work environment** caused satisfaction or dissatisfaction.
- After two pilot studies, Herzberg theory was additional developed and extended.

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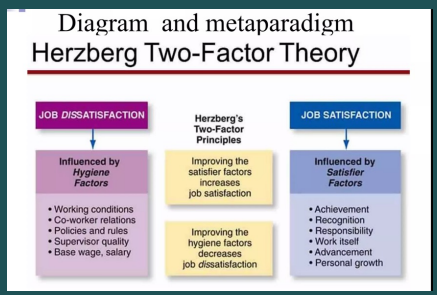
Diagram and metaparadigm
Herzberg Two-Factor Theory



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Usefulness

- Herzberg's theory continues to be used to determine the level of job satisfaction in research in a variety of international settings.
- many studies in nursing populations utilized. Also several have used it as a conceptual framework (i.e., Kacel *et al.*, 2005; Lephalala, 2006; Mitchell, 2009; Jones, 2011)).

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PRECEDE-PROCEED (L.Green)

84

Brief History

- The PRECEDE framework was first developed and introduced in the 1970s by Green and colleagues.
- PRECEDE is based on the basis that, just as a medical diagnosis precedes a treatment plan, **an educational diagnosis of the problem is very essential before developing and implementing the intervention plan**.

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- In 1990, PRECEDE-PROCEED was model added to the framework in consideration of the growing recognition of the expansion of health education to encompass policy, regulatory and related ecological/environmental factors in determining health and health behaviors.
- As health-related behaviors such as smoking and alcohol abuse increased or became more resistant to change, so did the recognition that these behaviors are influenced by factors such as the media, politics, and businesses, which are outside the direct control of the individuals.

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PRECEDE-PROCEED (L. Green)

- It provides a comprehensive structure for assessing health and quality of life needs and for designing, implementing, and evaluating health promotion and other public health programs to meet those needs.
- It guides planners through a process that starts with desired outcomes and then works backwards in the causal chain to identify a mix of strategies for achieving those objectives.
- In this framework, health behavior is regarded as being influenced by both individual and environmental factors, and hence has two distinct parts.

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First is an "educational diagnosis"

P R E C E D E

- Predisposing
- Reinforcing
- Enabling
- Constructs in
- Educational
- Diagnosis
- Evaluation

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Second is an "ecological diagnosis"

P R O C E E D

- Policy
- Regulatory
- Organizational
- Constructs
- Educational
- Environmental
- Development

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The model is multidimensional and is founded in the social/behavioral sciences, epidemiology, administration, and education.

It has main two principles;

1. Health behaviour should be in voluntary. It should come from individual/group
2. Health behaviour is affected by environmental factor like predisposing, policy or enabling factor

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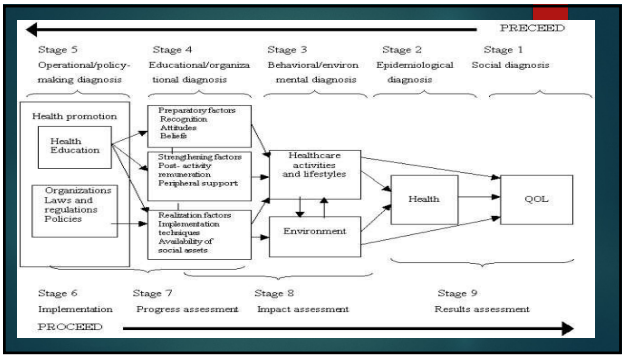

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PHASE 1 – SOCIAL DIAGNOSIS

- The first stage in the program planning phase deals with identifying and evaluating the social problems that have an impact on the quality of life of a population of interest.
- During this stage, the program planners try to gain an understanding of the social problems that affects the quality of life of the community and its members, their strengths, weaknesses, and resources; and their readiness to change.

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Methods used for social diagnosis may be one or more of the following:

- Community Forums
- Nominal Groups
- Focus Groups
- Surveys
- Interviews
- Central location intercept

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PHASE 2 – EPIDEMIOLOGICAL DIAGNOSIS

Epidemiological Diagnosis helps determine health issues associated with the quality of life.

- The focus of this phase is to identify specific health problem and non health factors which are associated with a poor quality of life.
- Epidemiological assessment may include secondary data analysis or original data collection.
- From phase 1 and 2 program objectives are created - that is the goal or goals you hope to achieve as a result of implementing this program.

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Phase 3 - BEHAVIORAL AND ENVIRONMENTAL DIAGNOSIS

BEHAVIORAL DIAGNOSIS

- This is the analysis of behavioral links to the goals or problems that are identified in the social or epidemiological diagnosis.
- Firstly, The behavioral ascertainment (fact finding) of a health issue is understood firstly through those behaviors that exemplify the severity of the disease
- Secondly, through the behavior of the individual who directly affect the individual.

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BEHAVIORAL DIAGNOSIS

- Thirdly, through the actions of the decision- makers that affects the environment of the individuals at risk, such as law enforcement actions that restrict the teen's access to cigarettes.
- Once behavioral diagnosis is completed for each health problem identified, the planner is able to develop more specific and effective interventions.

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ENVIRONMENTAL DIAGNOSIS

- This is a parallel analysis of social and physical environmental factors other than specific actions that could be linked to behaviors. In this assessment, environmental factors beyond the control of the individual are modified to influence the health outcome.
- For example, poor nutritional status among school children may be due to the availability of unhealthful foods in school.

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Phase 4 - EDUCATIONAL DIAGNOSIS

- Once the behavioral and environmental factors are identified and interventions are selected, **planners can start to work on selecting factors that if modified will be most likely to result in behavior change, and can sustain this change process.**
- These factors **are classified as predisposing factors, enabling factors, and reinforcing factors**

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Phase 4 - EDUCATIONAL DIAGNOSIS

- **Predisposing** factors include knowledge, attitudes, beliefs, personal preferences, existing skills, and self-efficacy towards the desired behavior change.
- **Reinforcing** factors include factors that reward or reinforce the desired behavior change, including social support, economic rewards, and changing social norms.
- **Enabling** factors are skills or physical factors such as availability and accessibility of resources, or services that facilitate achievement of motivation to

99

Phase 5 - ADMINISTRATIVE AND POLICY DIAGNOSIS

- This phase focuses on the administrative and organizational concerns, which must be addressed prior to program implementation.
- This includes assessment of resources, development and allocation of budget, looking at organizational barriers, and coordination of the program with all other departments, including external organizations and the community. These are detailed further in Green & Ottoson.

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Phase 5 - ADMINISTRATIVE AND POLICY DIAGNOSIS

- **Administrative Diagnosis** assess policies, resources, circumstances, prevailing organizational situations that could hinder or facilitate the development of the health program.
- **Policy Diagnosis** assesses the compatibility of the program goals and objectives with those of the organization and its administration. This evaluates whether the program goals fit into the mission statements, rules and regulations that are needed for the implementation and sustainability of the program.

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Phase 6 - IMPLEMENTATION OF THE PROGRAM

Health promotional intervention
Group
Mass
Individual

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Phase 7 - PROCESS EVALUATION

- It is used to evaluate the process by which the program is being implemented.
- It also helps identify modifications that may be needed to improve the program.

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Phase 8 - IMPACT EVALUATION

- It measures the effectiveness of the program with regards to the intermediate objectives as well as the changes in predisposing, enabling, and reinforcing factors.
- Often this phase is used to evaluate the performance of educators.

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Phase 9 - OUTCOME EVALUATION

- It measures change in terms of overall objectives and **changes in health and social benefits or the quality of life**.
- That is, it determines the effect the program had in the health and quality of life of the community.

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Conclusion

- PRECEDE-PROCEED model is a participatory model for creating successful community health promotion and other public health interventions.
- It is based on the premise that behavior change is by and large voluntary, and that health programs are more likely to be effective if they are planned and evaluated with the active participation of those people who will have to implement them, and those who are affected by them.

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Conclusion

- Thus health and other issues must be looked at in the context of the community.
- Interventions designed for behavior change to help prevent injuries and violence, improve heart-healthy behaviors, and those to improve and increase scholarly productivity among health education faculty are among the more than 1000 published applications that have been developed or evaluated that use the Precede-Proceed model as a guideline.

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HEALTH BELIEF MODEL

- The **health belief model** (**HBM**) is a social psychological health behaviour change model developed to explain and predict health-related behaviours, particularly in regard to the uptake of health services.

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AN OVERVIEW OF THE MODEL:

- The HBM was developed in the **1950s** by **social psychologists at the U.S public health service** and remains one of the best known and most widely used theories in health behaviour research.
- The HBM suggests that people's beliefs about **health problems, perceived benefits of action and barriers to action, and self-efficacy** explain engagement (or lack of engagement) in health-promoting behaviour.
- A stimulus, or **cue to action**, must also be present in order to trigger the health-promoting behaviour

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HISTORY

- One of the first theories of health behaviour, the HBM was developed in the 1950s by **social psychologists Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegel's, and Howard Leventhal at the U.S. Public Health Service**.
- At that time, researchers and health practitioners were worried because few people were getting screened for tuberculosis(TB), even if mobile X-Ray cars went to neighbourhoods.

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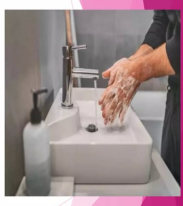
TWO CONCEPTS OF HBM

- Two components of health-related behaviour are:

1) **The desire to avoid illness, or conversely get well if already ill**

2) The belief that a specific health action will prevent, or cure, illness.



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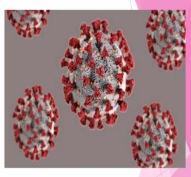
CONSTRUCTS OF HEALTH BELIEFE MODEL

- There are six constructs of the HBM.

1. **PERCIEVED SUSCEPTIBILITY**
2. **PERCIEVED SEVERITY**
3. **PERCIEVED BENEFITS TO ACTION**
4. **PERCIEVED BARRIERS**
5. **CUES TO ACTION**
6. **PERCEIVED SELF-EFFICACY**



- The first four constructs were developed as the original tenets of the HBM. The last two were added as research about the HBM evolved.

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PERCEIVED SUSCEPTIBILITY

- Perceived susceptibility refers to subjective assessment of risk of developing a health problem.
- The HBM predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviors to reduce their risk of developing the health problem.
- Individuals with low perceived susceptibility may deny that they are at risk for contacting a particular illness

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- **For example:**

The citizens who are having the perception of being affected by novel corona virus if social distancing is not maintained strictly, they are adopting that health behaviour of social distancing, whereas some people with low perceived susceptibility are not maintaining that kind of health behaviour.

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Perceived severity

- Perceived severity refers to the subjective assessment of the **severity** or the seriousness of a health problem and its potential **consequences.**
- The HBM proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health problem from occurring (or reduce its severity).
- **For instance**, an individual may perceive that novel corona is not medically serious, but if he or she perceives that novel corona disease is having much more serious consequences world wide, that engages people in behaviors to prevent this current health problem.

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PERCEIVED BENEFITS

- Health-related behaviors are also influenced by the perceived benefits of taking action.
- **Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behavior to decrease risk of disease.**
- If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behavior
- **For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer.**

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PERCIEVED BARRIERS

- **This refers to a person's feelings on the obstacles to performing a recommended health action.**
- **There is wide variation in a person's feelings of barriers, or impediments, which lead to a cost/benefit analysis.**
- **The person weighs the effectiveness of the actions against the perceptions that it may be expensive, dangerous (e.g., side effects), unpleasant (e.g., painful), time-consuming, or inconvenient.**

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CUE TO ACTION

- **This is the stimulus needed to trigger the decision-making process to accept a recommended health action.**
- **These cues can be Internal (e.g., chest pains, wheezing, etc.)**
- **External (e.g., advice from others, illness of family member, newspaper article, etc.) promoting engagement in health-related behavi**

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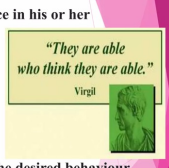
SELF EFFICACY

- **This refers to the level of a person's confidence in his or her ability to successfully perform a behaviour.**
- **This construct was added to the model most recently in mid-1980.**
- **Self-efficacy is a construct in many behavioural theories as it directly relates to whether a person performs the desired behaviour.**



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I. Vaccination use example II. Mammography use example

- 1. **Perceived susceptibility:** I. Mothers believe that there infants are at high risk to communicable disease like poliomyelitis. II. A middle aged woman with family history of breast cancer believes that she is vulnerable to cancer of breast.
- 2. **Perceived severity :** I. Mothers believe that these diseases are highly infectious and spread easily. II. She knows that her grandmother died of breast cancer.
- 3. **Perceived benefits:** I. She believes that the recommended action of using vaccination is safe to be used and would protect the infant from getting infected with polio. II. She knows that mammography is effective in decreasing deaths due to breast cancer.
- 4. **Perceived barriers:** I. She identifies her personal barriers to use vaccination. II.She cannot cover the cost of mammogram.
- 5. **Cues to action** I. Mothers receive reminder cues for action in the form of incentives (such as messages on TV and newspapers. II. She sees an aid that low cost mammography is available at nearby hospital.

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APPLICATION OF HBM

- **The HBM has been used to develop effective interventions to change health-related behaviors by targeting various aspects of the model's key constructs.**
- **Interventions based on the HBM may aim to increase perceived susceptibility to and perceived seriousness of a health condition by providing education about prevalence and incidence of disease, individualized estimates of risk, and information about the consequences of disease (e.g., medical, financial, and social consequences).**

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The Transtheoretical Model (Stages of Change)

- he Transtheoretical Model (also called the Stages of Change Model), developed by Prochaska and DiClemente in the late 1970s, evolved through studies examining the experiences of smokers who quit on their own with those requiring further treatment to understand why some people were capable of quitting on their own.
- It was determined that people quit smoking if they were ready to do so. Thus, the Transtheoretical Model (TTM) focuses on the decision-making of the individual and is a model of intentional change.
- The TTM operates on the assumption that people do not change behaviors quickly and decisively. Rather, change in behavior, especially habitual behavior, occurs continuously through a cyclical process. The TTM is not a theory but a model; different behavioral theories and constructs can be applied to various stages of the model where they may be most effective.

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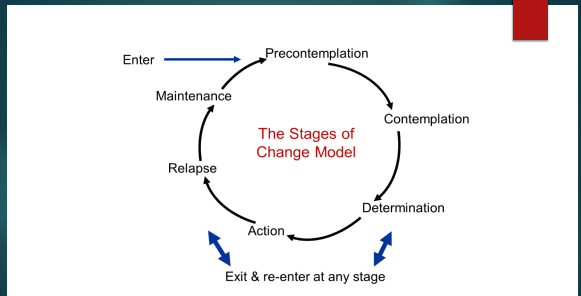
- The TTM posits that individuals move through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. Termination was not part of the original model and is less often used in application of stages of change for health-related behaviors.
- For each stage of change, different intervention strategies are most effective at moving the person to the next stage of change and subsequently through the model to maintenance, the ideal stage of behavior.

123



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1. **Precontemplation** - In this stage, people do not intend to take action in the foreseeable future (defined as within the next 6 months). People are often unaware that their behavior is problematic or produces negative consequences. People in this stage often underestimate the pros of changing behavior and place too much emphasis on the cons of changing behavior.
2. **Contemplation** - In this stage, people are intending to start the healthy behavior in the foreseeable future (defined as within the next 6 months). People recognize that their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both. Even with this recognition, people may still feel ambivalent toward changing their behavior.
3. **Preparation (Determination)** - In this stage, people are ready to take action within the next 30 days. People start to take small steps toward the behavior change, and they believe changing their behavior can lead to a healthier life.

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4. **Action** - In this stage, people have recently changed their behavior (defined as within the last 6 months) and intend to keep moving forward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors.
5. **Maintenance** - In this stage, people have sustained their behavior change for a while (defined as more than 6 months) and intend to maintain the behavior change going forward. People in this stage work to prevent relapse to earlier stages.
6. **Termination** - In this stage, people have no desire to return to their unhealthy behaviors and are sure they will not relapse. Since this is rarely reached, and people tend to stay in the maintenance stage, this stage is often not considered in health promotion programs.

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To progress through the stages of change, people apply cognitive, affective, and evaluative processes. Ten processes of change have been identified with some processes being more relevant to a specific stage of change than other processes. These processes result in strategies that help people make and maintain change.

1. Consciousness Raising - Increasing awareness about the healthy behavior.
2. Dramatic Relief - Emotional arousal about the health behavior, whether positive or negative arousal.
3. Self-Reevaluation - Self reappraisal to realize the healthy behavior is part of who they want to be.
4. Environmental Reevaluation - Social reappraisal to realize how their unhealthy behavior affects others.
5. Social Liberation - Environmental opportunities that exist to show society is supportive of the healthy behavior.
6. Self-Liberation - Commitment to change behavior based on the belief that achievement of the healthy behavior is possible.
7. Helping Relationships - Finding supportive relationships that encourage the desired change.
8. Counter-Conditioning - Substituting healthy behaviors and thoughts for unhealthy behaviors and thoughts.
9. Reinforcement Management - Rewarding the positive behavior and reducing the rewards that come from negative behavior.
10. Stimulus Control - Re-engineering the environment to have reminders and cues that support and encourage the healthy behavior and remove those that encourage the unhealthy behavior.

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Limitations of the Transtheoretical Model

- The theory ignores the social context in which change occurs, such as SES and income.
- The lines between the stages can be arbitrary with no set criteria of how to determine a person's stage of change. The questionnaires that have been developed to assign a person to a stage of change are not always standardized or validated.
- There is no clear sense for how much time is needed for each stage, or how long a person can remain in a stage.
- The model assumes that individuals make coherent and logical plans in their decision-making process when this is not always true.

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Behavior Change and communication (BCC)

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BEHAVIOUR CHANGE

- Comprehensive process in which one passes through the stages of:
  - Unaware >> Aware >> Concerned >> Knowledgeable >> Motivated to change >> Practicing trial behavior change >> Sustained behavior change

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BEHAVIOUR CHANGE COMMUNICATION

- BCC is an **interactive process with communities** (as integrated with an overall program) **to develop tailored messages** and approaches using a **variety of communication channels** to develop positive behaviors; promote and sustain individual, community and societal behavior change; and maintain appropriate behaviors.
- Behavior change communication (BCC) is the **strategic** use of communication to promote positive health outcomes, based on **proven theories** and **models** of behavior change.
- **BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation.** Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives.

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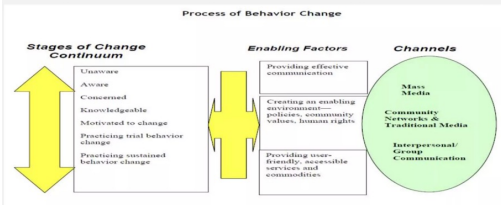
PROCESS OF BEHAVIOUR CHANGE



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CRITERIA FOR DEVELOPING BEHAVIOUR CHANGE COMMUNICATION MESSAGES

Research centered

Client centered

Benefit Leaning

Service Interrelated

Professionally developed, and interrelated to behavior change

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IMPORTANCE OF BCC

- Increase in knowledge and attitude of the people
- BCC helps to trigger and stimulate people for adopting positive behavioral approaches
- BCC promotes appropriate and essential attitude change
- As BCC strategies and messages are tailored for specific target groups, these strategies are efficient and effective.
- BCC approaches are more sustainable and acceptable
- BCC helps to increase learning and skills
- It improve aptitudes and feeling of self-adequacy

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BCC AT DIFFERENT LEVELS

- **At individual-level**
  - BCC helps in learning, mindfulness, convictions, and sentiments about wellbeing practices. It plays a significant role in deciding wellbeing conduct.
- **At community-level**
  - BCC approach stimulates community to take ownership towards the approach. Additionally, it will also help the community to replicate the positive practices in bigger level.
- **At national level**
  - BCC will play a significant role in lobbying & advocacy of certain practices. These approaches will support and encourage government and other stakeholders to bring a positive whim among all the citizens for adopting positive behavioural practices.

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GUIDING PRINCIPLES OF BCC

- BCC should be integrated with the goal and objective of the program
- Formative BCC assessments must be carried out while developing BCC messages
- Target population must participate during BCC development
- Key and direct stakeholders need to be involved from the design stage of BCC
- Pre-testing must be done for effective BCC materials
- BCC programs must involve planning for monitoring and evaluation.
- BCC strategies must be positive and action oriented.

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LIMITATIONS OF BCC

a) Material-focused as opposed to conducting focused:

- In most of the cases, BCC approaches are considered as 'material-focused' rather than 'conduct focused.
- This implies the greater part of the consideration; time and assets go into the generation of materials, (for example, handouts).
- In any case, while alluring materials may grab somebody's eye, they do not without anyone else persuade individuals to change conduct.

b) Limited capacity within local line agencies:

- Local agencies and organizations might not have enough skills and ability to develop triggering BCC messages.
- There may be limited abled human resource to facilitate the process of effective BCC message generation
- BCC messages if not prepared without having proper idea about the context of the target population might be useless and go in vain

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International Union for Health Promotion and Education (IUHPE)

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International Union for Health Promotion and Education (IUHPE)

- The **International Union for Health Promotion and Education** (IUHPE) is the non-governmental organisation (NGO) with a global membership of professionals, decision-makers, researchers and public health organisations involved in health promotion and health education.
- Its mission is to contribute to promoting health and health equity globally. One of its current strategic prioritiesis to support the development of health promotion systems (www.iuhpe.org).
- More than 65 years, IUHPE has operated an independent, global, professional network of people and institutions committed to improving the health and wellbeing of the people through education, community action and the development of healthy public policy.

IUHPE UIPES www.iuhpe.org

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Goals

The IUHPE aims to achieve the following goals:

- Greater equity in the health of populations between and within countries of the world;
- Effective alliances and partnerships to produce optimal health promotion outcomes;
- Broadly accessible evidence-based knowledge and practical experience in health promotion;
- Excellence in policy and practice for effective, quality health promotion; and
- High levels of capacity in individuals, organizations and countries to undertake health promotion activities.

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Objectives

To achieve its goals the IUHPE will pursue the following objectives:

- Increased investment in health promotion by governments, intergovernmental and non-governmental organizations, academic institutions and the private sector;
- An increase in organizational, governmental and inter-governmental policies and practices that result in greater equity in health between and within countries;
- Improvements in policy and practice of governments at all levels, organizations and sectors that influence the determinants of the health of populations;
- Strong alliances and partnerships among all sectors based on agreed ethical principles, mutual understanding and respect;
- Activities that contribute to the development, translation and exchange of knowledge and practice that advance the field of health promotion;
- A strong and universally accessible knowledge base for effective, quality health promotion;
- Capacity-building opportunities for individuals and institutions to better carry out health promotion initiatives and advocacy efforts.

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Role of IUHPE

- **Increased investment in health promotion** by governments, intergovernmental and non-governmental organisations, academic institutions and the private sector;
- **An increase in organisational**, governmental and inter-governmental **policies and practices** that result in greater equity in health between and within countries;
- **Improvements in policy and practice of governments at all levels**, organisations and sectors that influence the determinants of the health of populations;
- **Strong alliances and partnerships** among all sectors based on agreed ethical principles, mutual understanding and respect;
- **Activities that contribute to the development**, translation and exchange of knowledge and practice that advance the field of health promotion;

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Role of IUHPE

- The **wide dissemination of knowledge to health promotion practitioners** as well as to policy-makers, government officials and other key individuals and organisations;
- **A strong and universally accessible knowledge** base for effective, quality health promotion;
- **Improved mechanisms for the exchange of ideas**, experience and knowledge that promote health and wellbeing;
- **A global forum for mutual support** and professional advancement of members; and
- **Capacity-building opportunities** for individuals and institutions to better carry out health promotion initiatives and advocacy efforts.

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Activities/Projects

i. Advocacy
ii. Capacity building, education and training
iii. Communications and marketing
iv. Finance and internal control
v. Partnership and institutional affairs
vi. Strategy and governance

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Importance of IUHPE in the context of contemporary public health.

- **Accreditation:** The IUHPE Health Promotion Accreditation System comprises a devolved model within which National Accreditation Organisations.
- Capacity building, Education and Training in health promotion
- Community Health
- Evaluation
- Global Road Safety
- Health Promotion Effectiveness
- International Health Promotion on Programmes and Strategies
- Knowledge transfer

- Non-Communicable Diseases
- Physical Activity
- School Health
- Social Determinants of Health and Health Inequalities
- Tobacco Control
- IUHPE Research Report Series
- Research
- UN important resources for health promotion

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Role of health promotion and education in public health, primary health care development

Prevention and Risk Reduction:

Public Health: Health promotion focuses on preventing diseases and promoting healthy behaviors at the population level. It involves interventions that address lifestyle factors, environmental conditions, and social determinants of health to reduce the risk of disease.

Primary Health Care: By integrating health promotion into primary health care, individuals receive preventive services and education during routine health visits, helping to identify and address risk factors before they escalate into more significant health issues.

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Empowerment and Education:

1. **Public Health:** Health education empowers individuals and communities to make informed decisions about their health. It provides knowledge and skills necessary for adopting and maintaining healthy behaviors.
2. **Primary Health Care:** Education is a fundamental component of primary health care, enabling individuals to actively participate in their own health management. Informed patients are more likely to adhere to treatment plans and engage in preventive measures.

Community Engagement:

1. **Public Health:** Health promotion often involves community-based initiatives that engage and involve local communities in decision-making processes. This fosters a sense of ownership and sustainability of health interventions.
2. **Primary Health Care:** Community engagement is a key principle of primary health care, emphasizing the importance of local communities in identifying their health needs and participating in the planning and delivery of health services.

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Addressing Health Inequities:

1. **Public Health:** Health promotion strategies aim to reduce health inequities by addressing social determinants of health, such as income, education, and access to resources.
2. **Primary Health Care:** Development of primary health care services includes a focus on equity and accessibility, ensuring that essential health services are available and affordable to all members of the community.

Disease Management and Health Literacy:

1. **Public Health:** Health promotion includes initiatives to enhance health literacy, enabling individuals to understand and manage their health conditions effectively.
2. **Primary Health Care:** Health education within primary health care settings supports disease management by providing individuals with the information and resources needed to manage chronic conditions and adhere to prescribed treatments.

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Policy Advocacy:

- **Public Health:** Health promotion often involves advocating for policies that support a healthy environment and lifestyle choices at the population level.
- **Primary Health Care:** Advocacy for policies that promote access to essential health services, health education, and preventive care is integral to the development of primary health care.

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Unit II: Fundamental Factors for Health Promotion and Education

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Communication

- Communication is a dynamic process that takes place around us all the time. In fact we spend 70% of our time receiving and sending messages.
- The origin of the word "communication" is "communicare" or "communis" which means "to impart", "to participate", "to share" or "to make common." The sense of sharing is inherent in the very origin and meaning of "communication."

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- Keith Davis: Communication is a process of passing information and understanding from one person to another.
- John Adair: Communication is essentially the ability of one person to make contact with another and make himself or herself understood.
- William Newman and Charles Summer: Communication is an exchange of ideas, facts, opinions or emotions of two or more persons.
- Louis Allen: Communication is a bridge of meaning. It involves a systematic and continuous process of telling, listening and understanding.
- Peter Little: Communication is a process by which information is transmitted between individuals and / or organizations so that an understanding response results.
- Murphy, Hildebrandt, Thomas: Communication is a process of transmitting and receiving verbal and non-verbal messages. It is considered effective when it achieves the desired response or reaction from the receiver.

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The process of communication:

- Communication is a two-way process involving the following elements: a sender, a message, a medium, a channel, a receiver, a response and feedback.
- However, it is not sufficient to have just all these elements; there should be cooperation and understanding between the two parties involved.
- It is important to have a common frame of reference or context for successful and meaningful communication, e.g. a common language or common interpretation of a gesture.

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- Essentially communication involves the sender or the communicator and the receiver. Both should necessarily share a mutually accepted code e.g. a common language.
- The context in which the communication takes place is called the "communication environment". The content of the code is sent in a certain medium (oral, written or non-verbal) using channels (air, mikes, body, pictures, text, etc.) in the form of encoded messages. The "code" is not restricted to only language; it may also involve the use of costumes, gestures, colors among other things.

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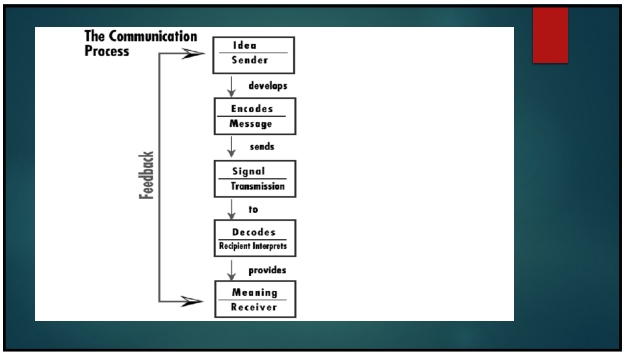

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- The sender sends a "message" using a "medium" and a "channel" to the "receiver". The message arrives in the sensory world of the receiver. The receiver's brain filters the message on the basis of his/her knowledge, emotions, attitudes, and biases and gives the message a unique meaning. This meaning may trigger a response which the mind of the receiver forms. The receiver encodes his/her response and sends it across as "feedback" into the sensory world of the sender. This completes one cycle of communication and the process continues in a cyclic manner, i.e. cycle after cycle, as long as the people involved care to communicate.

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components of the communication process

- Idea or impulse that arises in the sender's mind
- Formal expression of the idea or impulse using a medium and channel : encoding
- Interpretation of the message by the receiver: decoding
- Reaction or response of the receiver
- Conveying the reaction/response in the feedback using a medium and channel 6. Decoding of the feedback received

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essentials of effective communication

- A common communication environment
- Cooperation between the sender and the receiver
- Selection of an appropriate channel
- Correct encoding and decoding of the message
- Receipt of the desired response and feedback

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Noise:

- In some cases, the message may fail to produce the desired response because of a semantic gap or a barrier between the sender and the receiver. This is termed as "noise"; it refers to any unplanned interference in the communication which causes a hindrance in the transmission of the message.

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Types of "noise"

- Channel noise: This refers to static, mechanical failures, problems in volume, pitch, legibility of text, etc.
- Semantic: Here "noise" is generated internally resulting from errors in the message itself: ambiguity, grammatical errors, wrong spellings, incorrect punctuation, etc.

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Feedback:

- The transmission of the receiver's response to the sender is called "feedback." It is one of the most vital factors of the communication process.
- The sender needs to know whether the receiver of the message has received it in the intended way and whether he responds in the desired manner. Of course, even if one receives a response, it may or may not be the one you had expected. But once you receive some response, you know that the message has been communicated, e.g. a notice for a meeting. There could be both positive and negative responses to this message; some may turn up for the meeting and some may not. Communication is said to be fully effective only when you get the desired response

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- Feedback helps in improving communication as it enables the sender to pinpoint defects in the transmission of the message. A skillful communicator is always looking for warning signs that the communication is not going well and adjusts messages accordingly. Being alert to feedback helps the sender know whether he/she is on the right track. In the long run, it helps in understanding one's strengths and weaknesses in the communication context.
- Feedback may be either immediate or delayed. For example, oral responses are immediately conveyed but in case of written communication, the feedback may take some time.

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Elements of Communication

- There are six elements of Communication which includes:
  - Sender/encoder
  - Message
  - Channel
  - Treatment of Message
  - Receiver/decoder
  - Feedback/Audience Response

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1. Sender/Communicator/Encoder

- The sender also known as the encoder decides on the message to be sent, the best/most effective way that it can be sent. All of this is done bearing the receiver in mind. It is his/her job to **conceptualize**.
- Credibility means trustworthiness and competence.

Characteristics of good communicator:
1- Objective.
2-Audience
3-Message
4-Organization and treatment of message.
5-Professional abilities and limitation.

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2. Message

Message should clearly state what to do, how to do and when to do and what would be the result.

- A good message should be:
- In-Line
- Clear
- Significant
- Specific
- Simply stated.
- Accurate
- Timely
- Applicable
- Adequate
- Handled by the communicator.

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3. Channel

- The channel is that which is responsible for the delivery of the chosen message form. For example post office, internet, radio.
- Channel of the communication constitutes the medium through which information flows from sender to receiver.

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According to form

- **Spoken**
- Farm and Home visit
- Farmers Call
- Meetings
- Radio Talk
- **Written**
- Personal letter
- Farm publication
- Newspaper

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According to nature of personnel involved

- **Personal localite**: Local leader, Local people
- **Personal Cosmopolite**: Communication channel from outside the social system of the receiver.
- **Impersonal cosmopolite**: Communication channel from outside the social system of the receiver and at the same time no personal face to face contact is involved.

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According to nature of contact with the people

- Individual contact: Farm visit, farmers' Call, personal letter.
- Group Contact: Group meetings, Small Group Training, Study tour.
- Mass contact: Mass Meetings, Exhibition, Radio, Television.

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4. Treatment and presentation

- Treatment means the **way a message is processed** so that the information gets across the audience.
- The purpose of treatment is to make the **message clear, understandable and realistic to the audience**.
- Presentation means **how the message is communicated or placed before the audience.**
- Treatment and presentation of the message shall depend to great extent on **choice of the channel and nature of the audience.**

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5. Receiver/ Audience/ Decoder

- The receiver or the decoder is responsible for extracting/decoding meaning from the message. The receiver is also responsible for providing feedback to the sender. In a word, it is his/her job to **interpret**.
- The audience or receiver of message is the target of communication.

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6. Audience response

- Response of the audience is the ultimate objective of any communication function.
- Response of an audience to message received may be in the form of some kind of action, mental and physical.
- Variety of responses:
- Understanding vs knowledge.
- Acceptance vs Rejection.
- Remembering vs Forgetting.
- Mental vs Physical Action.

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Models of communication

Aristotle Model (1946):

- Aristotle (384 BC - 322 BC) was a Greek philosopher and polymath, a student of Plato and teacher. of Alexander the Great. He proposed a communication model before 300 B.C. This model is more focused on public speaking than interpersonal communication.
- According to Aristotle three elements are involved in communication namely, tha communicator, the speech or message, and the receiver of the message who is also known as audience or communicant.

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- Aristotle has visualized a public meeting or delivery of speech to the gathering of a large group of people. Though it is direct face-to-face communication this model provides least opportunity to the audience to ask questions to the speaker and clarify their doubts. Mere transmission of message by the communicator is not communication.

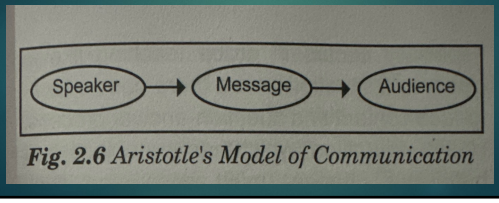

Fig. 2.6 Aristotle's Model of Communication

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Shannon and Weaver Model

- In 1941 Cloud Shannon, a mathematician and Warren Weaver, an electrical engineer presented a model of communication in an electronic system like telephone and radio and is called engineering model. This model consists of the following components:
  - Source or communicator
  - Transmitter
  - Signal or message
  - Receiver
  - Destination or communicant.

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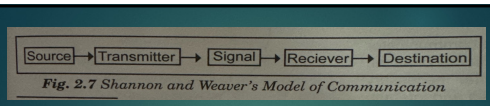

Fig. 2.7 Shannon and Weaver's Model of Communication

The communicator sends the message through the transmitter. The message is received by the receiver and then by the destination or communicant. The message travels in the form of energy, which is called signal. In this model of communication there is no face-to-face contact between the sender and communicant.

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Schramm Model:

- The components of communication process in this model are:
  - Source
  - Encoding
  - Signal or message
  - Channel
  - Decoding and
  - Receiver

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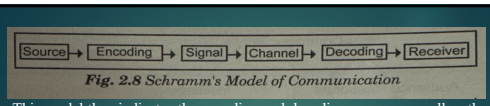

Fig. 2.8 Schramm's Model of Communication

This model thus indicates the encoding and decoding process as well as the channel or medium through which the message or signal is transmitted.
This process of communication occurs in the telegraph system while sending and receiving the telegram.
The above-mentioned two models of communication are of communication engineering type.
They help in person-to-person talk without face-to-face contact situation i.e., in telephone, radio and telegraph system.
Though these are not perfect models for health education some of the underlying ideas or elements of communication has been applied by the social scientists in the field of health education and behaviour change.
Radio is commonly used with an intention of providing health education.

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Leagan Model (1963)

- J P Leagan defined communication as a process by which two or more persons exchange ideas, facts, impressions in way that each gains a common understanding of the meaning, intent and use of message.
- He proposed a model of communication which has considered the role of feedback, The components of the model are:
  - Communicator
  - Message
  - Channel
  - Treatment
  - Audience
  - Audience response.

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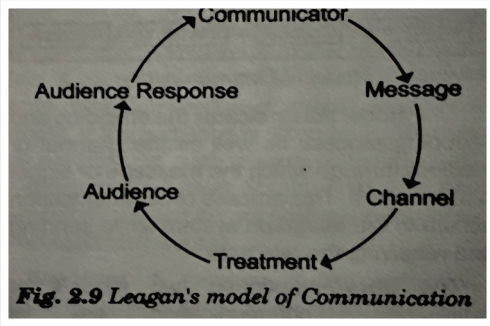

Fig. 2.9 Leagan's model of Communication

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- According to this model the communicator sends the message through some channel.
- The audience receives it after necessary treatment according to his need and interest.
- It provides some provision for necessary response or feedback by the audience to the communicator, which helps the communicator to know if the message is understood in a way he meant.
- This kind of communication process especially occurs in group teaching like in classroom situation where there can be face-to-face contact and question-answer process.
- Health education, which has the objective of behaviour change, must encourage such model of communication.

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Westley-Maclean Model

- Bruce Westley (1915-1990) one of the creators of journalism studies served as a teacher at the University of Wisconsin, Madison, between 1946 and 1968. Malcolm S. MacLean Jr (1913-2001) was director of University of Journalism School (1967-74) and co founder of the University College at University of Minnesota, USA.
- In 1957 Westley and MacLean proposed a model of communication which can be looked in two contexts - interpersonal and mass communication. The point of difference between interpersonal and mass communication is the feedback. In interpersonal, the feedback is direct and fast and in the mass, the feedback is indirect and slow.

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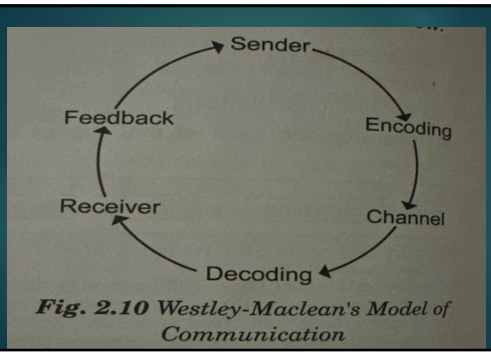

Fig. 2.10 Westley-Maclean's Model of Communication

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- This model also gives some clear and comprehensive meaning of communication
- Here the communicator treats or encodes the message and sends through some channel which is then decoded, treated or interpreted by the receiver The receiver provides feedback or response regarding the comprehension and appropriateness of the message.
- This gives the communicator a chance to improve his message and way of presentation if needed. Unlike in Leagan model here the communicator also treats the message to make it appropriate to the receiver of the message.
- This model can be effectively applied in face-to-face communications like person to person talk. discussion, demonstration, etc.

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Characteristics of communication

- 1. **Communication is a process:** It occurs with systematic involvement of the elements like the source, message, channel and receiver. Also the purpose of communication may not be achieved by a single attempt and might need continued efforts.
- 2. **Communication is interdependent:** It cannot occur in the absence of any one of the elements 3. Communication is reciprocal: It is a two way process flowing from the source to the receive: and from the receiver to the source. There will be feedback process to bring the perception of message as close as possible between the sender and receiver of the message.
- 4. **Communication occurs in a cultural context:** It is based on the shared cultural behaviour between the source and the receiver.
- 5. **Communication is universal:** It occurs between the health educator and the people, between the teacher and the students, between two individuals and so on

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