Definitions of the final themes mapped to construct the conceptual model

**A priori themes after deductive reasoning**

**A priori themes retained as such**

1. **Awareness**: The knowledge about health risks and the benefits of different health practices, including knowledge about the causes, consequences and solutions for a particular problem behaviour.
2. **Self-evaluation**: Self-assessment of a particular behaviour in terms of possibilities and potential avenues for bringing about a change in the said behaviour.
3. **Helpful relationships**: Includes relationships that promote caring, trust, openness, acceptance and support for the healthy behaviour change.
4. **Perceived seriousness**: Judgment as to the seriousness or severity of the disease, health problem or behaviour.
5. **Personal modifiers**: Characteristics that influence personal perceptions, such as culture, education level and past experiences.
6. **Attitude**: Refers to the degree to which a person has a favourable or unfavourable evaluation or appraisal of the behaviour in question.

**A priori themes retained with modifications**

1. **Identifying stages-of-change (pre-contemplation, intention and action)**: This is the key construct of the model, which focused on identifying cues to differentiate households to three stages-of-change (instead of the original five: pre-contemplation, contemplation, preparation, action, maintenance).
   - Pre-contemplation (pre-contemplation): people do not intend to take action in the foreseeable future.
   - Intention (contemplation + preparation): people intend to take action in the immediate future, hence are more aware of the pros and cons; and have already taken some significant steps in a positive direction.
   - Action (action + maintenance): people have made specific overt modifications in their life-styles or are engaged to prevent relapse.
2. **Household efficacy**: belief or confidence in their ability as a household to control their behaviour and bring about a change or cope with different situations without relapsing to the earlier unhealthy habit.
3. **Decisional balance**: relative weighing of the pros and cons of changing behaviour; and their opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease or health problem in terms of the expected costs and benefits.
4. **Substitution opportunities**: learning of healthier behaviour that can substitute for problem or unhealthy behaviour.
5. **Perceived risk**: self-assessment of the chances of acquiring a disease or health problem due to the continuation of an unhealthy behaviour.
6. **Perceived societal response**: perceived social pressure to perform or not to perform a particular behaviour.
7. **Cues to action**: events, people or things that prompt a desire to change behaviour.
New themes identified after inductive reasoning

1. **Accessibility**: combination of availability that includes physical access and affordability that includes all the costs associated with accessing foods.
2. **Perceived needs and preferences**: special needs and preferences of other household members as perceived by the female head of the household.
3. **Societal norms**: gender, socio-economic status and other higher hierarchical power structures in the household and community that influence behaviour.
4. **Perceived household response**: includes perceived willingness (or consent) to participate in a behaviour-change intervention; and the level of cooperation expected from other household members for such an endeavour as perceived by the female head of the household.