



Behaviour Change Communication Guidelines



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Glossary of Key Terms

Ability An individual's skills and proficiency to carry out a certain behaviour. Determinants groups within ability include knowledge, social support, skills and self-efficacy, roles and decisions and affordability.

Behaviour change communication is an approach to hygiene promotion that uses an in-depth understanding of people's behaviour to design persuasive communication.

Behavioural determinants are the factors that may influence whether an individual has the opportunity, ability and motivation to engage in a given hygiene or sanitation behaviour. Behavioural determinants can either facilitate or inhibit behaviour of interest among a certain population and can be internal or external.

Communication channel is a medium through which a message is transmitted to its intended audience, such as print media or broadcast.

Community Led Total Sanitation (CLTS) is an innovative methodology for mobilising communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of open defecation (OD) and take their own action to become ODF (open defecation free).

Drivers are strong internal thoughts and feelings that motivate behaviour. They can be positive or negative, and can stem from unmet physical, emotional, or psychological needs. In CLTS for example the negative driver of disgust is used as the driver.

Focus behaviour and population: The behaviour that needs to be changed, such as ceasing open defecation, upgrading to hygienic latrines and handwashing with soap. The group targeted to adopt the identified behaviour.

Formative research is research carried out to provide information to plan intervention programmes. In this context it is the basis for developing effective strategies, including communication channels, for influencing behaviour change. It helps to identify and understand the characteristics of target populations that influence their decisions and actions.

IEC has been defined as an approach which attempts to change or reinforce a set of behaviours in a "target audience" regarding a specific problem in a predefined period of time using information, education and communication.

IPC are interpersonal communications, i.e., face-to face communications



Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. This definition is based on the World Health Organization Ottawa Charter 1986.

Hygiene education involve activities aimed at raising awareness and conveying knowledge of the links between hygiene practices and health.

Hygiene promotion is a planned approach that aims to reduce the incidence of poor hygiene practices and conditions that pose the greatest risk to the health of children, women and men.

Motivation: The drives, wishes, urges or desires that influence an individual to act out a certain behaviour. Determinants within motivation include attitudes and beliefs, values, emotional/physical/social drivers, competing priorities, intention and willingness to pay

Opportunity as a group of behavioural determinant refers to the institutional or structural factors that influence an individual's behaviour. Determinants within opportunity include access/availability, product attributes, social norms and sanctions/enforcement.

PHAST stands for Participatory Hygiene and Sanitation Transformation. It is an innovative approach designed to promote hygiene behaviours, sanitation improvements and community management of water and sanitation facilities using specifically developed participatory techniques.

WASH Water, sanitation and hygiene.



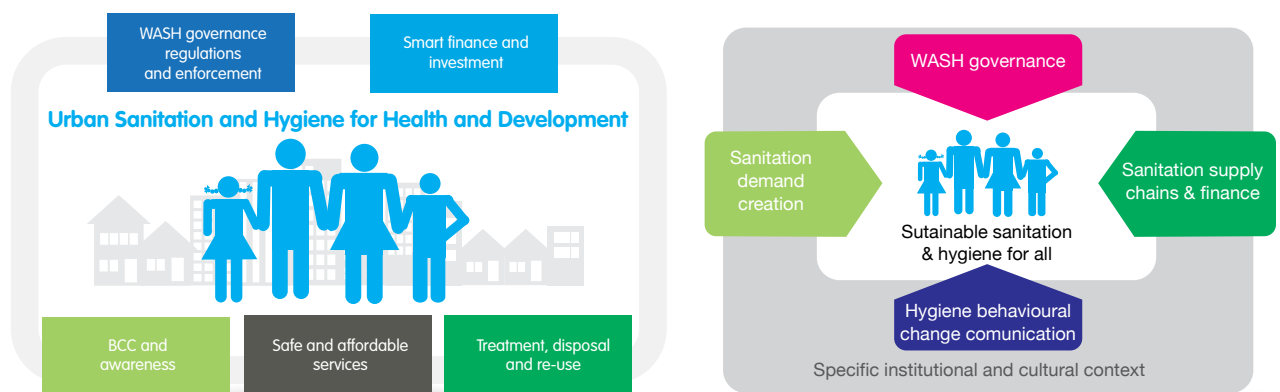


1. Background

1.1 Sustainable Sanitation & Hygiene for All

Sustainable Sanitation & Hygiene for All (SSH4A) is SNV's comprehensive approach for area-wide sanitation and hygiene services. Developed since 2008 in Nepal, Bhutan, Cambodia, Vietnam and Laos with IRC, the SSH4A approach is now implemented with rural communities in over 75 districts across 15 countries, contributing to progress in Asia and Africa. In 2011 it was adapted and expanded to urban contexts in Bhutan, then Nepal, Indonesia and Bangladesh as 'Urban Sanitation and Hygiene for Health and Development'. The focus is on the development of capacities and approaches that can be scalable through a government-led, district-wide approach.

The SSH4A programme is comprised of four complementary components supported by knowledge and learning as illustrated in the diagram below for both rural and urban contexts. In both the rural sanitation and hygiene approach, as well as in the urban sanitation and hygiene approach, evidence-based behavioural change communication is a key component. Hence, the importance of these guidelines for both programmes.



1.2 Purpose of these guidelines

Since 2008, the programme has been working to introduce and build capacity in behavioural change communication methodologies at local level, with the active involvement of local and national agencies. The approach with the line agencies has consisted of a participatory review of existing information, education and communication (IEC) or hygiene promotion work, definition of priority behaviours (primarily HWWS and hygienic usage) based on survey data, developing skills in formative research, development of BCC strategies, design of messages and campaigns and, finally, monitoring effectiveness.

The work on BCC has been supported by a structured learning process including:

- Regional learning events – first in Laos in 2010, which introduced the participants to the use of FOAM and SaniFOAM, as well as barrier analysis, and then in follow-up in Bhutan in 2015;
- Subsequent comparative studies (2010; 2015), D-group discussions; and
- Draft BCC guidelines, 2010.

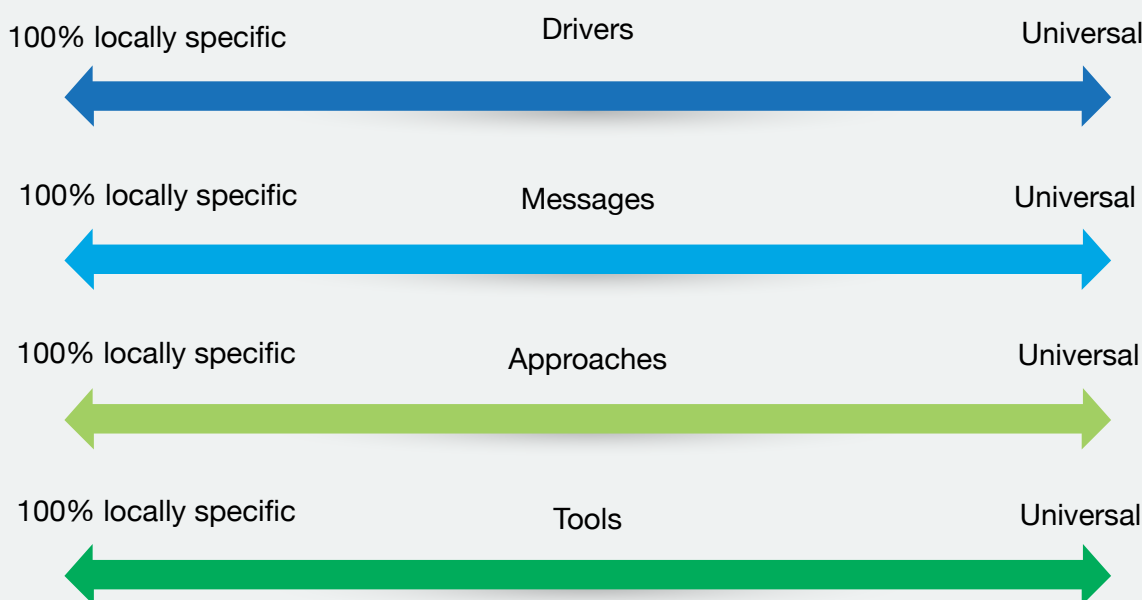
The purpose of these revised guidelines is to document the current thinking of the programme informed by this learning process and provide guidance to the SNV teams and partners engaged in the process of capacity development in BCC. They seek to complement existing resources available in the sector.

2. Introduction to Behaviour Change Communication

2.1 Hygiene promotion developments in the sector

Within the WASH sector there is an increasing understanding that hygiene promotion requires more than business-as-usual approaches. Whilst in practice there are still many health-based blanket campaigns and IEC material-based approaches, there is a growing consensus in the sector that hygiene promotion should be behaviour centred with focused messaging and there is research seeking to identify universal drivers. Some organisations tend to favour a desirable technology as the trigger for action and use social marketing to make it desirable. A variation of this approach is Unilever's work on making soap desirable. Other organisations have relied strongly on social empowerment and reflection approaches.

The question whether we can expect universal answers, guidance or solutions is ongoing. While this may make our work easier to scale (in theory), the local context cannot be overlooked. CLTS basically proposes one universal driver ("disgust"), an almost universal approach and an almost universal set of tools.



Some say that a number of drivers are universal for humankind, namely those in the most basic part of the brain that relate to human survival. For example, Val Curtis from the London School of Hygiene and Tropical Medicine (LSHTM) says that behavioural determinants like disgust and nurture (the drive to care for children) could well be universal to humankind (See the Evo-Eco model¹ and the SuperAmma campaign²) The research that this group is doing may well result in a number of almost universal drivers that others can simply take and adjust. Another aspect of this set of work is that a lot of our hygiene behaviours are part of a particular setting and a routine. The idea is that a new behaviour should fit within a routine in order to be sustainable.

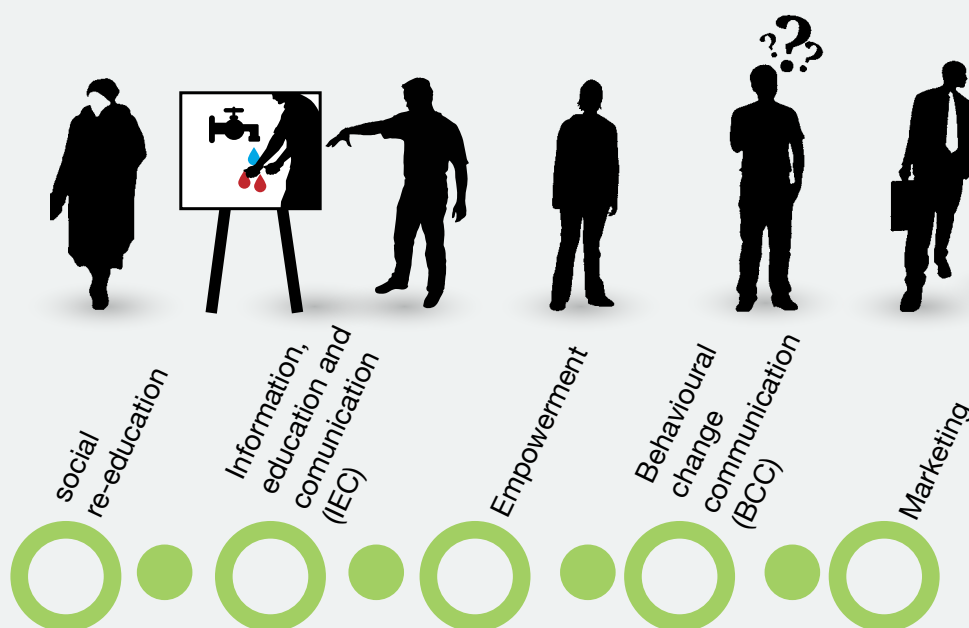
The work on triggering handwashing tends to assume that drivers are similar throughout (most of) the world, and also that the same tools can be used. One could even say that approaches based on empowerment, such as PHAST, assume that empowerment is a universal motivator or driver, or at least that the approach is universal.

1. <http://www.hygienecentral.org.uk/research-behaviour.htm>
2. <http://www.superamma.org/index.html>



2.2 What is Evidence-based Behaviour Change Communication?

Before we start, it may be good to clarify what Evidence-based Behavioural Change Communication is. Communication aiming to influence personal hygiene behaviour has been part of health and WASH programmes for a very long time. Yet, data on hygiene behaviour practices remains alarming. When we look at communication approaches over time, we can see a trend moving from informational and educational communication towards more persuasive communication influenced by marketing approaches.



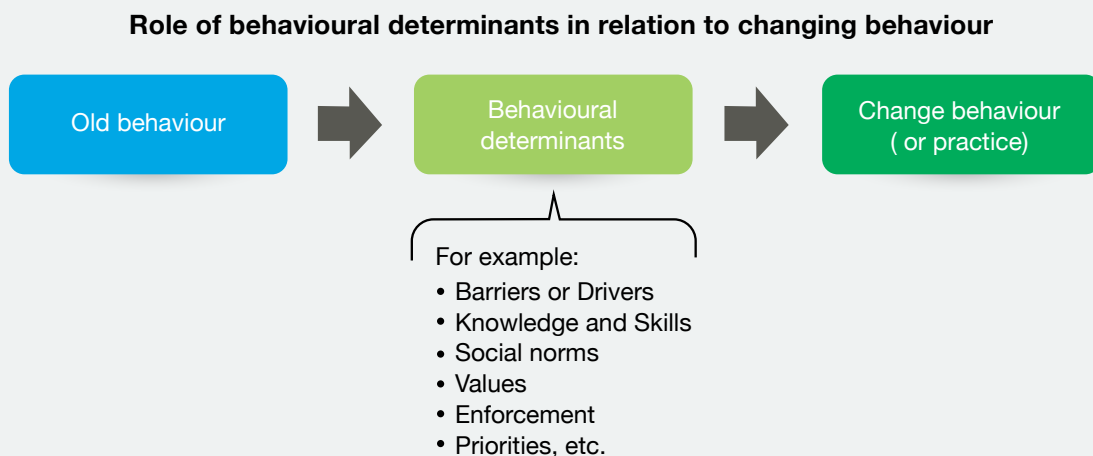
In the past, a lot of our communication aimed to inform and educate people about the dangers of improper hygiene behaviour and to teach people what good practices are. Knowledge, Attitude and Practices (KAP) studies were used to map out where the gaps were. However, the time to go deep into attitudes and beliefs was limited. Now our sector has learned that we need to give much more attention to behavioural determinants, including attitudes and beliefs, because a lot of persistent hygiene behavioural challenges are related to this.

Evidence-based BCC starts from trying to understand on a deeper level how people think and feel, and what motivates them to practice or not practice a behaviour. It is behaviour centred. The insights gained from studying behaviour form the basis for message development. This is something that we do intuitively when trying to convince a person to behave in a certain way. When you know someone very well (e.g., your husband or wife), you know exactly which arguments to use and when to use them in order to make your communication effective. Of course trying to do the same at scale is a different ballgame, e.g., for all teenagers in a district or province, or for all fathers/mothers in an area.

BCC is an approach to hygiene promotion that uses an in-depth understanding of people's behaviour to design persuasive communication.

2.3 Understanding behaviours

In order to change a behaviour, we need to better understand the factors that influence that behaviour. These factors (and the way they change) are based on evolving theories of behaviour change. In order to assist in the analysis and understanding of specific behaviours, behavioural frameworks commonly group the factors (known as ‘behavioural determinants’) that may influence whether an individual has the opportunity, ability and motivation to engage in a given hygiene or sanitation behaviour.



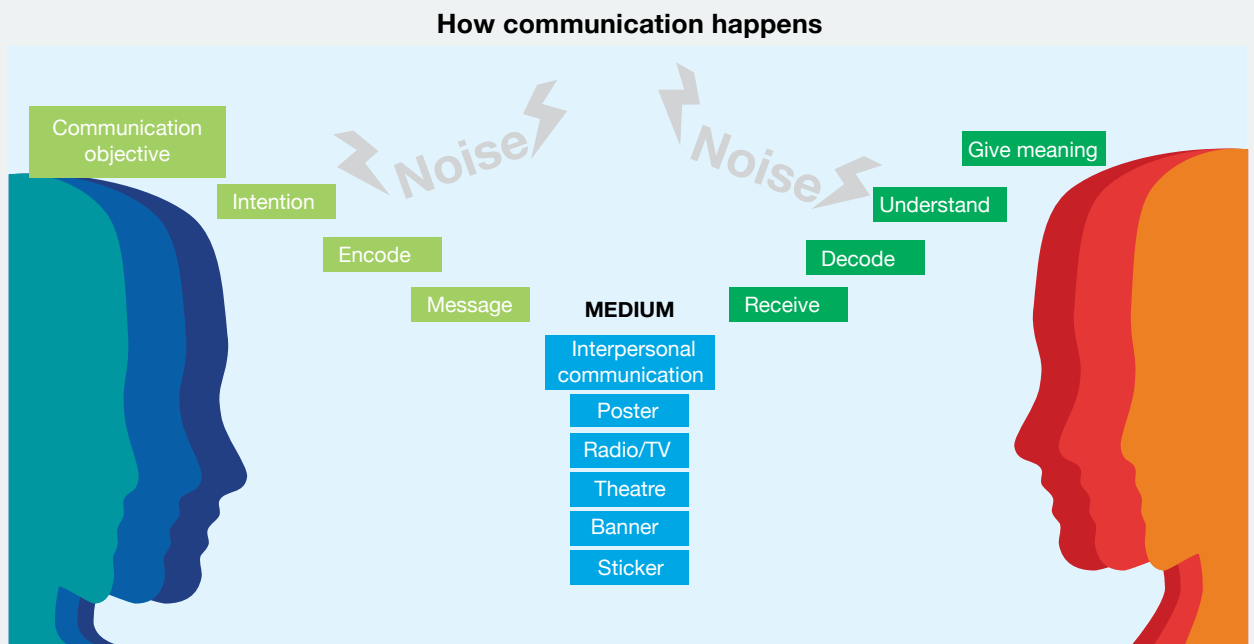
The behavioural determinants are used to bring about the desired behaviour change. For example, in CLTS a motivator is disgust (or pride). Increasingly, it is thought that behavioural determinants are largely universal. But while these determinants may be universal, their concrete meanings are population and setting specific. Therefore formative research is used to understand the specifics within population segments.

Messages, in turn, are framed on the basis of the determinant to be addressed – for example: “You are eating other people’s shit”. Of course for one determinant, there are different possible messages. Tools are the methods you use in implementation, such as mass-media promotion, certain triggering tools, drama or songs, or the way you engage local authorities.

2.4 Communication as a process

A range of different models have been developed to explain the communication process. In its simplest form, communication is a process that takes place between a sender and a receiver as shown in the figure below.

The process of communicating an intended message is broadly as follows: 1) the sender has an intention (message to communicate); 2) this is encoded into a form that can be shared with the receiver/s (speech, text, etc.); 4) the message is transmitted to the receiver/s via a chosen medium (face-to-face, email, radio, TV, poster, etc.); 5) the receiver/s receive the message; and finally, 6) the receiver/s decode the message so that it is understood and has meaning.



2.5 Use of frameworks to understand behavioural determinants

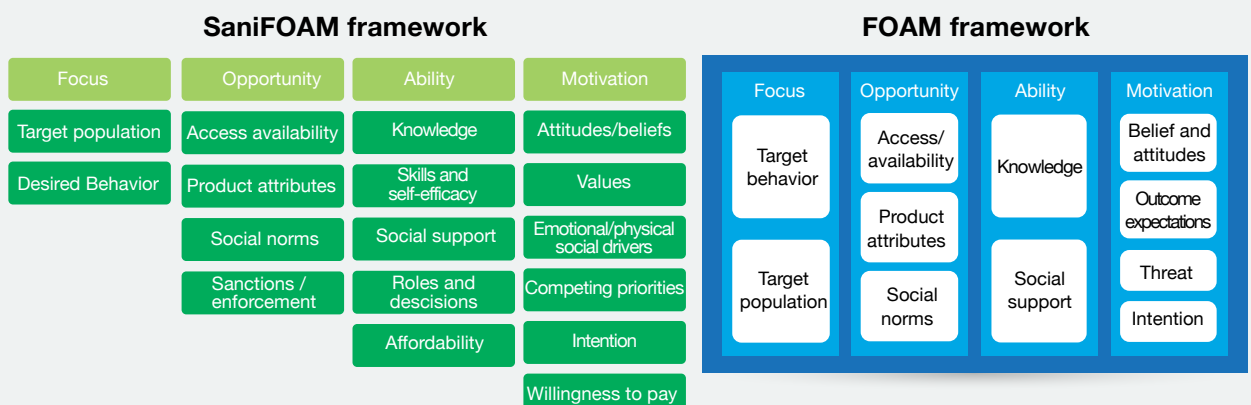
There are a number of different approaches used to understand behavioural determinants, key examples of which are summarised below. A behavioural model, or a 'framework', helps us understand a behaviour and its underlying factors. The value of using a model is in providing a way to organise our thinking and to analyse our findings.

SANIFOAM and FOAM³ (WSP)

These two behavioural frameworks were developed by WSP in 2008, based on the work of Population Services International, to address sanitation (SaniFOAM) and handwashing (FOAM) practices. These have been the primary frameworks used by SNV and partners to organise and analyse formative research in rural SSH4A since 2010.

SaniFOAM categorizes sanitation behavioural determinants under three headings as follows:

- **O**pportunity: Does the individual have the chance to perform the behaviour?
- **A**bility: Is the individual capable of performing the behaviour?
- **M**otivation: Does the individual want to perform the behaviour?

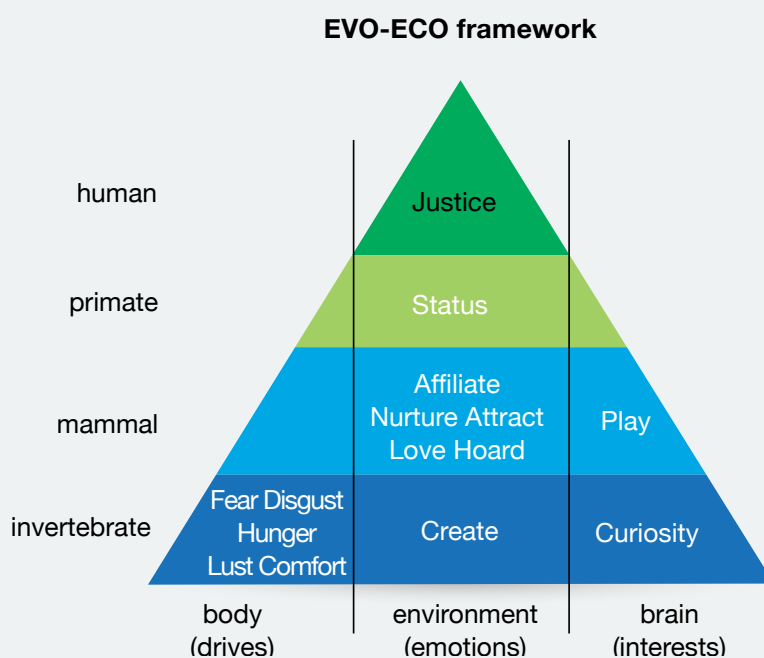


3. Devine J (2009), Introducing SaniFOAM: A Framework to Analyze Sanitation Behaviours to Design Effective Sanitation Programs, World Bank Water and Sanitation Programme, online at http://www.wsp.org/wsp/sites/wsp.org/files/publications/GSP_sanifoam.pdf.

Evo-Eco⁴ (LSHTM)

Evo-Eco has evolved from the fields of evolutionary biology and ecological psychology. It is based on the insight that our brains have evolved to provide adaptive behavioural responses to rapidly changing or complex environmental conditions. The Evo-Eco model is comprised of three basic components - the environment, which presents a challenge or opportunity to the individual; the brain, which produces potential responses to that challenge; and the body, which engages in interactions with the environment (i.e., produces behaviour) that changes that environment.

The environmental component of Evo-Eco includes social, physical, and biological factors, while the brain component includes planning, motivation, and habit as factors. Motivational factors are split into disgust, status, affiliation, attraction, nurture, comfort, and fear. Using focus group discussions in 13 studies in 11 countries, LSHTM identified the key motivations for handwashing as: disgust, nurture, comfort, and affiliation.⁵



RANAS model-(Eawag)

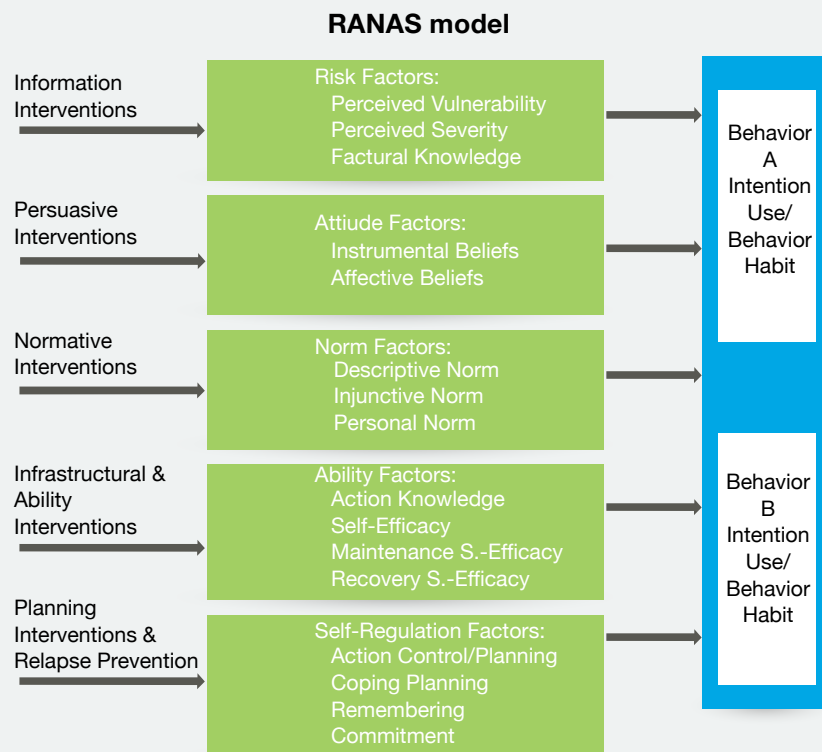
The RANAS model (Risk, Attitudes, Norms, Abilities, and Self-regulation) approaches behavior change systematically from a health psychology background. It goes beyond SaniFOAM/FOAM and Evo-Eco in that it includes not only the conceptual model, but also the behaviour change techniques that respond to the factors to be changed, as well as an analytical tool for identifying these.

The model is divided into (1) factor blocks, (2) behavioural factors, (3) target behaviours, and (4) behaviour change interventions corresponding to the factor blocks. Practitioners are advised to first measure the incidence of each of the factors to be changed in the population, and then analyze the intervention potential of these factors. The RANAS model factors can be measured in a standardised way by developing several questions corresponding to factor.⁶

4. <http://ehg.lshtm.ac.uk/the-evo-eco-approach/>

5. Curtis V, Danquah LO, Aunger RV. 2009. Planned, motivated and habitual hygiene behaviour: an eleven country review. *Health Educ Res.* 24(4):655-673.

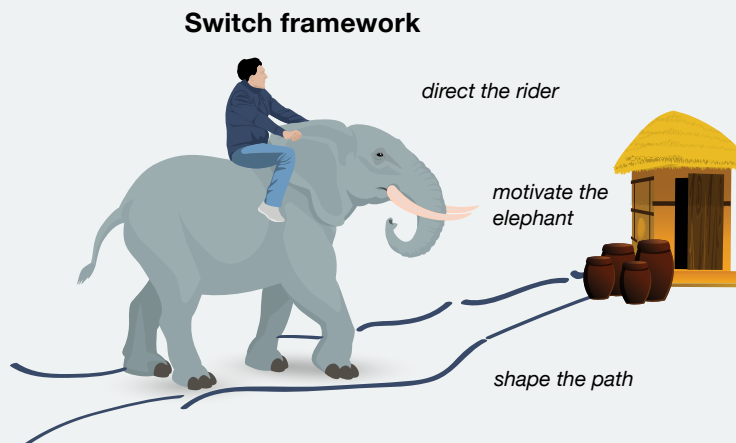
6. Mosler H.J. (2012) A systematic approach to behaviour change interventions for the water and sanitation sector in developing countries: a conceptual model, a review, and a guideline, *International Journal of Environmental Health Research*, 22 (5), 431-449



The Switch framework: Elephant, rider and path

An example of a simplified theory of behaviour change is the Switch framework, developed by Dan and Chip Heath. This framework is now applied by a variety of institutions interested in changing behaviour.⁷ The Switch framework emphasises both the rational and emotional sides of behaviour change. The model uses the analogy of an elephant and its rider – while our rational side (the rider) may recognize the need for a change, the emotional side (the elephant) tends to pursue behaviour that we are accustomed to.

The Heath brothers suggest that solving the elephant-rider problem involves three things: 1) directing the rider by making sure the rider knows where to go and how to get there; 2) motivating the elephant by making him feel he wants to change by making the change seem small and encouraging a positive mindset (change is possible); and 3) shaping the path by changing the environment so that path is clear for both rider and elephant by building habits, sharing success stories, etc.



7. <http://heathbrothers.com/books/switch/>

Forming habits

Handwashing habit formation means converting handwashing from a behaviour that people must think about and decide to undertake (intention and decision making) into a procedure that we automatically undertake in response to cues, without involving the decision-making parts of our brain (habit). Habits are environmentally triggered and a key part is that environmental cues must be immediately available or the behaviour won't occur unless motivation is extremely high⁸.

There are key principles in integrating habit formation into approaches, documented as part of the Global Handwashing Project⁹. These are: 1) supporting environments/products for new behaviour must be immediately/ consistently available; 2) leverage context by disruption or piggybacking on old behaviour; 3) eliminate choice, steps, and perceived effort; 4) create cuing ecosystem, ideally rewarded; 5) enhance cue-response learning; 6) foster procedural memory through doing; and 7) encourage meaning-making around habit.

A note on frameworks:

SNV's teams and partners in the Asia region have gained increasing experience in formative research, specifically using WSP's FOAM and SaniFOAM frameworks. From this work, we have learned that local formative research involving stakeholders contributes both to a better understanding of behaviours and change in hygiene promotion practice, but that change is slow. While these frameworks are helpful, their application requires strong support in the analysis phase. The risk is that without this support the research findings may not be translated into changed practice, but, rather, the same lists of activities (leaflets, workshops, etc.) are proposed. A start has been made to simplify the frameworks for local use, with teams going through a first phase of limiting behavioural determinants before undertaking research. However, using a framework to guide the process and support this analysis remains key.

2.6 Current challenges in BCC in practice

The effectiveness of behaviour change communication is not only about the quality of the design process, but also how it is understood and applied in practice. It is influenced by a number of factors, including the capacity of line agencies and implementers, the skills and preferences of the communicators / facilitators and the priority given to hygiene promotion in general. The following are current key challenges with BCC in practice based on the team's experiences:

- **Material-centred rather than behaviour-centred:** Even with changes at the national level, at local government level most hygiene promotion is still characterised as 'material-centred' rather than 'behaviour-centred'. This means that the bulk of attention, time and resources go into the production of materials (such as leaflets). However, we have learned that while attractive materials may help to catch someone's attention, they do not by themselves convince people to change behaviour.
- **Focusing on health benefits:** The most commonly used motivator for hygiene promotion at local level is still "health", which is rarely a sole trigger for behavioural change. Messages based on germs and health have been found to be ineffective (e.g. Biran et al 2009). Evidence from formative research studies globally shows that social, physical and emotional drivers (pride, loss of face, convenience, comfort, etc.) are some of the most common reasons households choose to invest in latrines.¹⁰ Recent work, including studies by LSHTM in Indonesia, India and Zambia, has shown the potential for using emotional drivers such as disgust, nurture and affiliation for changing handwashing behaviours.

8. Wood et al in Neal et al, 2014, "Handwashing and the Science of Habit" Water and Health, UNC, October 13, available online at <http://whconference.unc.edu/files/2014/11/Neal.pdf>.

9. <http://globalhandwashing.org/step-three-habit-formation/>

10. <http://www.wsp.org/sites/wsp.org/files/publications/WSP-What-Influences-Open-Defecation-Global-Sanitation-Review.pdf>

- **Addressing too many behaviours and audiences at a time:** Many of SNV's earlier formative research studies were designed to look at multiple behaviours and determinants across several audiences. As a result, the studies lacked sufficient focus and findings were often not sufficiently in-depth to be useful for designing effective BCC campaigns. Future research studies would benefit from selecting only or two behaviours to explore, and clearly defining which determinants they will focus on. Beyond the studies, many hygiene promotion programmes themselves also aim to address too many behaviours and audiences at once – for example handwashing with soap, food hygiene, safe water handling, bed nets, etc.
- **Limited capacity within local line agencies:** Even when hygiene messages are defined centrally, there can be a loss of quality due to limited understanding on the part of local line agency staff. There is a need for local innovation in hygiene promotion practices, as well as for translating international insights into local understanding to achieve better quality results.
- **Gender stereotypes and roles in BCC:** There is a tendency to focus only women as the primary parties responsible for hygiene in the family, without understanding the limited influence that women may have on male behaviour if men are not targeted as well. Male support for proper hygiene behaviour by all family members may have a decisive influence on behaviour in the family. To address this, BCC strategies should carefully balance attention to include men. Although women will often be the primary caretakers, this should not result in a total absence of communication directed to men and boys. Furthermore, stereotyped images, such as exclusively depicting women teaching children how to wash their hands or girls cleaning the family toilet, should be avoided. It is better to balance these with images of men who also take a leading role in hygiene (without overdoing this). If this generates comment and debate, that is a positive result.



3. Process of designing Behaviour Change Communications

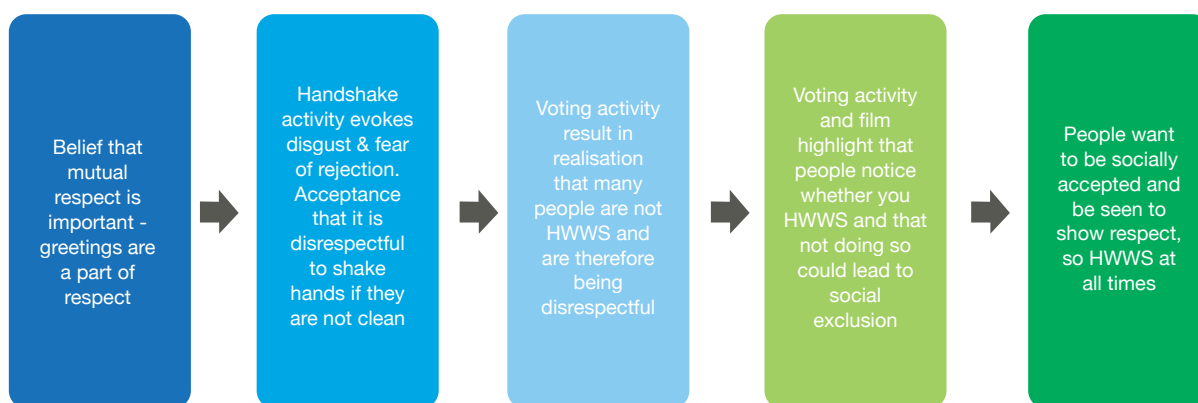
Improving behaviour change communications involves working on both the quality of the design process and strengthening the capacity of line agencies and partners to implement the agreed design. A helpful way to think through the design process has been developed by LSHTM in terms of “Behaviour Centred Design”¹¹. This approach uses five steps, summarised as:

- a. Assess what is known (and not known) about the behaviour in question and define the parameters of the intervention, including specifying the exact behaviours to be changed;
- b. Build – Carry out Formative Research, the results of which will provide the insights that go into the creative brief;
- c. Create the intervention with the help of professionals from local or international creative agencies;
- d. Deliver the intervention, through appropriate channels (including mass media, village and school events, local extension agents, activation agencies). The emphasis being on motivating activities focused on changing behaviour, rather than health knowledge;
- e. Evaluate the intervention, which is complemented by a process evaluation to learn what worked and what didn’t in order to improve future interventions.

In designing the BCC intervention, there are two linked processes that shouldn’t be overlooked.

The first of these is developing a theory of change. A theory of change is essentially a theory about how the BCC intervention works and how it is expected to lead to the intended outcomes. It also sets out key steps in this process. Like a logic model, it is a visual aid, as it diagrammatically illustrates the expected pathway¹² from the current behaviour/state of the world, via the interventions, to the new desired behavior/state. The theory of change should be developed following selection of the most salient behavioural determinants that can be affected through communications, as identified through the formative research.

The following is an example of a theory of change developed by LSHTM related to handwashing with soap. It uses the concept of respect, and is focused on affiliation and disgust as motives.



11. Further information available at <http://ehg.lshtm.ac.uk/behaviour-centred-design>

12. Adapted from <http://resyst.lshtm.ac.uk/news-and-blogs/TOC> which includes a link to further resources including an online theory of change toolkit at <http://mhinnovation.net/resources/theory-change-toolkit>



Clarifying the theory of change guides the definition of three levels of objectives – behavioural objectives, communication objectives and outreach objectives. The behavioural objective is the new behaviour we want the target audience to adopt and includes a targeted percentage of change, which is linked to the baseline data. The communication objective states which behavioural determinants must be addressed (and changed) by the communication activities in order for the target audience to adopt the behavior – e.g, knowledge, attitudes, beliefs, etc. Finally, the outreach objective states the intended reach of communications including targets, which are linked to the percentage change in the behavioural objective above.

Using the following example of handwashing with soap, the three can be seen in a hierarchy. Being clear about the relationships and differences between them helps in organising the design thinking, and subsequent implementation and monitoring.

Behavioural objective: Increase handwashing with soap by caretakers of children under five by 20% at critical times in Thimphu City

Communications objective: After the campaign, caretakers of children under five (target audience) will:

- *Believe* (key determinant) that even clean-looking hands can be dirty if soap isn't used
- *Know* (key determinant) that cleaning hands with rice balls is not enough, washing hands with soap and water is the best way to clean hands

Outreach objective: 100 caretakers of children under five will have been exposed to the messaging

Each objective tells us something important:

- ➔ Whether people are now washing their hands? (Behavioural objective)
- ➔ Whether people have changes their beliefs towards handwashing? (Communication/campaign objective)
- ➔ Whether people have heard the message? (Outreach)

Communication objectives are not the same as the behavioural change goal. But rather they define the goals of each campaign – what must change within the target audience before they can adopt the desired behaviour. For a family to invest in buying a latrine, for example, they must at minimum know the cost, know where to buy it, and understand the benefits of a latrine. Communication objectives should be included in all BCC strategies and creative briefs, as they form the basis for development of messages and materials. They should also be included in the monitoring and evaluation system as a way to track changes in behavioural determinants.

Too often we focus on just one or two of the objectives and skip others altogether. Without understanding the link between each objective we won't have the full picture as to why people did or didn't change their behaviour.

4. The BCC component of SSH4A

4.1 Objective of the BCC component

Hygiene behavioural change communications should be sustained over time. They should also be responsive to changing priorities and needs of both an evolving sector and emerging health issues. This cannot all be done within the scope of any programme within a limited period of one or two years. More important than conducting any specific campaign on one specific behaviour is to build the capacity in local line agencies or other appropriate organisations to develop, test and implement BCC. Anchoring innovative BCC for hygiene in local organisations is the essence of the BCC component of SSH4A. The process of engaging partners is as important as the BCC work. In working with partners, a longer-term vision of professionalising BCC, formalising systems, and improving the links with data from surveillance and the need to innovate can be created, looking beyond campaigns.

Therefore, the specific objective of the BCC component is to improve the **capacity of the client or change agent to implement behaviour change communication activities at scale in their area, leading to improved performance.**

4.2 Capacity development process

It's important to consider the process of capacity development and ensure that this is integrated with the key steps in developing BCC. The following figure illustrates the process and highlights that while some steps are relatively straightforward, there are key 'tensions' to address and be aware of. To complete all of the steps on the left-hand side without consideration of the steps on the right may not contribute sustainably to achieving the objective of the component.

Stand-alone hygiene BCC process	Tension level	Hygiene BCC process with professional and organisational capacity building objectives
-		Make an inventory and reflect on past hygiene promotion efforts and studies
Select a target behaviour(s) and target group(s)		Enhance awareness and incentives for building toilets; augment investment in building wastewater treatment systems
Analyse and validate behavioural determinants		Create awareness of the importance of considering determinants beyond health and do evidence-based design; Challenge of low analytical capacity; Benefit of experience for validating of determinants
Define behavioural objective, communication objective and outreach objective		Integrate objectives into a BCC plan or strategy that is linked to broader local government WASH planning
Make a creative brief		Make a creative brief
Hire a creative agency to design and test BCC activities		Clarify roles, use existing human resource capacities for creation when appropriate.
Creative agency tests BCC concepts and activities		Testing with participation of extension staff
-		Training of local staff on BCC activities.
Implementation of BCC activities, monitoring and quality control		There may be some self-monitoring and self-quality control, but access to information is potentially better; Participatory reflections can be used to adapt implementation when needed
Evaluation of effectiveness		There may be resistance to external evaluation
-		Learn to see it as a learning cycle and start again



4.3 Who to work on BCC with?

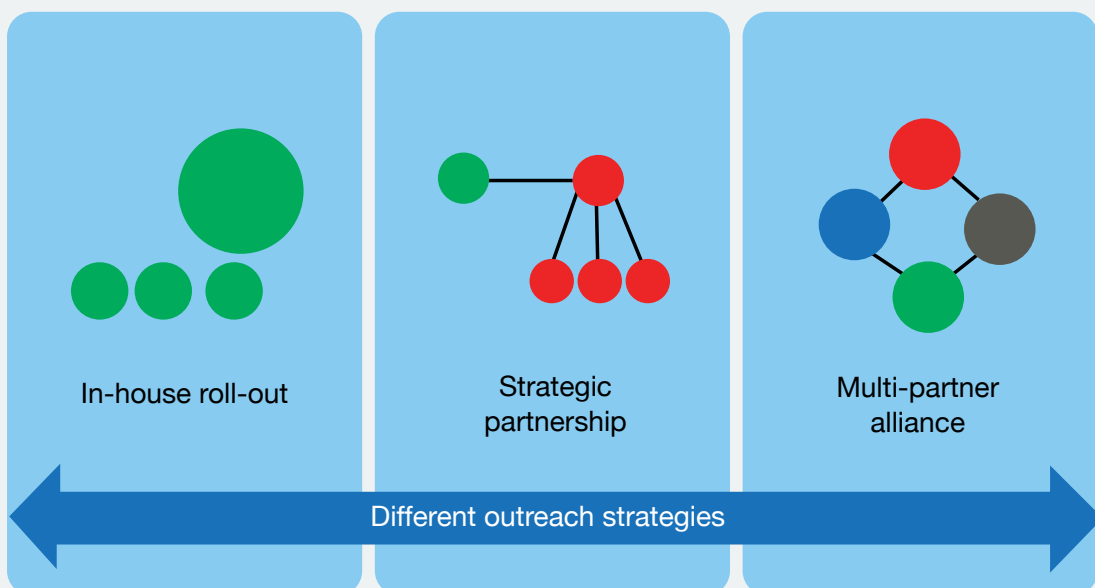
The key agency to work with is the government organisation with the long-term mandate to work on hygiene promotion. This is not always the water supply and/or sanitation agency that the programme may have traditionally been working with. Nor may they be present at each level of government. For example, they may be present at the national and district level but not the sub-district level. The lead agency needs to be clarified and the relationship between any supporting or implementing partners also agreed. In the process, the communication and joint planning or monitoring may also be strengthened.

In the process of implementation it may be important to form strategic alliances with organisations that have outreach or additional credibility with the target group. Existing health extension provides opportunities, for example through health workers, mother-child care support, etc. Alignment with these other agencies also provides entry points to integrate sanitation and hygiene messages into other programmes, such as nutrition or maternal child health. Beyond the traditional agencies, innovative approaches are needed to reach different target groups – for example, using sport to reach men and boys.

The following questions assist in thinking more strategically about whom to work with on BCC and in what roles, including supporting outreach:

- Who should be the main **implementing** organisation(s)?
- Who should **lead and steer**?
- Who should be **supporting**?

Your outreach strategy needs to consider different models to achieve its objective sustainably and at scale. Examples of different ways of looking at this are shown below.



4.4 Summary of key steps in evidence-based Behaviour Change Communication component

Step	Key points and learning to date	Tools and Examples
ASSESS what is known/not known about the behaviour		
1. Define the behavioural objective	<p>Why? To define the target behaviour and population and ensure focus.</p> <p>Select 1-2 key behaviours, based on a consideration of data (for example from the baseline).</p>	
2. Review existing research and communication materials by behaviour and population group to understand the behavioural determinants of interest	<p>Why? To find out what we already know about the behaviour (and what we don't know), and to learn from past experiences These should be mapped against a behavioural framework (for example, by Opportunities – Abilities – Motivation [OAM]).</p> <p>Given the additional literature available both globally and within the region, a thorough literature review should be carried out before developing research protocols for further study. For example, significant knowledge already exists regarding latrine adoption in SNV programme countries in Asia.</p> <p>Once we have clarity on what is already known and what we don't know about the behavioural determinants, it will be clear that some are already well covered. These may just need to be validated in the specific context.</p> <p>From this, we come up with a limited list of determinants that we may want to know more about for a target population. We do not need to create an entire OAM framework for our research, it's too much.</p>	<p>Vietnam and Bhutan:</p> <p>UNICEF Vietnam IEC inventory and the inventory by SNV Bhutan (shorter).</p> <p>WSP Working Paper: What influences open defecation and latrine ownership in rural households?: findings from a global review:</p> <p>http://www.wsp.org/sites/wsp.org/files/publications/WSP-What-Influences-Open-Defecation-Global-Sanitation-Review.pdf</p>
BUILD further knowledge		
3. Conduct formative research, guided by a research protocol and using a behavioural analysis framework	<p>Why? To describe your target audience by understanding their needs and aspirations; to understand the factors which influence their behavior; to determine best ways to reach them.</p> <p>Develop a research protocol (refer to FAQs). Our research questions are specific to the determinants we want to learn about. In addition, one research question can be added to understand the preferred and trusted communication channels.</p> <p>Use a behavioural analysis framework suited to your needs so that you have a structured way of organising the study, data and findings. Examples being SaniFOAM, FOAM, doers-non-doers (see Key Resources):</p> <ul style="list-style-type: none"> • Make sure that someone with in-depth understanding is present in the field – you will need to analyse results and adjust your questions every day. You cannot make a question guideline, roll it out and only start after all field work has been done. It is not a household survey. • Don't make it too big! <p>Learning to date:</p> <ul style="list-style-type: none"> • Most studies have focused on latrine adoption and HWWS, much less on MHM, faecal sludge management and safe water consumption. • Studies that include too many behaviours and/or too many audiences = too many interviews = too much data = shallow data analysis. • There is a tendency to include too many determinants, remember there is no need to examine all behavioural determinants. • Clearly state the behaviours, audiences, determinants that will be explored. • Tools for school children need to be tailored to them. • Gender hasn't be sufficiently considered. • Research reports need to have quotes to provide evidence for conclusions and help readers understand the depth of the conclusions. 	<p>WSP Sanitation Marketing Toolkit: http://www.wsp.org/toolkit/conducting-formative-research</p> <p>SaniFOAM and FOAM frameworks:</p> <p>http://www.wsp.org/wsp/sites/wsp.org/files/publications/GSP_sanifoam.pdf</p> <p>http://www.wsp.org/sites/wsp.org/files/publications/WSP_IntroducingFOAM_HWWS.pdf</p> <p>As of January 2015, SNV Asia country teams had completed a total of 15 formative research studies: Bhutan (4), Cambodia (2), Laos (4), Indonesia (1), Nepal (2) and Vietnam (2).</p> <p>Examples:</p> <p>Bhutan: Formative research studies on HWWS in rural areas, latrine upgrading, FSM (urban), MHM.</p> <p>Cambodia: Formative study on barriers and motivations to latrine adoption among the poor.</p> <p>Nepal: Formative study on barriers and motivations to latrine usage/maintenance and HWWS.</p>

Step	Key points and learning to date	Tools and Examples
CREATE		
4. Define the theory of change and objectives	<p>Why? To identify the priority behavioural determinants from the formative research that can be affected through communication and the process for doing so (for example, insufficient access to water due to climate may be a key factor but it is one that cannot be addressed via communication and therefore should not be chosen as a communication objective). This also ensures the subsequent communication objectives and outreach objectives are based on a clear design logic.</p>	SNV Bhutan BCC Workshop Reports
5. Design the communication campaign	<p>Why? To ensure everybody has the same, correct understanding about the campaign's purpose, objectives and approach (messages, target groups, channels, etc.).</p> <ul style="list-style-type: none"> In some cases, the design will be done in-house. In other cases, the team will create a 'communications brief' and contract a creative agency to develop the design. Developing a communications brief will provide a clear explanation of the campaign's purpose and objectives, describe the problem using supporting data, and identify the target audience, communication channels and the preferred 'look and feel' of the campaign along with collaboration with stakeholders. <p>Learning to date: Consider working with a creative agency to professionalise your campaign.</p>	<p>Examples of Creative Briefs: http://www.wsp.org/sites/wsp.org/files/userfiles/WSP-Creative-Brief.pdf</p> <p>Campaign design example: http://www.superamma.org/campaign.html</p>
6. Pre-test multiple creative concepts and products	<p>Why? To ensure your campaign concepts and materials are understood, attractive, acceptable and persuasive to your target groups.</p> <p>Your campaign concept is like an "umbrella" for the campaign. By maintaining a single look and feel, a set tone, and focusing on set messages and delivery channels, your interventions/materials will be easily identifiable as part of a single campaign.</p> <p>Ideally generate 2-3 concepts to test.</p> <p>Learning to date:</p> <ul style="list-style-type: none"> Pre-testing is an area that has received insufficient attention. In some cases, materials are not linked to formative research findings. Messages so far have maintained a strong focus on knowledge, rather than the recommended shift to emotional, aspirational messages. 	<p>Pre-testing quick tips: http://www.wsp.org/sites/wsp.org/files/userfiles/WSP-Pre-testing-Communication-Materials.pdf</p> <p>SNV Vietnam's BCC Campaign in Nghe Anh</p>
7. Finalise behavior change communication package	<p>Why? Packaging the final products will ensure consistency in approach and support the uptake and make the available externally.</p>	<p>Examples:</p> <p>Stop the Diarrhea Campaign http://www.watershedasia.org/stop-the-diarrhea-campaign-menu-of-options/</p> <p>Super Amma Campaign http://www.superamma.org</p>

Step	Key points and learning to date	Tools and Examples
DELIVER		
8. Develop localised BCC strategy	<p>The BCC strategy is a specific part of a district sanitation plan, going into greater detail on the BCC aspects. It aims to improve the quality and effectiveness of BCC.</p> <p>It includes:</p> <ul style="list-style-type: none"> • A shared vision regarding BCC. • Defines the behavioural, communication and outreach objectives and proposed interventions. • How the BCC strategy links to the overall sanitation planning (district/provincial plan). • The reasons behind the selected key behaviours (why these behaviours). • The outcomes of the formative research and the identified motivators, if possible the messages and innovative channels of communication. • The adjustments/ improvements that will be made to BCC and IEC as a result of the above reflections., • Roles and responsibilities. <p>Learning to date:</p> <ul style="list-style-type: none"> • The BCC strategy or plan is a key tool in post-ODF and sustainability. • Sometimes communication objectives developed directly address the research finding but not the underlying issue. It is important to reflect on underlying issues. 	<p>Examples:</p> <p>SNV Bhutan</p> <p>SNV Nepal</p>
9. Implement campaign/activities	This should include the training of staff in line with the outreach strategy. This will aim to improve the consistency in messaging and build communication skills.	
EVALUATE		
10. Monitor, measure and adapt	<p>Why? To troubleshoot bottlenecks in the BCC campaign design or implementation promptly, and also to keep everybody on the same page. This will also allow the approach to be adapted and improved over time.</p> <p>Refer to 4.5. Monitoring should be done at four levels:</p> <ul style="list-style-type: none"> • Outreach • Communication objective • Behavioural • Capacity outcomes 	Outreach Monitoring Tool in AKVO, SSH4A Results Programme

4.5 Monitoring impact, outcomes and effectiveness

4.5.1 Impact measurements

As part of its performance monitoring, SNV monitors the behaviour change using standardised indicators globally and reported annually (see summary below). These are measured through household surveys.

Measuring behaviour change: SNV Impact Indicators 1-3

1.1 Progress in number of households and number of people (male and female) with access to a sanitary toilet
1.2 Progress in number of schools and number of students (boys and girls) with access to a sanitary toilet
2.2 Progress in number of additional households and number of people (male and female) that use a hygienic toilet
2.3 Progress in number of schools and number of students (boys and girls) that use a hygienic toilet
2.4 Progress in number of households and number of people (male and female) with adequate handwashing facilities with soap in or near the toilet
2.5 Progress in number of schools and number of students (boys and girls) with adequate handwashing facilities with soap in or near the toilet

4.5.2 Capacity development outcomes

Throughout each step of the process there should be clear roles and engagement with the relevant line agencies in line with the objective of the component. Reflecting this, the outcome-level measures progress with regards to increased capacity of local organisations to implement behaviour change communication at scale and with quality.

The following outcome indicator applied in the Asia programmes uses a scorecard, with the lead agency responsible for designing, planning, organising and implementing behaviour change communication activities.



Outcome Indicator 7: Capacity to implement behaviour change communication at scale					
Organisational elements and statements	SCORES				
	0	1	2	3	4
Your organisation ...					
1.Has a BCC strategy or action plan that includes sanitation and hygiene focus behaviours and target groups in line with national guidance and/or plans					
2.Has a clear division of roles and responsibilities to implement the strategy or plan					
3.Has adequate human and financial resources to implement BCC activities in line with its strategy or plans					
4.Develops BCC based on formative research or evidence of motivators					
5.Tests effectiveness of messages and approaches with the target audience					
6.Provides training to facilitators or other implementers in BCC approaches to an adequate standard					
7.Regularly assesses the performance of facilitators or others responsible for BCC interventions					
8.Reviews approaches based on monitoring or lessons learned					
9.Monitors the usage and effectiveness of BCC materials					
10.Adapts or tailors the approaches and messages based on the changing context, lessons learned and/or specific target populations					

Notes: 1. Additional explanations and examples are provided in the SSH4A Performance Monitoring Guidelines
2. Scores: 0 = non-existent; 4 = fully present.

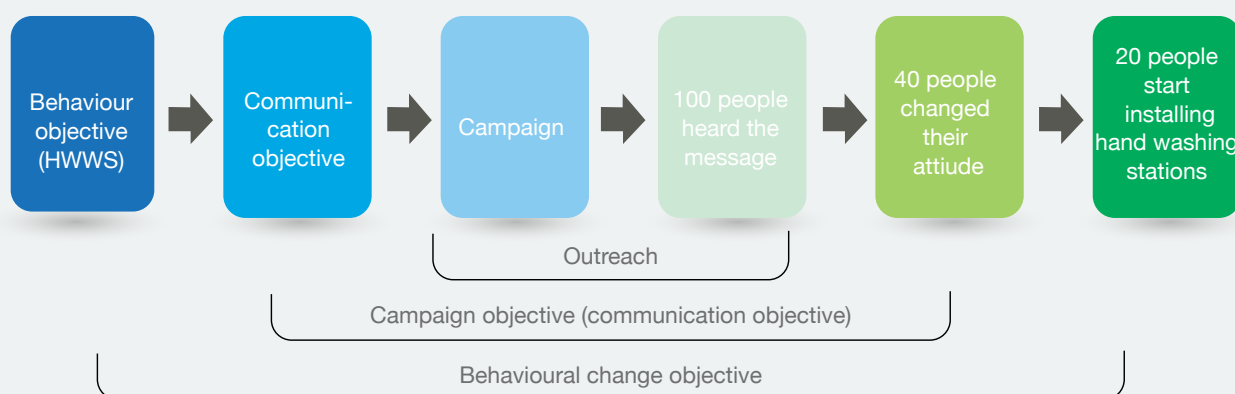
Currently the SSH4A Results programme measures the existence and quality of a strategy in terms of progress using Sustainability Indicator 5: Progress on institutionalising hygiene behavioural change communication.

Sustainability Indicator 5: Progress on institutionalising hygiene behavioural change communication	SCORES				
	0	1	2	3	4
Your organisation ...					
1.The BCC strategy has activities related to rural sanitation and/ or hygiene					
2.Has focus (on specific selected behaviours and target groups)					
3.Engages other actors, besides the lead line agency					
4.Is based on (formative) research with target group					
5.Includes other motivators besides health					
6.Includes other communication channels besides health sector					
7.Uses communication methods based on adult learning principles					
8.Is monitored for outcomes					
9.Is sustained (> 6 months)					
10. Is integrated into a broader WASH or planning strategy such as a local sanitation plan					

Note: Measured by SNV with the relevant agency or provincial/regional/district stakeholder.

4.5.3 Effectiveness

When measuring the effectiveness of hygiene promotion, a distinction should be made between measuring the change in behaviour itself, the communication objective and the outreach objective. To recap, these are shown in the diagram below:



For example, in monitoring, if we didn't see a change in handwashing behaviour as expected:

- Was it because they didn't receive the message (outreach issue)?
- Was it because the messages didn't address the right determinant (communication objective issue)?
- Was it because the behavioural determinant changed, but it didn't actually impact on the behaviour?

Therefore, in addition to looking at the behaviour, there is also value in measuring whether the targeted behavioural determinants changed as a result of the campaign. There are examples where the behaviour did not change, but the population did change their attitude towards the issue¹³. In that case, we need to shift to another behavioural determinant, and thus formulate a new communication objective, in order to ultimately influence the behaviour itself.

Measuring communication objectives can thus help us to understand if they were effective. For example, after the campaign, do more or less people 'believe' (example key determinant) that even clean-looking hands can be dirty? This can be done through quantitative or qualitative measures (depending on the determinant in question), but can be as simple as conducting some further FGDs after the initial interventions. It is also useful as a means for cross-checking if the determinants are still relevant and still effective.

Without outreach, well-designed campaigns will have no value. While measuring outreach will not tell us if behaviours have changed, it is a means of monitoring the number of people reached and exposed to the messages through the different mediums. This will also identify any logistical issues in, for example, the distribution of materials. The measurement of outreach has been done with standardised forms per medium in AkvoFLOW in the SSH4A Results programme.

13. In the March 2015 Dgroup discussion, Robert Otim from SNV Uganda working on the Uganda National Handwashing Initiative, shared that there was an aggressive mass media campaign in Uganda that at least managed to change some of the attitude towards handwashing with soap: 95% of the population longer thinks it is a trivial thing. However, this was not yet sufficient to result in a change in behaviour.



The different mediums considered are:

- Interpersonal communication;
- Materials for distribution;
- Materials for display;
- Radio;
- Television;
- Large gatherings;
- Small groups;
- SMS.

They are then reported on using the following standard form:

Medium	Target group	Communication objective	Behaviour objective	Aggregate number of people reached (disaggregated by sex)		Total number of people reached
				FEMALE	MALE	

The results of the monitoring at these three different levels is then shared in a discussion with the key stakeholders/partners in a process of sense making. From this there will be a clearer understanding of the meaning of the data, ownership and any necessary adjustments to be made.



5. Frequently asked questions regarding the BCC component

What's the difference between the formative research and the baseline survey?

The baseline survey is about WHAT people do.

The formative research is about WHY people do it.

The baseline survey has breadth (large sample size, more indicators).

The formative research has depth (small sample size, focus on 1-2 behaviours).

The baseline aims to measure whether we make progress in each of the four components of the programme, as well as in impact.

The formative research aims to inform the development of improved messages and the development of the local BCC strategies.

For SNV, the formative research comes after the baseline, using the data from the baseline to define its focus.

The data collection for the impact indicators of the baseline is done with one single set of questions for all households. It does not require as much capacity from the surveyors as the formative research. The data collection for the formative research is an iterative process. It requires refinement of questions after every interview/FGD, and high-quality personnel and training in qualitative research methods.

What's the difference between the district/provincial sanitation plan and the BCC strategy?

The district sanitation plan covers all aspects of sanitation, listing:

- **Targets** set by the local stakeholders related to ODF and/or improved sanitation. Typically we will achieve full ODF by
- **Activities** that the district/ province will promote to achieve those targets. It may include several different activities, often in terms of demand creation (mostly CLTS), sanitation supply chain development, and BCC.
- **Budget, time lines, roles and responsibilities** for those activities.
- **Monitoring indicators** for how progress will be monitored.
- **Specific** - it can be a district or provincial sanitation plan, or the above elements can be addressed within other local planning documents.

The BCC strategy is a component of the district sanitation plan, going more into detail for the BCC aspects. Each of the strategies may have different owners related to the responsibilities for sanitation and hygiene respectively. It aims to improve the quality and effectiveness of BCC/ IEC. It includes:

- A shared vision or objective regarding BCC;
- How the BCC strategy links to the overall sanitation planning (district/provincial plan);
- The outcomes of the reflections resulting from the review of existing materials;
- The reasons behind the selected key behaviours (why these behaviours);
- The outcomes of the formative research and the identified motivators, if possible the messages and innovative channels of communication;
- The adjustments/ improvements that will be made to BCC and IEC, as a result of the above reflections;
- Roles and responsibilities.

What are the steps to formative research?

A significant amount of research has already been conducted to date. The formative research studies explored the barriers and motivations to the following behaviours: latrine adoption, handwashing with soap (HWWS), upgrading to hygienic latrines, fecal sludge management (FSM), safe water consumption, and menstrual hygiene management (MHM).

The process is like a funnel, serving to narrow down the reasons why people perform a specific behaviour. It is not to research the same questions in subsequent studies nor to research all of the behaviours. The following are key steps in developing the focus of the research.

1. Find out what we already know about the behaviour – for example find other studies within country and the wider region;
2. Map these findings to a framework, such as OAM;
3. Review what we now know given results of question 1. Are some determinants well covered? Do we need to know more about other determinants? Do we need to validate these findings from another region to our region?;
4. Based on this we come up with a list of LIMITED determinants. Unless there is no existing research or knowledge about what we want to know, we try to limit the number of determinants. We do not need to create an entire OAM framework for our research, it's too much and there may be difficulties in analysing that much data;
5. Our overall research objective is to understand the barriers and motivations to a specific behaviour. Our research questions are specific to the determinants we want to address, plus one question on communication channels;
6. You may want to include a doer/non-doer analysis. Refer to the existing guides in the Key Documents section;
7. Document this in the research protocol. Refer to the examples in the existing studies.

What should be in the formative research protocol?

A formative research protocol is as important when the research is done in-house as when the research is contracted out. Below is an example of the contents:

1. Introduction;
2. Rationale for the FR, including a review of outcomes of the baseline data, which justifies the selection of 1-2 behaviours;
3. Objective of the formative research;
4. Introduction of the theoretical framework – see 2.5;
5. Behavioural change questions for each behavior and selection of target population;
6. Methodology;
7. Hypothesis for behavioural determinants;
8. Team (team training);
9. Timeline;
10. Budget, etc.

How should we include communication channels?

As part of formative research it is useful to also collect data on preferred and trusted communication mediums by target group. This then helps the design of subsequent communication activities to be tested.

There are a few points to keep in mind:

- Which groups are reached by each channel? How often and when? Consider gender, poverty, and different cultural and social groups. Does this include any household decision makers for example? How effective would this channel be in terms of capturing attention, interest and recall? It is not complex to find out which channels are used and which are most trusted. This can be done through a few simple FGDs.
- What are the costs involved?¹⁴

The following is a list of example communication activities adapted from Population Services International:

Example Communication Activities

Interpersonal Communication – Interactive, one-to-one personal communication:

- **Peer education** – When done on a one-to-one basis;
- **Outreach** – Again, when done on a one to one basis;
- **Provider Counselling** – Delivered by a caregiver, health professional, or a similar person directly to the target person in a one-on-one setting.

Small Group Activities – Interactive communication between one person and several individuals at the same time:

- **Peer education** – When done with a group of people rather than just one person;
- **Outreach** – Again, when done with a group of people rather than just one person;
- **Community/organisational meetings;**
- **Small group activities** – Examples include CLTS triggering events, workshops, street theatre, peer education and outreach. Materials, such as brochures, are often distributed as part of these activities.

Media:

- **Mass or local media** – Includes tools such as television, radio, outdoor billboards, newspaper, magazines, etc. “Mass” typically refers to reaching large audiences at the same time, often most or all of the entire country. “Local” often refers to media specific to a given city or region;
- **Public relations (PR)** – Communication presented via mass media in a news format, such as TV news reports or newspaper articles;
- **Event sponsorship** – Includes sporting events, award presentations, concerts, etc. Good for short, simple messages, including brand promotion;
- **Educational programming** – An entertainment vehicle such as a television programme, mobile video unit, pop song, or game that also communicates health messages, models risk reduction behaviour, shows the consequences of risky behaviour, etc;
- **SMS;**
- **Social Media.**

14. Adapted from the Hygiene Improvement Projects “Sanitation Marketing for Managers Guidance and Tools for Program Development”, USAID, July 2010 available online at <http://www.hip.fhi360.org/page/5007.html>

Each medium has its strengths and weaknesses. For example, images can be more powerful than words. Radio can reach many more people than IPC but IPC can tailor the messages to each individual and enable two-way communication. Traditionally people in particular are thought to have the most direct influence on our behaviours, either directly or when the mass media demonstrate people like ourselves practising recommended behaviours¹⁵.

Therefore it is important to think about the 'communication mix' and choose both primary and supporting channels to reach your target groups. There is a balance to be found between reach (i.e., number of people your messages will reach by the channel) and effectiveness (i.e., will a message via the channel be persuasive and credible).



15. Adapted from "A Manual on Communication for Water Supply and Environmental Sanitation Programmes", 1999, Unicef Technical Guidelines Series.



6. Key resources

Reference documents

A Guide to Behaviour Centred Design (Draft), Robert Aunger and Valerie Curtis, Hygiene Centre, London School of Hygiene and Tropical Medicine, 2015

A draft guide using an evolutionary framework, it unites findings about how brains learn, with a practical set of steps and tools to design successful behaviour change programmes. This document is designed to encourage behaviour change practitioners to think differently about behaviour – both in understanding how and why it is produced and in how to design programmes to change behaviour. It describes the process of developing, creating and testing a behaviour change intervention, with five key steps.

<http://ehg.lshtm.ac.uk/behaviour-centred-design>

Barrier Analysis Facilitators Guide: A Tool for Improving Behaviour Change Communication in Child Survival and Community Development Programs,

Food for the Hungry and Core Group, 2010

A rapid assessment tool used in community health and other community development projects to identify behavioural determinants associated with a particular behaviour. This guide is written for trainers to teach others about Barrier Analysis and/or to learn the techniques themselves. It guides trainers through a step-by-step process for conducting the analysis and provides background information on the technique as well as some basic information on behaviour change theory.

<http://www.c-hubonline.org/resources/barrier-analysis-facilitators-guide-tool-improving-behaviour-change-communication-child>

FOAM and SaniFOAM Working Papers, WSP

The two Working Papers provide an overview of the respective FOAM (Focus on Opportunity, Ability, and Motivation) frameworks for handwashing and sanitation behaviours. The frameworks, developed for use in resource-poor settings, can be adapted across diverse socioeconomic environments.

They are currently being applied as part of WSP's Scaling up Sanitation programme, as well as by multilateral and bilateral agencies, academic institutions, and by government agencies and NGOs working in water and sanitation.

Devine J (2009), Introducing SaniFOAM: A Framework to Analyze Sanitation Behaviours to Design Effective Sanitation Programs, World Bank Water and Sanitation Programme

http://www.wsp.org/wsp/sites/wsp.org/files/publications/GSP_sanifoam.pdf

Coomes Y and Devine J (2010), Introducing FOAM: A Framework to Analyze Handwashing Behaviours to Design Effective Handwashing Programs, World Bank Water and Sanitation Programme

http://www.wsp.org/sites/wsp.org/files/publications/WSP_IntroducingFOAM_HWWS.pdf

Synthesis reports of formative research

Planned, motivated and habitual hygiene behaviour: an eleven country review

Curtis, Danquah and Aunger, 2009

A review of the results of formative research studies from 11 countries to understand the planned, motivated and habitual factors involved in HWWS. Key 'motivations' for handwashing were disgust, nurture, comfort and affiliation. Fear of disease generally did not motivate handwashing, except transiently in the case of epidemics such as cholera. 'Plans' involving handwashing included to improve family health and to teach children good manners. Environmental barriers were few as soap was available in almost every household, as was water. Strategies for promoting HWWS include creating social norms, highlighting disgust of dirty hands and teaching children HWWS as good manners.

Curtis, Valerie, Lisa Danquah and Robert Aunger (2009) 'Planned, motivated and habitual hygiene behaviour: an eleven country review.' *Health Education Research* 24(4): 655-673.
Open access via <http://her.oxfordjournals.org/content/24/4/655.long>

What Influences Open Defecation and Latrine Ownership in Rural Households: Findings from a Global Review,

Kathryn O'Connell, WSP, 2014

This review collects the results from formative quantitative and qualitative research reports and presentations from eight countries: Cambodia, India (Rajasthan, Meghalaya, and Bihar), Indonesia (East Java), Kenya, Malawi, Peru, Tanzania, and Uganda. The most salient factors influencing rural sanitation behaviours that emerged from the review include access to and availability of functioning latrines, sanitation products, and services; latrine product attributes (for example, perceptions of cleanliness and durability); social norms around open defecation; perceptions of latrine affordability; self-efficacy to build latrines; and competing priorities for other household items. The review also identified a number of emotional, social, and physical drivers. These include shame and embarrassment associated with open defecation, as well as perceptions of improved social status, privacy, and convenience associated with latrine ownership and use.
<http://www.wsp.org/sites/wsp.org/files/publications/WSP-What-Influences-Open-Defecation-Global-Sanitation-Review.pdf>

Online resources and toolkits

BCC DGroup is SNV's moderated discussion group and a library of shared resources. It currently has 420+ members from 43 countries, including practitioners from urban and rural sanitation, SNV advisors, and government and knowledge partners. Requests to join can be made at <https://dgroups.org/snv/washasia/bcc>

Hygiene Central is managed by the research group at the London School of Tropical Health and Medicine. It includes a range of resources for practitioners, including webinars, publications, toolkits, fact sheets and updates on their current work, including Evo-Eco, the Super Amma campaign and behavior-centred design.
<http://www.hygienecentral.org.uk>
<http://ehg.lshtm.ac.uk/behaviour-centred-design>

WSP Online Toolkits for Behaviour Change and Sanitation Marketing

Presented as a portal for accessing resources, tools, publications and videos, this includes practical examples of the different steps including formative research, working with creative briefs and campaign development for both behaviour change and sanitation marketing.
<http://www.wsp.org/hwvs-toolkit/behaviour-change>
<http://www.wsp.org/toolkit/what-is-sanitation-marketing>

BEHAVIOUR CHANGE COMMUNICATION GUIDELINES
SUSTAINABLE SANITATION & HYGIENE FOR ALL (SSH4A)

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