Simavi is an international non-profit organisation working towards a world in which basic health is accessible to all. Our goal is to structurally improve the basic health of 10 million people in marginalised communities in Africa and Asia by 2020. By doing so, we enable them to build a better existence and break the cycle of poverty. Our experience over the past ninety years has shown us that investing in water, sanitation and hygiene (WASH) and in sexual and reproductive health and rights (SRHR) is vital for people to be able to lead a healthy life. Therefore we concentrate our efforts in these two areas.

All our programmes are based on three integrated pillars: 1) Empower communities to demand quality services and to practice healthy behaviour; 2) Create a supportive, enabling environment in which all stakeholders are aware of their roles and responsibilities, work together and can be held accountable; 3) Ensure that people use affordable, suitable and sustainable WASH and SRHR services. This is the core of our Theory of Change – it’s designed to ensure that everyone involved, from community to governmental level, works together towards realising sustainable improvement of basic health.

Behaviour Change Communication in Health

Background
Being able to lead a healthy life is influenced by many factors. It doesn’t only depend on increased access to WASH facilities, medicines or treatment. Improved insights in health behaviour can provide a tremendous impact in the onset and course of health problems and act as a basis for health promotion.

However, making a long-term change in behaviour is rarely a easy process. Individual, social and other external factors should be integrated to positively influence healthy behaviour. There are many different theoretical models, frameworks and strategies to guide behaviour change interventions: in this document we will explain our approach to changing health behaviour in a sustainable way and show how it is used effectively in our WASH and SRHR programmes.

Behaviour change in health issues is strongly embedded in Simavi’s Theory of Change. It stimulates healthy behaviour of empowered communities, improves utilisation of sustainable WASH and SRHR services, and contributes to a supportive environment.

Behaviour Change Communication (BCC) is widely used and stimulated by Simavi. BCC is a strategy for obtaining and maintaining healthy behaviour at individual, community and national level. By triggering positive health-seeking behaviour we increase awareness and the demand for quality services with the ultimate aim to increase sustainable access and use of these services. Our strategy is composed of several building blocks – first we’ll explain behavioural change at the three different levels, then the different building blocks.

**Individual level**
Simavi focuses on the following types of individual health behaviour:

- Healthy living, such as birth spacing, safe sex, breastfeeding, washing hands before eating, using latrines instead of open defecation, etc.
- Recognition of early symptoms and prompt self-referral for treatment, such as oral rehydration in case of diarrhoea, birth preparedness plans for delivery, etc.
- Utilisation of health and WASH services, antenatal and postnatal care, child health, (provision of) contraceptives and obstetric care, operation and maintenance schemes, water testing services, water filters, etc.

Knowledge, awareness, beliefs and feelings about certain health practices can play an important role in determining health behaviour. Simavi addresses these motivations, concerns and constraints (see cases) to help individuals to achieve sustained changes in health practices and create a sustained demand for health resources.

**Community level**
At household and community level, power relations, social status, cultural values and economic priorities may determine health practices, as well as the (perceived) accessibility of services and availability of goods. Simavi’s community participatory approach is based on the perspective of a community. Influential members of the community (village leaders, village health committees, traditional birth attendants, teachers, elders) have a major influence on the behaviour of individuals. We involve and cooperate with the community and use the role of influential change makers right from the start of the programme. This increases ownership and the sustainability of health programmes. An example of a community mobilisation approach often used by Simavi is Community Led Total Sanitation (CLTS).

**National level**
Lobby & advocacy strategies on national level affect individual health behaviour. National decisions to improve health infrastructure, health policies and make sufficient qualified health staff available, have a great influence on improving and maintaining individual health behaviour. In our programmes, Simavi focuses on the responsibility of national government stakeholders to improve allocation of qualitative health facilities in line with the need of the community.

**Simavi’s building blocks**
We use a large variety of proven approaches and building blocks to inspire sustainable behaviour change. Simavi also stimulates local partners to use better analysis structure when using BCC. This can be done with the Stages of Change model. Special techniques...
and interventions are developed within each stage to stimulate progress to the next stage².

Obtaining an insight into individual differences in behaviour helps an individual to reach the final stage of this change process. It also supports the community to positively influence the enabling environment. Messages are tailored to individual differences and different communication channels will be developed to influence each individual.

The following tools and strategies are used as Simavi’s building blocks to improve health behaviour:

**KAP study**
Simavi supports local partners to use the Knowledge Attitude and Practices (KAP) approach to better understand their local practices on different levels. A KAP study provides formative research and is built on what local individuals and communities know, do and need across different cultures, genders and ethnic groups. In this stage of formative research, risk practices are investigated through observations, interviews & focus group discussions.

**Community Led Total Sanitation (CLTS)**
Simavi promotes the use of CLTS; a fixed approach composed of different building blocks. This methodology aims at mobilising communities to completely eliminate open defecation. Communities are facilitated to conduct their own appraisal and analysis of open defecation and take action to become open defecation free (ODF). The methodology focuses on behavioural change only - financial incentives are not included. At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. CLTS focuses on the behavioural change needed to ensure real and sustainable improvements – we invest in community mobilisation instead of hardware, and shift the focus from toilet construction for individual households to the creation of open defecation free villages. By raising awareness, providing skills and letting people perceive the benefits of healthy behaviour, CLTS triggers the community’s desire for collective change and propels it into action. This encourages the community to innovate, provide mutual support and about appropriate local solutions, leading to greater ownership and sustainability. Simavi has used the CLTS approach for a long time with positive long-term results.

**Social marketing**
With social marketing Simavi utilises commercial marketing principles to promote the adoption of behaviour change for communities. Social marketing works from a user perspective. Like commercial marketing, the primary focus

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**Case Text Messages on SRHR in Malawi (individual level)**

In 2011 the Unite For Body Rights (UFBR) programme ‘My Choice My Future’ started in Malawi. This programme is based on three pillars: 1) comprehensive sexuality education; 2) accessibility and quality of SRHR services; 3) an enabling environment. It is executed by 5 partner organisations in Malawi, supported by Simavi, Choice and Rutgers WPF. Simavi’s partner organisation Youth Net and Counselling (YONECO) implements the programme in Mangochi. Within the whole UFBR programme YONECO has created a behavioural change communication method of ‘texting and hotline’.

In Mangochi more young people now visit the health services for SRHR. Also the use of contraceptives has increased.

During their work raising awareness with peer educators, YONECO discovered that young people don’t feel comfortable discussing sensitive issues face to face. Also they want immediate answers and don’t want to wait to meet a peer educator. Therefore YONECO created a hotline that youth can use to call or text with questions on SRHR. Questions are collected in a database that is used to create better insights into the behaviour and factors that influence youth behaviour. This analysis is then used to text young people with specific messages on SRHR for healthy behaviour. Peer educators also discuss the text messages during the community visits, ensuring communication operates at different levels.

**Case The Total Sanitation Approach in Indonesia**

In 2010, Simavi set up a community-based total sanitation programme in Eastern Indonesia. Two partners included sanitation marketing in their projects. Objective was to achieve STBM - the Indonesian approach to CLTS, which besides on open defecation, also focuses on clean drinking water, hand washing with soap, solid waste management and liquid waste management.

By December 2013, a total of 1,360,000 people in 985 villages had been monitored. Already more than 970,000 respect all five aspects of the STBM approach with 6 months to go in the program. Further results included some government health systems adopting the STBM implementation using the SHAW approach, and monitoring methods of the SHAW programme were adopted by the national Indonesian government.

Behaviour change through social marketing and improving community capacities were key to the programme’s success. Sanitation programmes incorporated the need to raise awareness, create demand for sanitary toilets and increased capacities for sustained WASH services and practices. Healthy practices among WASH are now deeply internalised in daily life.
is on the consumer; social marketing is based on learning what people want and need, rather than trying to persuade them to healthy behaviour. Local knowledge, vision and beliefs should be taken into account when deciding about the availability and affordability of a convicting product or service. Our goal is to create demand for health services and products. Our social marketing is developed around the so-called 4P framework:

1. **Product**: An object (e.g. a latrine or contraceptive), a service (e.g. antenatal check-ups) or a practice with objects/services (e.g. washing hands with soap).
2. **Price**: Products and services need to be affordable in terms of money and (if applicable) extra effort needed.
3. **Place**: The products and services must be easily available and communication must reach the audiences.
4. **Promotion**: This requires understanding the motivations of audiences and the channels of communication they trust.

**Impact**

As shown above, Simavi stimulates and supports local partners in the process of behaviour change communication by using a mix of building blocks. Behaviour Change Communication is integrated and combined with other programme interventions within our WASH and SRHR programmes. This integral approach leads to improved community mobilisation and empowerment. It ensures sustained quality and access to WASH and SRHR services. The case studies below provide some examples.

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**Case Drama groups for safe motherhood**

In Tanzania most women prefer to give birth in their own home instead of a health facility. There are several reasons for this behaviour, but it is mostly due to local culture and the preference of delivering with a traditional birth attendant. Since these attendants are not medically qualified, this results in a high percentage of maternal deaths. PATUTA is a local NGO in Mpwapwa that has been supported by Simavi to change this behaviour to women delivering with skilled medical assistants.

Since 2010 there has been a significant rise in both the number of women delivering with skilled attendants, as well as the number of TBAs referring women to health facilities.

PATUTA adopted multiple approaches to change behaviour. They worked with the government to analyse the reasons why women don’t want to deliver in health clinics. They also analysed the behaviour and motivation of traditional birth attendants. Their integrated strategy supports awareness raising within the community, as well as stimulation of the traditional birth attendants to refer women to health clinics. In the communities they work with local theatre groups and village leaders. During the weekly village meetings the theatre groups perform plays on different SRHR issues, including delivery. These plays are well written and while entertaining, also provoke discussion on the matter. With support of the village leaders the community agrees on bylaws for those who don’t deliver with skilled attendants. Behaviour change on community level has proven to be very effective.

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**Case Posters & calendars on WASH in Nepal**

NEWAH has been a strong partner organisation in Nepal since 2003 and is well known for their implementation of WASH services in local communities. Our three-year programme focused on six Village Development Committees (VDCs) in Gorkha and Baglung District. Behaviour change is one of the key activities within their health and sanitation promotion programme. As part of their BCC NEWAH produced posters and calendars on WASH-issues that were placed in strategic locations. These included a calendar for the Nepali year 2061 with satirical cartoons conveying sanitation and hygiene related messages. The confrontational messages provoked on the spot discussions. The central messages of the posters include the critical times for hand washing, how germs are spread, water purification techniques and the need for latrines.

Three thousand copies were produced and distributed to communities, local government and local NGOs throughout Nepal. With this kind of health promotion a huge secondary audience can be reached.