Proceedings of the Learning Event on Sustainable Sanitation & Hygiene for All

Health Development Army, Gosh Beret Kebele, South Gondar Zone, Ethiopia. Photo from Field Group 2 outputs. 2018.

"Chasing the SDGs: scale, sustainability and new frontiers in rural sanitation and hygiene."

Bahir Dar, Ethiopia: 23D 26 April 2018

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List of Acronyms

BCC	Behaviour Change Communication
CBD	Central business district
CLTS	Community-led total sanitation
CLTSH	Community-led total sanitation and hygiene
DFID	UK Agency for Overseas Development
FSM	Faecal sludge management
GTP	Growth and Transformation Plan
HAD	Health Development Army
HEW	Health extension worker
HWWS	Hand-washing with soap
JMP	Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
M&E	Monitoring and evaluation
MDH	Millennium Development Goal
MEL	Monitoring, evaluation and learning
MHM	Menstrual hygiene management
MOE	Ministry of Education
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOWE	Ministry of Water and Environment
MSF	Multi-stakeholder Forum
NGO	Non-government organisation
NWCO	National WASH Coordinating Office
NWSC	National WASH Steering Committee
NWTT	National WASH TT
OD	Open defecation
ODF	Open defecation Free
OWNP	One WASH National Programme
PLWD	People living with disability
PMU	Programme management unit
SDG	Sustainable Development Goals
SIDA	Canadian's Agency for Overseas Development
SLTSH	School-led total sanitation and hygiene
SSH4A	Sustainable Sanitation and Hygiene for All Programme
STBM	Community-based total sanitation (Indonesia)
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for Overseas Development
WASH	Water, sanitation and hygiene
WB	World Bank
WIF	WASH implementation Framework

I. Background

Sustainable Sanitation and Hygiene for All

The Learning Event was conducted through SNV's Sustainable Sanitation and Hygiene for All (SSH4A) programme. In Ethiopia, SSH4A RP was implemented across six project woredas - Sekota Zuria, Dehana, Gazgibla, Abergele, Ziquala and Sehala - in the Waghimra zone of Amhara Regional State between April 2014 and March 2018 and in Estie Woreda in South Gondor Zone of the Amhara Regional state from January 2017 to March 2020. The learning event was held at Bahir Dar in Amhara Regional State.

The SSH4A programme was introduced in 2008 and now reaches over 10 million people in more than 12 countries across Africa and Asia. SSH4A is a collaboration between SNV, national governments and line agencies, and knowledge partners. It is a single framework tailored to each country context, with shared indicators for outcome and sustainability. The framework consists of five interconnected components. The first four – WASH governance, sanitation demand creation, sanitation supply chains & finance, and hygiene change communication – are illustrated in Figure 1.

Figure 1: Four components of the SNV Sustainable Sanitation & hygiene for All Framework. Source: SNV

The fifth component is focused on promoting exchange between countries: analysis, dissemination and learning; this Learning Event is part of the fifth component.

SSH4A Learning activities

Learning activities are not a one-off event: they are a process. This learning activity included the following events:

i. Preparatory online DGroup. These discussions took place between 06 March and 14 April 2018 in 2018. The purpose and outcomes of these discussions is articulated in Annex II of this report.
ii. Learning Event Workshop. This was held in Bahir Dar, Amhara Regional State, Ethiopia. This report articulates the proceedings and outcomes of this event.
iii. In-country follow-up (depending on country priorities) and included as the country shopping bag in this report.

Learning Event Attendees

Participants for this Learning Event included representatives from the eight countries that are currently implementing SNV's SSH4A Results Programme – host-country Ethiopia, Ghana, Kenya, Mozambique, Nepal, Tanzania, and Uganda In addition, there were representatives from Bhutan, where SNV is implementing WASH activities with funding from the Australian Department of Foreign Affairs (DFAT), as well as from Indonesia, Benin, Burkina Faso, Rwanda and Zambia where SNV is implementing other sustainable sanitation initiatives that are supported through other funding sources.

Other participants included representatives from the Programme Management Unit (based in Kenya), the SNV Global Support Unit (based in the Netherlands), SNV WASH programme staff from Indonesia and Honduras, as well as government representatives from Ethiopia, Bhutan, Indonesia, Kenya, Mozambique, Nepal, Rwanda, Tanzania, Uganda and Zambia.

A full list of participants is available in Annex I.

Preparatory DGroup Discussions

A series of DGroup discussions were held between 06 March and 14 April 2018, in preparation for the Learning Event and following the same theme of *Chasing SDGs: Scale, sustainability and new frontiers in rural sanitation and hygiene*. The discussion covered three topics:

1. Challenges in effective implementation of hygiene behavioural change communication (BCC) in rural sanitation and hygiene programmes;
2. Design assumptions in behavioural change communication (BCC) in rural sanitation and hygiene programmes; and
3. Implementation and institutional embedding of BCC.

A summary of each DGroup discussion is available in Annex II.

II. Scheduled Program

Programme		
Day	***Time***	***Activity***
Monday	8.30	Registration
	9.00	Official opening, coffee ceremony by Mayor of Bahir Dar town, Head of Amhara Regional State Bureau of Finance and Economic Cooperation Head and SNV Country Director
		Round of introductions by participants
	11.00	BREAK
	11:30	Presentation of the programme
		Block 1: Realities and Priorities
	11:45	Introduction to Block 1
	12:15	Stocktaking of progress, equity and scale in rural sanitation
	13:00	LUNCH
	14:00	Country milestone discussions and sharing
	15:15	BREAK
		Block 2: The Ethiopian Experience
	15:30	Introduction to the Ethiopian experience
		Explanation and preparation for the field assignment
	17:00	Closure
Tuesday	07:00 - 18:00	Field assignment
Wednesday	8.30	Good morning
		Consolidation of findings
	10:30	Presentation of findings and feedback from stakeholders
	13:00	LUNCH
		Block 3: Post ODF
	14:00	Introduction to block 3
		Presentation of Faecal Sludge Management in Post-ODF
	15.15	BREAK
	15.30	SNV Cambodia's experience in Post-ODF
		Country reflections
	17.00	Closure for the day
Thursday		**Block 4: Building Blocks for Progress**
	8.30	Programme of the day and introduction to block 4
		Mix country group work on building blocks for progress
		Presentation on the RWSSP monitoring exercise (of BCC)
	10:30	BREAK
	11:00	Secret Intelligence Service (SIS): our mission is clear
	13:00	LUNCH
	14:00	Set-up of the World Café feedback
		World Café sessions
	15.30	BREAK
	15.45	Country shopping bags reflection
		Sharing of shopping bags & written evaluation
		Closure sessions
	17:00	Closure
	19:00	Cultural Dinner

III. Opening Remarks

Opening remarks by Ms Meseret Kebede, Communication and Management Support Officer
Ms Kebede commenced the event by welcoming local and international government representatives, SNV country teams and support staff.

IV. Official Opening

Presented by His Excellency Ayenew Belay, Mayor of Bahir Dar,
The Mayor of Bahir Dar, His Excellency Ayenew Belay welcomed all participants, and thanked SNV for the invitation to open the event. He expressed his gratitude to be able to welcome people from all around the world to discuss Sanitation and Hygiene in the context of the SDGs

Presented by Dr Tilahun Mehari, Head of Amhara Regional State Bureau of Finance and Economic Cooperation Head
Dr Tilahun Mehari, Head of Amhara Regional State Bureau of Finance and Economic Cooperation Head, welcomed all participants. He noted the importance of coming together to exchange experiences and ideas to find ways to ensure the achievement of the ambitious SDGs: all countries have a lot to learn from each other. Based on previous progress, Dr Mehari estimated that Ethiopia would need another 12 years to ensure universal access to basic sanitation and hygiene facilities, highlighting the need to find strategies to increase the speed of scaling up access to basic sanitation. He noted that continued reliance on donor support and a lack of continuous funding is an impediment to maintaining and improving access, as is delivering services to areas that are hard to reach due to geographic and infrastructure challenges.

To meet these challenges in Ethiopia, Dr Mehari noted the need to ensure:

- Adequate staffing for WASH interventions;
- Roll-out of national strategies;
- Increasing national financing and investment from <1% to near 4% of GDP;
- Strengthening of sector-wide performance.

He concluded by expressing how he is looking forward to working with all stakeholders to strengthen the government's One WASH strategic approach towards ensuring universal access to sanitation and hygiene throughout Ethiopia.

SNV Ethiopia Programme Insights

Presented by Mr Worku Behonegne, SNV Country Director Ethiopia. Presentation available in Annex III.
Mr Behonegne welcomed all the participants. He stated that it was evident from the programme achievements that using a results based model, focused programming brings real, measurable results that can be scaled up.

He then provided an overview of SNV's engagement in Ethiopia, which began in 1974. He noted the importance of working with government structures and aligning with government priorities, and developing a sense of ownership to ensure government change. By following these principles, SNV currently reaches over 6 million people in in eight regions and Addis Ababa through 17 projects in the agriculture, energy and WASH sectors. The eight current agricultural programmes funded through a number of donors, including SIDA, USAID, Agriterra, Comic Relief, and EKN. Two SNV-implemented energy programmes – NBPE II and NBPE+ - reach some 280,000 people and are funded through the Government of Ethiopia with support from DGIS/Hivos and the EU.

In terms of WASH programming, SNV implements two water supply programmes: iWET, reaching 800 thousand people with funding through the AFAS foundation and TWASH reaching round 2 million people with funding through USAID. SNV's SSH4A sanitation approach reaches nearly 750 thousand people in two areas: Waghimra zone (495,180) and Este woreda (248, 175), both in Amhara Regional State. SNV strives to maximise the impacts of its programmes through creating synergies, including, for example, the SSH4A and renewable energy programmes connecting toilets to bio-digesters as a way to manage human waste hygienically and safely while generating biogas for cook stoves and lamps and fertilizer for agricultural use. SSH4A ensures that no one is left behind, providing advice and guidance on technologies to ensure PLWD and elderly people are able to access basic sanitation and supporting menstrual hygiene management (MHM) for women and girls.

Mr Behonegne concluded by noting that if we want to go fast, we should go alone but if we want to go far, we should go together. SNV wants to go far and these learning events provide an ideal platform for all to work together: to share experiences, achievements and challenges from many countries and diverse settings.

Coffee Ceremony

The opening session concluded with a traditional coffee ceremony: this ceremony is performed in households at least two or three times a day and at any important occasion. The set up for the ceremony incorporates the colours of the Ethiopian flag: green for the fertility of the land, yellow for hope and religious freedom, and red for power and faith. Coffee is served with a small snack, such as popcorn or bread.

V. Introduction to the Learning Event, 2018

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands. Presentation available in Annex III.

Ms Kome began her introduction by noting that SSH4A and other WASH initiatives have been growing very well and that while it is important to recognise the hard work and achievements to date, it is also important to look beyond the programmes and their coverage to move forward to achieving the SDGs. A summary of her presentation is captured, below.

Bringing sanitation and hygiene in focus

When the concept of WASH was first introduced, the "water" component tended to take priority. Activities focused on improved water supply and the construction of a few toilets, with no real focus on hygiene and sanitation. Toilet construction is not sanitation: sanitation is about individual and collective behaviour. To realise the public health benefits of improved sanitation, it is necessary to achieve area wide coverage and collective population adoption of sanitation practices. If area-wide sanitation is not improved, new water sources may quickly become contaminated.

SSH4A has a people-centred objective achieved through four interlinked

- Sanitation demand
- Sanitation supply
- Have the knowledge and tools to achieve sanitation
- WASH governance – support to achieve

First of these is demand: it is difficult to get people to adopt new practices if they do not actually want them. Concurrently, is important to understand the challenges in terms of supply chain once the demand is created. If demand is generated before supply chain is in place then the structure will fall apart very quickly. People also need to understand how to

use these new facilities. Messaging needs to be consistent and clear: progress will be slow and uncertain if the target audience is receiving many different and conflicting messages.

Orienting the Learning Event: Chasing the SDGs

Learning events are a component of SNV's SSH4A programme. The intention of these events is that discussion is not limited to SNV programmes, rather to promote discussion about good practices among partners and staff, to facilitate an exchange of ideas and to deepen our understanding of the topic.

This learning event intends to provide an opportunity to discuss in depth the on-going efforts in rural sanitation explore best practices and share experiences in rural sanitation and hygiene, with a view towards achieving the sustainable development goals (SDG), in particular:

SDG 6.2: *by 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations*.

This goal presents three challenges in one:

1. End open defecation (OD) for all;
2. Use of basic sanitation by all;
3. Use of safely managed sanitation.

In addition, of course, we need to include:

4. Hand washing with soap after defecation. Can this fourth one be achieved for all by 2030?

To achieve this SDG, we will need to ensure that we include households, schools and health facilities in the chase.

In total, there are 17 SDGs. These goals are interconnected and it can be tempting to try to chase them all. It is, however, very challenging to achieve all goals in one area at one time. It is very important to understand what your contribution can be and also what are others contributing in theirs. The characteristics of a good chase are focus and persistence.

It is also essential to understand where you are starting from: your baseline. For example, if an area still has widespread defecation it is not possible to aim for "use of safely managed sanitation by all". And we need to be aware of factors, such as rapid population growth, that create new challenges or exacerbate existing ones. Nonetheless, those starting from a low baseline should not be discouraged: it takes time - as well as focus and persistence - to effect lasting change. Ms Kome used an example from of the Netherlands to show how a country that currently enjoys around 98 per cent coverage of improved sanitation facilities was using quite basic, shared latrines in many parts until around 1940.

Objectives and Logic of the Workshop

She then introduced the objectives of the workshop:

- Taking stock of progress towards sustainable full coverage and use;
- Develop a deeper understanding of the journey and milestones, and the choices involved;
- Identifying new tools and perspectives that are useful for upcoming milestones.

The workshop is organised into five blocks:

Block I: Realities and priorities
Block II: The Ethiopian experience

Block III: Post ODF
Block IV: Building blocks for progress
Block V: Country group session and wrap up

These blocks follow a logic, moving from a stocktaking and reflection on where each country stands now in terms of access to basic sanitation and improved facilities and identification of key priorities moving forward in Block I to an overview of the Ethiopian "One WASH" programme from national and woreda (district) levels in Block II. Block III explores strategies and priorities once an area has reached ODF status and Block IV develops suggestions for building blocks to ensure progress towards achieving SDG 6.2. Block V concludes the learning event, with Country Team sessions including reflections on the messages, strategies and feedback that each country will take home in their "shopping bag".

In addition, there is a field assignment on Day 2. Six mixed-country teams are given the opportunity to each visit a different kebele (cluster of villages), to meet with local government officials and the community and to visit households and schools. Each group is tasked with interviewing different constituents, to elicit a testimony and develop a case study, in order to better understand the reality of SNV's SSH4A programme in Ethiopia. The fieldwork is structured with a clear objective and a defined set of deliverables.

The proceedings of each block are described in detail in sections VII through XI of this report, with additional materials generated through the fieldwork available in Annex IV.

Learning Event programme by day

The daily programme is presented in Figure 2.

Figure 2: Daily programme of the SNV Learning Event, Ethiopia 2018.

VI. Expectations of Participants by Country

Prior to commencing Block I, participants from each country were invited to introduce themselves and each country team was asked to share two of their expectations for the event. These expectations are summarized in Table 3, below.

Country	Expectations
Benin	1. Rural sanitation: share experience on scale up, sustainability and improving quality; 2. Learn best practices and experiences from different countries.
Bhutan	1. Practical monitoring tools and systems to measure achievement towards the SDGs; 2. Learn about how to move forward post ODF; 3. Learn more about faecal sludge management (FSM) and emptying; 4. Need to look at financing systems – learn how to get the government to invest in sanitation as well.
Burkina Faso	1. Learn how to create sustainable facilities with CLTS; 2. Discuss the scale-up of CLTS: how to progressively reach villages and the whole country; 3. Learn how to sustain ODF status with sanitation marketing.
Ethiopia	1. Experience sharing; 2. SDG progress in hygiene and sanitation; 3. Using appropriate technologies; 4. M&E and research.
Ghana	1. Learning from other countries about their programmes towards achieving the SDGs; 2. Share our experiences.
Honduras	1. To learn how the SSH4A programme has been implemented; 2. To learn from other countries.
Indonesia	1. To discuss the challenge of quality and scale – as we broaden coverage, how do we maintain quality? 2. What are we talking about in terms of services in post-ODF?
Kenya	1. Learn how to maintain the momentum; 2. Sanitation is not given a priority in Kenya: how to change this? 3. Learn how other countries have started and maintained sanitation campaigns including sanitation financing; 4. Learn about structures and approaches for achieving district wide sanitation.
Mozambique	1. Learn how to speed up the implementation of WASH and achieve the SDGs; 2. Discuss how to motivate sanitation facility leaders to meet inclusive business and to sustain service (including FSM); 3. Better understand the M&E systems and to track results at national level.
Nepal	1. Sustainability of behaviour practices 2. Technical options for approaches to faecal sludge management 3. Alignment of RSS4A to new federal structure (capacity building)
Rwanda	1. Sustainability of the achieved goals to sanitation and hygiene in rural areas 2. Disability inclusion in WASH 3. Learn the best practices from other countries 4. Private sector engagement
Tanzania	1. Best practices from other countries and share those Tanzania 2. Reaching the last mile
Uganda	1. How to sustain rural sanitation and hygiene achievements? 2. Learn about post ODF experiences from other countries 3. Compare best practices and appreciate different concepts
Zambia	1. Learn and share with others lessons to improve future implementation 2. BCC: putting knowledge into practice 3. Harmonization and alignment of indicators to SDGs 4. Sustaining positive gains 5. Narrowing the gaps towards universal access

Table 1: Expectations of the Learning Event, by country. SNV Learning Event, Ethiopia 2018.

VII. Block I: Realities and Priorities

Overview of Block 1

Why is this relevant?
In order to effectively chase the SDGs it is necessary to understand where we are now and to identify clear priorities to achieve our goals. This reflective exercise allows each country to learn from the experiences of other country teams and to share lessons learned from their own experiences in return. The analysis of data and current achievement against key indicators provides evidence for action to sharpen focus and clearly prioritise future activities towards achieving SDG 6.2.

What are the objectives of this block in terms of knowledge and learning outcomes?

- To review data (disaggregated by key variables) collected through the 2015 JMP survey against five key indicators.
- To reflect upon their own data and how this may be used to focus future activities.
- To learn from other countries' strengths and weaknesses in chasing the relevant SDG indicators.
- To use this knowledge to improve sanitation and hygiene implementation in their own countries.

What was the process?

- An introductory presentation of the aggregate data from all countries against the five indicators that comprise the JMP sanitation ladder.
- Country group work to review the data from their country and to reflect upon and answer the following questions:
    1. What is the situation today?
    2. What do we know?
    3. What are our priorities for learning and progress?
- Sharing and exchange of experiences: plenary discussion where each country presented the answers to the questions.

Introduction

Presented by Antoinette Kome, Learning Event Facilitator, SNV Global. Presentation available in Annex III.

Realities and Priorities

During the DGroup discussions, participants were asked to reflect upon the realities and priorities towards achieving the SDGs, guided by the following three questions:

1. What is the situation today?
2. What do we know?
3. What are our priorities for learning and progress?

Ms Kome began this block by inviting country groups to review data from JMP survey 2015 to assess the current **realities** and **priorities** for moving forward. Each country reviewed their progress against five key SDG targets: (i) rate of OD; (ii) use of unimproved facilities, (iii) use of improved facilities shared between two or more families; (iv) use of improved facilities which are not shared and (v) use of safely managed sanitation by all. Data disaggregated by key variables including gender of head of household, wealth quintiles and households with and without people living with disability (PLWD) allowed each country to assess which

populations were at risk of being "left behind". These data are available in Annex V. For most countries, very good progress had been made on moving towards ending OD. For many, however, achieving use of improved facilities that are not shared and beyond basic was still a challenge. It was difficult to assess achievement of use of safely managed sanitation by all due to a lack of data. Countries were grouped into the following categories (Figure 3):

- Those still needing to focus on reducing OD;
- Those working towards reducing sharing;
- Those working to improve the quality of facilities;
- Those countries that were exhibiting low rates of progress; and
- Those countries with "last mile" challenges.

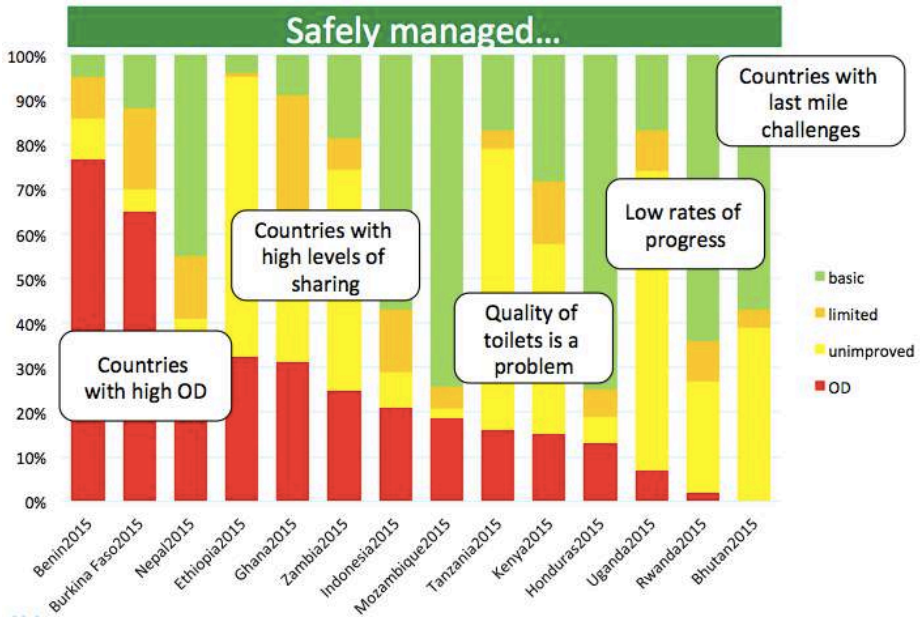

Figure 3: Achievement against four key SDG 6 indicators, by country. Presented at SNV Learning Event, Ethiopia, 2018.

When asked how long it would take to achieve basic sanitation by all, it is clear that we need to devise ways to speed up the process, how to scale up without losing quality. There are choices in how to approach scale up: do you go for vertical scaling: working to get smaller units, such as individual villages, able to access safely managed sanitation by all? Or do you work to achieve more basic sanitation (e.g. ODF) nationwide?

The decision to elect vertical or horizontal scaling, or more usually a combination of both, depends on a variety of factors unique to each country (Figure 4). For example Bangladesh elected to aim for ODF throughout the country. This was achieved in 2013 but now communities need to make additional investment to create improved facilities. Conversely, if some villages make the full investment to achieve use of safely managed sanitation by all from the beginning, it can be very difficult to then scale up because of the amount of time and effort that would be required to this.

In Ethiopia, the government has organised a "Health Development Army" (HDA): a group of volunteers in each community that work to disseminate public health messaging and advice. The HDA allowed sanitation messaging, including stopping OD, to be rolled out nationwide. In contrast, Bhutan is a country with very different ecological zones and a number of different ethnic communities. As such, they preferred to start with pilot programmes in each zone to ensure that the interventions were appropriate and effective for each area. Tanzania decided that a "step-by-step" approach was necessary due to a lack of qualified, experienced staff.

Other countries preferred to go gradually, perhaps due to lack of a clear strategy or limited understanding of the available human resources and infrastructure and the need they were facing.

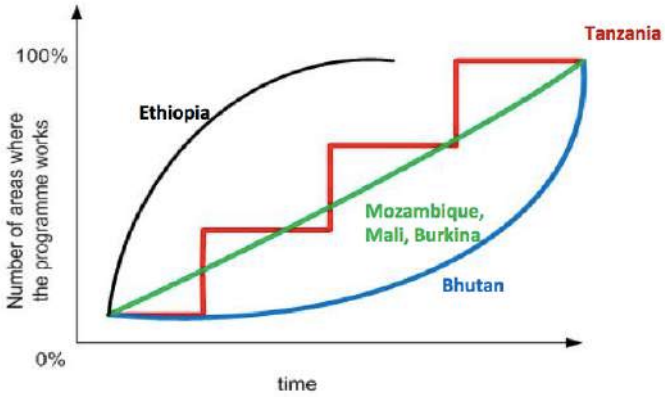

Figure 4: Expectations for scale-up of sanitation activities. Results from DGroup discussions 2012 and 2014. Presented at SNV Learning Event, Ethiopia, 2018.

Community-led total sanitation (CLTS) is a strategy employed by many programmes with great success. This strategy, however, is village-focused and may not be effective when scaling up. To organise for scale-up, country programmes need to decide whether they are aiming for horizontal scaling (e.g. ODF nationwide) to vertical scaling (e.g. selected villages have achieved use of safely managed sanitation by all. Distinct methodologies are required to reach these diverse goals.

Scaling is more than repeating the same approach in different areas. The Zambia country programme has introduced an innovative form of monitoring, engaging the head of each chiefdom to provide monthly monitoring and verification, with data submitted to the district via a purpose-built mobile app. The Chiefs are provided with a smart phone, trained on how to use the app and verify the data received from the sub-chiefdom data collection team. They are provided with talk-time minutes each month to ensure they are able to submit the aggregated results.

During the DGroup discussions, many people mentioned the need for improved monitoring. Sound, verified data is essential to track the reach and quality of sanitation coverage as programmes scale up. It is essential that data is disaggregated by key variables – gender, gender of head of household, and socio-economic status and other country specific vulnerable groups, for example – in order to identify which constituents are being left behind and may need more support and focus.

It takes considerable budget to take programmes to scale and for it to be sustainable. This needs to come from government budgets. Many countries, however, remain donor-dependant for sanitation interventions, with sanitation rarely viewed as a priority by the government. In Honduras, the government employs a participatory budgeting process where the community is asked what they believe is most important and thus should be included in the budget. Improved water supply is frequently included as a priority with sanitation rarely identified as important. Yet water without sanitation may be very problematic from a public health perspective, as water sources may become contaminated.

Discussions around scaling conducted between 2012 and 2015 highlighted the need to consider

- **What** will be the approach and its components;
- **Who** will be leading, implementing and supporting the scale up;

- Are you aiming for **vertical** or **horizontal** scaling; and
- How to achieve **functional** scaling: adjusting for different groups to ensure that no one is left behind.

All these factors contribute to developing the **scale-up strategy**.

Ms Kome reviewed the different types of strategic partnerships that could be utilised to implement a scale-up strategy, including in-house roll-out, strategic partnerships with other stakeholders, multi- partner alliances, and generating social movements (Figure 5).

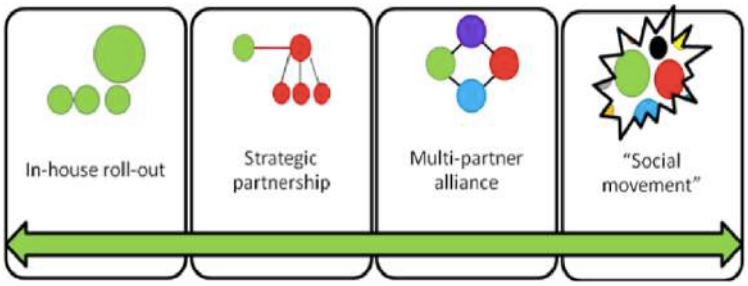

Figure 5: Types of strategic partnerships. Presented at SNV Learning Event, Ethiopia 2018.

All these strategies have been employed by the different countries implementing SSH4A; a sample of these is shown in Table 2. In the face of declining donor and government funding, the need to find innovative ways to continue outreach gains prominence.

In-house (govt) roll-out	Strategic partnership	Multi-partner alliance	Social movement
Kenya Working through the MOH and then engage natural leaders that emerge in the CLTS process **Uganda** Within MOH, through Village Health Team. **Zambia** Min of local government and local leaders, mobilising community members	**Ethiopia** Through MOH and then the Health Extension Workers (HEW). Locally support of other front line workers is sought Health Development Army, teachers, Agricultural development agencies, local government administrators (and more than 100 CSO organisations)	**Mozambique** (proposed strategy) Involve all key agencies in the government structure, as well as schools and locally organised groups.	**Nepal** Work with local bodies in the lead, coordinate the effort and engage with everyone locally who has a network or penetration in remote communities.

Table 2: Examples of different strategic partnerships among some SNV supported countries. SNV Learning Event, Ethiopia 2018.

Country milestone discussions and sharing

During Ms Kome's introductory presentation, each country group had been provided with data from JMP 2015, including disaggregated data. Following Ms Kome's presentation, each group was given time to reflect on the data and to consider the following questions:

Stocktaking

1. Where are you on the sanitation ladder?
2. Who are the groups lagging behind in terms of access and use?
3. At which "scale level" did you tackle sanitation?

Next milestones

1. What are your future milestones?
    a. On the sanitation ladder?

b. For all?
c. In which administrative unit?

Figure 6 presents current achievement on the sanitation ladder for each country, according to JMP survey 2015. Country team responses to the other questions are presented in Table 3.

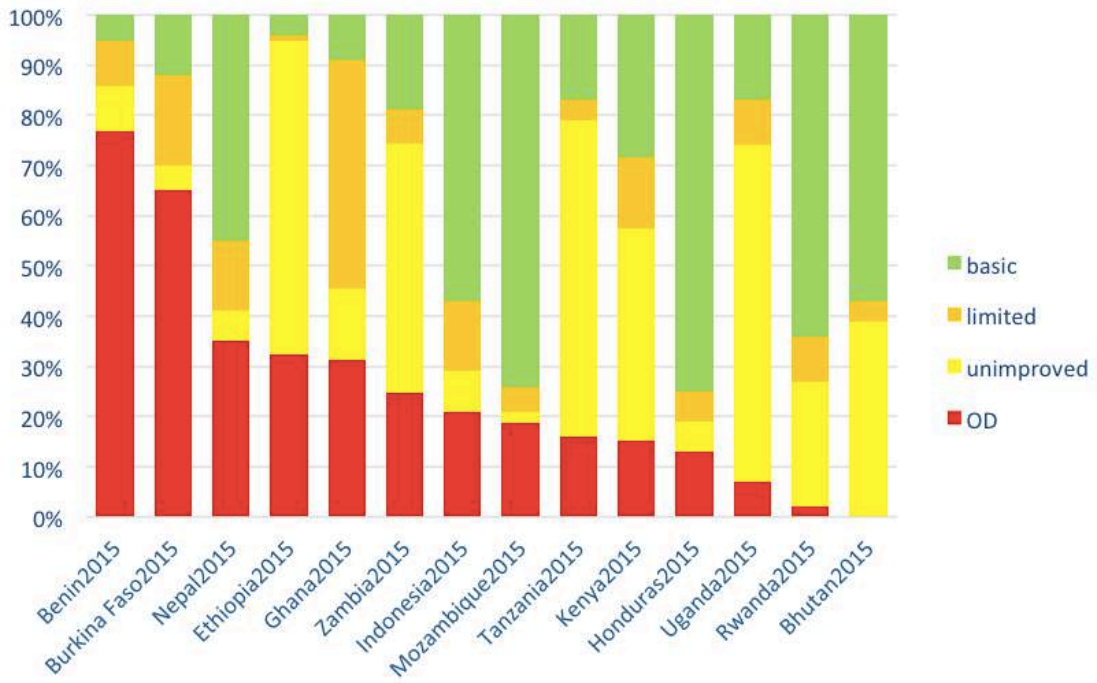

Figure 6: Current achievement on the sanitation ladder* of 14 countries participating in the SNV Learning Event, Ethiopia 2018. Source: JMP 2015. *Not enough data available to assess "use of safely managed facilities by all".

Country	What groups are lagging behind?	At which scale level does your country work?	Next Milestones?
Benin	Poor people Pastoralists People with disabilities	Localities: a village is composed of several localities	***Post ODF*** For ODF communities, focus on sustainability and quality of facilities
Bhutan	Poorest Temp. settlements Single headed households Stubborn People living with disability (PLWD)	***2010-2013*** District level ***2014-2023*** National level	***Basic households*** 100% + hand washing with soap (HWWS) ***Basic institutions*** 100% + HWWS and menstrual hygiene management (MHM) ***Safely managed*** 50%
Burkina Faso	Rural areas PLWD	Village level	***2016-2020*** 30% (2600) villages ODF 25% access; 30% good hygiene practice 200 institutional latrines ***2021-2025*** 80% (4500) villages ODF 75% access, 70% good hygiene practice

			2000 public latrines ***2026-2030*** 100% (1731) villages ODF 100% access to sanitation 100% good hygiene practice 2000 public latrines
Ethiopia	PLWD Pastoralists Elderly	Development unit level	Increase access to improved and safely managed facilities Improved access for PLWD, elders and pastoralists Development unit
Ghana	PLWD Poorest wealth quintile Female headed households	District level Village/community level	Achieve universal ODF by June 2030 ***For all*** Population using safely managed facilities Basic hand washing facilities New strategy being organised to look at rural sanitation: implementation, policies, gaps in reporting ***Administrative Unit*** National level: MSWR MMDA/DAs
Honduras	Poor and poorest	Currently Sub-district 2019 → district	***Programme level*** 2000 households with improved basic sanitation HHW, improved floors, improved cook stoves
Indonesia	***Country Level*** Eastern provinces Remote areas Islands Poor people ***SSH4A Level*** Isolated remote areas Poorest people	2014-2017 Sub-district → district* Since mid-2017 District → Province * Lesson learned: should have involved province from the outset	***For OD communities*** push for environmentally safe (basic for post-ODF) ***For ODF communities*** sanitation services that secure safely managed at scale and hygiene services for "use by all at all times" and total hygiene (additional pillars. Starting at sub-district, moving to district by keeping province from the outset → for monitoring and scale-up
Kenya	Poorest people: landless; low income	Sub-location	Improve data quality Strengthen sub-location steering committees
Mozambique	Elderly Widowed women PLWD	Currently at community level; aim to reach locality level (next administrative unit up)	Finalise the national rural strategy and cascade down at all levels Improve government leadership and priorities sanitation and hygiene,

			including financing Coordination between partners, involving different ministries, private sector and development partners Operationalize the WASH national information management system (SIMAS) and finalise the ODF verification protocol Build capacity on sanitation and hygiene implementation, especially at district and lower administrative units
Nepal	PLWD: 9% of households with PLWD share latrine; 33% of households with PLWD don't have an environmentally safe toilet		End remaining OD practices at ward level Focus on BCC for toiles upgrade Follow up and facilitate toiled upgrade for households with PLWD Follow up for improvement to environmentally safe toilet for households with PLWD
Rwanda	Vulnerable people Poor people PLWD (in terms of technology choices) Girls in school: MHM is still an issue	District to district	Increase budget allocation from public finance Advocacy for development partners Engage the private sector Decentralisation
Tanzania	Seasonal migrants Pastoralists Small scale miners Poorest and poor WQ PLWD	Village level → focus on ODF Only one ODF district* but many villages *Funding of around TZS 350-400 per district from sanitation from different donors including DFID, WB & UNICEF)	ODF by end 2018-04-25 Basic sanitation at 75% by 2021 Universal access to basic sanitation by 2030 National sanitation campaign Development of national BCC strategy
Uganda	Poorest wealth quintile	Sub-county level	***Sanitation ladder*** Last mile households Improved quality Reduction in shared access, with policy guidelines ***For all*** Access and usage improved Child faeces disposal

			HFs, schools, & institutions included ***Admin units*** Move towards districts
Zambia	Poor people Women	District	***Sanitation ladder*** eliminate OD and use of unimproved toilets BCC on pit emptying or twin pit options Attention to fly management

Table 3: Results of the Country Team Group Work: Realities and Priorities. SNV Learning Event, Ethiopia 2018.

All participants were then asked to line up to indicate their national coverage of access to improved services. Country teams were then grouped according to level of coverage to discuss the challenges they each faced and to exchange ideas on how these challenges may be addressed in order to increase access to improved services. Each country group was asked to discuss the achievements, challenges and priorities for their own country with others in their group and to identify some commonalities and differences. The outcomes of these discussions are presented in Table 4.

Group 1: Uganda, Burkina Faso, Ethiopia, Benin (Countries with high OD)

- Ethiopia has national government backing; other countries do not yet have national buy-in
- SNV working with advocacy and BCC to encourage change without subsidy; some nations still use subsidy to try to motivate behaviour change but this seems to be less effective;
- Some issues with the data: the M&E system needs to be strengthened.

Group 2 – Rwanda, Nepal, Zambia (Countries with high levels of sharing)

- Access is quite high but still several challenges: access by all is very difficult to achieve;
- Lot of national commitment in Nepal and Rwanda towards achieving access, in Zambia this has been adopted by traditional leaders;
- Technologies are costly and have limited availability, especially as you travel further from the CBD;
- Still some capacity gaps and gaps in knowledge at all levels
- Limited funding: water supply still tends to attract the greatest share of funding;
- In general, female-headed households and poor households have less access to sanitation services;
- Low prioritisation of sanitation by households (especially in Rwanda and Zambia);
- Milestones: Focus on BCC, Try and reduce inequality, focus on improving access by all.

Group 3: Honduras, Mozambique, Tanzania (Countries where quality of toilets is an issue)

- Each country is at slightly different levels for ODF coverage;
- Interventions are still mostly focused on interventions at village level. In order to scale up need to develop a clear strategy;
- Still very donor dependant;
- Need clear strategies for upscale;
- Need clear strategies to meet the last mile
- Need to ensure the supply chain is robust: this should include involving the private sector;
- Need to improve quality of toilets.

Group 4 – Indonesia, Bhutan, Kenya (Countries with low rates of progress/last mile challenges)

- The diversity in Indonesia results in discrimination against certain groups, which makes it difficult to convince duty bearers to prioritize programs;
- Bhutan provided an interesting perspective on how to manage people who are lagging behind;
- Pastoralists are a low access group in Kenya;
- Some questions raised: Does the programme respond appropriately to issues of disadvantages groups? Are we monitoring this sufficiently in order to capture the groups that are left behind?

Table 4: Results of multi-country group work: Realities and Priorities. SNV Learning Event, Ethiopia 2018.

VIII. Block II: The Ethiopian Experience

Why is this relevant?

After many years of ad-hoc WASH interventions, Ethiopia has developed a national WASH strategy. Donors are encouraged to channel their support through a common funding mechanism to support the national strategy, ensuring coherent and equitable implementation. This block aimed to better understand this strategy and its impact to date, and for participants from other countries to learn from the achievements and challenges faced during implementation.

What are the objectives of this block in terms of knowledge and learning outcomes?

- To understand how the One WASH strategy in Ethiopia is structured and implemented, from a national and woreda-level perspective.
- To visit six kebele in Este Woreda, Ahmara Region, South Gondar Zone to observe the implementation of this strategy at woreda, kebele and household level.
- To provide feedback to the Ethiopia team on what is working well and recommendations to address observed challenges.

What was the process?

- A presentation providing an overview of WASH interventions in Ethiopia and the development of the One WASH strategy;
- A presentation on the implementation of One WASH activities at woreda level;
- Field trips to six kebele within Este Woreda.
- Presentations by each group on the results of their field trip including observations.

One WASH: National Overview

Presented by Abiy Girma, Coordinator of National One WASH Coordination Office, Government of Ethiopia. Presentation available in Annex III.

Mr Girma representing the National One WASH Coordination Office commenced his presentation with an historical overview of WASH interventions in Ethiopia. Prior to 2004, WASH activities tended to be project based and lacking integrations: water, sanitation and hygiene initiatives were implemented separately, with supply-side driven water supply the main focus of activities. The sector capacity was quite low and donor/NGO presence was weak, resulting in low budgets for WASH interventions.

From 2004 to 2012, the role of government moved from provider to partner as donors began implementing a programmatic approach with integrated water, sanitation and hygiene activities. A Memorandum of Understanding (MOU) was signed between the three key WASH sectors – water, health and education – facilitating greater coordination. Budgets increased and the involvement of the community (including women) improved leading to greater ownership. A demand driven approach was conceptualised and coordination with the private sector also improved.

Despite these forward steps, several key limitations and constraints remained. The programmes were not aligned, resulting in different approaches as well as different monitoring, evaluation and reporting requirements. There was no clear accountability or review mechanism for the MOU signatories, who also tended to view the programmes as add-ons to the national plan due to a lack of harmonization. Crucially, the Ministry of Finance had not been included as a MOU signatory partner, which was a barrier to advocating for

increased national budget for WASH activities. The programme approach further resulted in interventions being implemented in a few districts and towns only, leading to inequitable access to improved water, sanitation and hygiene. Concurrently, CSO involvement and partnership in WASH decreased.

The transition to the current One WASH National Programme (OWNP) began in 2012. OWNP is founded on two key documents: a new MOU and the WASH Implementation Framework.

The revised **MOU** includes the Ministry of Finance as a signatory, as well as the Ministry of Water and Environment (MOWE), the Ministry of Health (MOH) and the Ministry of Education (MOE) and establishes a harmonious working modality between the four ministries and other key partners. The rationale underpinning the MOU is that:

- Access to clean water and improved sanitation is a basic right;
- The provision of safe water, improved sanitation and hygiene education has far reaching public health benefits when provided as a package rather than separately.

The **WASH Implementation Framework** (WIF) was developed at national level with the intention to provide clarity and direction to the WASH sector and to ascribe accountability. It marks a move from separate, donor-driven programmes to an emerging sector-wide approach. It aims to establish and integrate One WASH programme, including both rural and urban areas with a view to achieving the Growth and Transformation Plan (GTP) and Sustainable Development Goals (SDGs) for safe water and improved sanitation and hygiene. One WASH intends to enable all national and external funds to contribute to a rational, harmonized approach to water, sanitation and hygiene activities throughout Ethiopia. This includes a single system for planning, budgeting, financial management, procurement, information, monitoring & evaluation and reporting. Currently, most large donors including but not limited to World Bank, Africa Development Bank, European Investment Bank and USAID pool their resources under the One WASH programme, while some smaller initiatives still operate outside this framework.

Institutional Arrangements and Organisational Structure

One WASH is underpinned by three Programme Pillars:

- Creating and enabling environment and good governance;
- Maximising availability and efficient use of human and financial resources to create demand for better WASH services; and
- Capacity development for improved delivery of WASH services at all levels.

At the national level, governance and guidance is managed by the National WASH Steering Committee (NWSC), with oversight and management tasked to the National WASH Technical Team (NWTT) and programme coordination managed by the National WASH Coordinating Office (NWCO). Programme implementation is managed through programme management units (PMU), situated within the three key ministries: water and environment, health, and education. PMUs report to NWCO, NWTT and NWSC who in turn provide oversight and ensure accountability (Figure 7). Sub-national organisational structure and institutional arrangements are presented in Table 5.

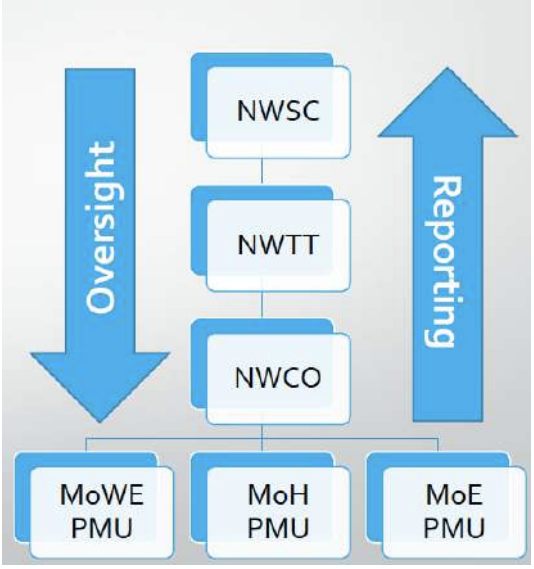

Figure 7: One WASH organisational structure, national level. Presented at SNV Learning Event, Ethiopia 2018.

Level	Governance & Guidance	Oversight & Management	Program Implementation	Program Coordination
Federal	National WaSH Steering Committee Development partners WaSH Sector **Working Groups**(4thematic groups)	National WaSH **Technical Team**	Ministry of Finance Economic Development and Federal Sectors' WaSH Program Management Units (WPMUs) E W H	National WaSH Coordination Office
Regional	Regional WaSH Steering Committee	Regional WaSH **Technical Team**	Bureau of Finance and Economic Development Regional Sectors' WaSH Program Management Units (WPMU H W E	Regional WaSH Coordination Office
Woreda			Woreda WaSH Program Management Units – (Water, Health, Education, Ag H W E Wo	Woredal WaSH Team

Table 5: Sub-national One WASH organisational structure. Presented at SNV Learning Event, Ethiopia 2018.

Progress under One WASH

Ethiopia has made significant advances in both water supply and sanitation coverage. The country met its Millennium Development Goal (MDG target) for water supply, increasing access to improved water source from 14 per cent in 1990 to 57 per cent by 2015. Sanitation coverage improved by 21 per cent, against a Sub-Saharan average improvement of just 6 per cent.

Another significant achievement is the establishment of the annual Multi-Stakeholder Forum (MSF). MSF is the largest and most important WASH sector conference in Ethiopia. It brings multiple stakeholders together, including government agencies, development partner, non-government organisations and other key actors, to review the sector achievements and challenges and to discuss the future goals for One WASH. MSF, in conjunction with the Joint Technical Review, is the primary instrument for the evaluation of WASH activities in Ethiopia. To date, there have been eight MSF events.

Challenges

Despite Ethiopia's many achievements in the WASH sector, several key challenges remain to be addressed. Harmonisation between the key WASH ministries and development partners has not happened as quickly as hoped and this process should be accelerated. Implementing partners often have low capacity resulting in sub-optimal efficiency and efficacy. Limited attention has been given to urban sanitation, a challenge exacerbated by increased population pressure due to accelerated urbanization and industrialization. In rural areas, limited road access, scattered settlements and undulating topography present significant challenges in increasing coverage for both safe water supply and improved sanitation and hygiene. The effects of climate change, including frequent droughts and flash flooding during the rainy season are a further challenge.

Chasing the SDGs

One WASH has identified six key focus areas that need to be addressed in order to achieve Ethiopia's Sustainable Development Goals:

- **Strengthening the enabling environment** to support sector-wide approaches and to strengthen public financial management for sustainable WASH services;
- **Innovation for sustainability** to develop sustainability accountability frameworks and real-time sustainability and functionality monitoring;
- **Water security and resilience** to ensure attention is given to water quality and well as water quantity and to implement risk-based programming as a response to climate change;
- **Moving beyond elimination of open defecation** to establish a systematic follow-up to ODF programmes at scale and approaches to sanitation beyond CLTS to move up the sanitation ladder;
- **Advocacy for WASH in institutions** Inclusion of WASH issues in school curriculums and WASH for children living with disabilities; and
- **Pulling more finance** to the WASH sector.

One WASH: Woreda level overview

Presented by Mr Ayalneh Tadesse, Head of Este Woreda Health Office.
Presentation available in Annex III.

Mr Tadesse is the Head of the Este Woreda Health Office. He began his presentation with an overview of Este Woreda. Situated 150 kilometres from Bahir Dar, Este Woreda is one of 18 woredas in South Gondar zone and one of 166 woredas in Amhara region. Home to nearly 205 thousand inhabitants (93.4% rural; 97.1% Orthodox Christian; 2.9% Muslim), it is largely accessible by asphalt road.

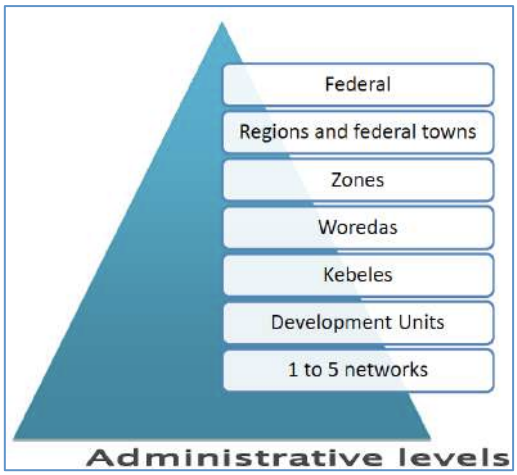

Figure 8: Key administration levels with the Government of Ethiopia. Presented at SNV's Learning Event, Ethiopia, 2018.

Woredas are a mid-level administration unit (Figure 8). One responsibility of the Woreda Health Office is to oversee the implementation of health extension packages (HEP) in the kebeles (areas similar to neighbourhoods, consisting of at

least 500 families) by health extension workers (HEW). There are 18 HEP packages, including seven that are focused on improving sanitation and hygiene:

- Healthy housing;
- Household toilet and hand-washing;
- Safe water storage and treatment at household level;
- Solid waste management;
- Liquid waste management;
- Separated kitchen with improved cook stove; and
- Separated animal shelters away from the main house.

At the start of SNV's SSH4A programme in Este Woreda, several key gaps were identified. Limited budget for sanitation and hygiene activities meant that local government did not prioritise implementing them in the community. Some kebeles had been declared primary ODF only to revert to open defecation due to a lack of proper demand triggering, while some were declared primary ODF without following the national guidelines for verification and certification and thus were either not truly ODF at the time of declaration and/or reverted to OD after the declaration. A lack of community guidance and capacity building resulted in sub-optimal latrines being constructed, which became breeding sites for flies and did not bring any public health benefits. WASH activities were poorly integrated among key stakeholders including kebele administrators, schools and kebele-level HEW and the health development army (HDA, a government-supported group of volunteers who are tasked with delivering health messages to household level) were not functioning as role models for their networks. Overall, there was a lack of proper documentation of activities including limited reporting and monitoring and evaluation structures.

SSH4A works within the existing government structures, including HEW, the HDA, kebele managers and administrators, and within schools. The programme faces challenges including water scarcity and geographic inaccessibility in some parts. Nonetheless, SSH4A has mobilised complementary efforts from development partners including one vehicle to support transport within the woreda, technical advice and support including one mobilizer at woreda level, and 11 community facilitators at health centre level. The capacity of government sector staff has been strengthened, most notably around sanitation demand triggering, development of a sanitation strategic plan and the design and use of monitoring and evaluation tools. A number of strategies have been employed to motivate the decision makers and supporters of government sectors, including the project launch workshop, multi-stakeholder forums, planning and review meetings, and orientation of the woreda WASH team for planning and verification.

Through SSH4A project support, the national WASH programme has met the following achievements in Este Woreda:

- Good progress on ODF declaration, in line with national standards (at the time of the presentation, four kebele are certified ODF, with several others very close to declaration);
- Establishment of three sanitation marketing centres and one private artisan;
- Global Hand-washing Day celebrated at all schools in the woreda; and
- Updated data available to support future planning following the baseline and mid-term surveys.

IX. Ethiopian Experience: Field Work Outcomes

A précis of the fieldwork outcomes are presented on the following pages, with full outputs available in annex IV.

Field Team 1: Amjaye Kebele

Figure 9: Team 1 with residents of Amjaye Kebele.

"I wish our mothers could be alive to see the opportunity of using a latrine.
Resident of Amjaye Kebele

Amjaye Kebele contains some 1,015 households with a population of 5,506 inhabitants (51% female). The Chairman leads the administrative duties, while the kebele manager looks after development. The kebele contains 12 villages (Got) which are networked through 140 "1 to 5" groups, which in turn are organised into 28 development units. Amjaye has nine schools, four churches, and one health post. The regional government has assigned two health extension workers have been assigned to deliver the 18 health extension packages, seven of which are related to sanitation and hygiene. Kebele water coverage is 88 per cent with 22 hand pumps and spring water available.

Key findings & achievements

Based on reports and observations, all members of the kebele use the latrines. Approximately 93 per cent of the latrines are 'improved', defined as two to three metres deep, with a slab, squatting hole cover, average height, roof and door offering privacy and a hand washing station. There are ten communal latrines that are used during large gatherings and located along the main internal roads. A PLWD-friendly latrine chair (50 Model) is promoted by the programme. The kebele is at the first level of verification – almost ODF – as indicated by a yellow flag. The yellow flag is followed by green (primary ODF) and then white (secondary ODF, including hand washing practice and safe water handling at household level). Kebele with red flags have not yet made sanitation and hygiene progress.

The One WASH programme and MOU is translated into practice and district and lower administrative levels

Challenges

- Some latrines were missing squat hole covers and ash or soap;
- Cow dung is used as a local innovation for a squat hole cover. This should be upgraded to avoid faecal matter contact;
- Need to develop a system for communal latrine maintenance (e.g. soap/ash and water replenishment at the hand washing station;

- There are no sanitation and hygiene options for different segments of the community, such as the elderly, PLWD and the poorest.

Recommendations

- Modify the model latrine chair to better suit the local conditions so that it may be accessed by all
- Provide further capacity training to the 1 to 5 networks and development units
- Introduce a hand washing system, such as the tippy tap to save water and to avoid hand contamination
- Allocate water in the female teachers' and students' latrine
- Involve the private sector to meet the community demand for a washable latrine

Testimony

Figure 10: Etenate Tebeje

The team visited Amjaye Kebele, Kaka village sampled out one family to share experience of using sanitation facility "latrine". The head of household happens to be a widow who lost her husband for the last 17 years due to illness.

A resident of the Amjaye Kebele lives in a house of one room and one store, plastered with mud like any other houses in the village. Her name is Etenate Tebeje. She is 55 years old with 10 children, five boys and five girls. Currently, Etenate lives only with her son who is 20 years old. Her elder children have moved to other places for work. Some of her children are married and has nine grandchildren: five boys and four girls.

A bit of history on the two latrines she has used: the older toilet was built by her late husband. It was filled and abandoned after 15 years of use. Her 20-year-old son built the toilet currently being used around five years ago. It was unfortunate that the team conducting the interview with the widow could not get data on the size of either pit.

When you walk on to the latrine currently being used, it seems to be improved, both the superstructure and substructure are totally built with local available materials, woods, cords, cow dung slab cover, roof made of glasses, bamboo made door and tippy tap for washing hands.

When questioned on the how she feels about using the latrine, Etenate replied as follows to express her appreciation and happiness. She said:
" I wish our mothers could be alive to see this opportunity of using latrine", remembering back to the time people used to openly defecation. "It is really a shame to see someone practicing open defecation". "Who knows what I'm doing in my house, and it is true in my latrine", this is to indicate the privacy of using an improved latrine.

Figure 11: The interviewee outside her latrine.

Field Team 2: Shimagle Giorgis Kebele

Figure 12: Coffee ceremony at Shimagle Giorgis Kebele.

"Now, even a child understands the importance of latrines, so there is no more open defecation
Leader, Men's Development Army, Shimagle Giorgis Kebele

Amjaye Kebele contains 1,202 households with a population of 7, 363 inhabitants. The kebele contains one health post, three schools and six churches. There are two health extension workers (HEW) in the kebele, as well as one WASH team. The WASH team is comprised of 11 members, including two women; one of which is also a health extension worker. There are two WASH Development Armies: Men's and Women's. These two groups meet separately once a week and are convened in monthly meetings that are chaired by the Health extension worker. Of the 31 water points that service the kebele, 22 were functioning on the day of the field visit.

Key findings & achievements

Latrine coverage is at approximately 98 per cent and the kebele has achieved the yellow flag, verifying that they are almost ODF. Most of the latrines visited had a slab made of local materials, with a superstructure, a squat hole cover and a hand washing facility.

There is a strong focus on infrastructure: The community shows great commitment to achieving full latrine coverage and to go the 'last mile', as evidenced by the public toilets that have been built along main roads and in public spaces to accommodate passers by.

The school has a WASH club and latrines are sex-segregated, although they are not separate structures.

Challenges

- Despite the strong focus on infrastructure, little attention appears to be paid to basic hygiene practices: animal faeces were observed throughout the village, including near the water source and in the household area.
- The example of a 'good' latrine as selected by the WASH Team had a concrete slab for the floor but did not have a squat hole cover, and had animals resting by the entrance.
- Some hand washing stations in the community were lacking water and/or soap or ash.

- The school had only four student latrines (without lockable doors) to service nearly 400 students each teaching session. The national standard is 1 toilet to 30 girls and 1:60 for boys.

Recommendations

- Continue to install and improve the infrastructure but focus stronger attention to ensuring that hygiene messaging is cascading down to households and that that messaging is understood and acted upon.
- Build the knowledge of the WASH Team around hygiene practices and help build their capacity to impart this knowledge to the community.
- Support the Health Development Army and WASH Team to develop a sanitation and hygiene plan, including an implementation plan.
- Given the lack of water in the area, ensure that all hand-washing stations are leak-free and consider installing tippy-taps to reduce water loss.
- Ensure that water points are fenced off to prevent contamination from animal faeces.

Testimony

Figure 13: Agin Ben, Shimegla Giorgis Kebele

Agin Ben, from Alemanya village, is a single woman who built her own toilet. Agin Ben's decision to upgrade her five-year old toilet was triggered by the kebele's Health Extension Officer.

With support from her brother and father, Agin dug the pit herself. She also makes sure to leave her toilet clean at all times.

For Agin, the responsibility for sanitation and cleanliness is a shared responsibility between man and woman. She says: "women and men are equal here". Agin is now a happy owner of an improved latrine, and intends to stay that way.

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Field Team 3: Zigora Kebele

Figure 14: Group 3 at Zigora Kebele.

We have an issue of sustainability. It is not only constructing of toilets, it is about monitoring and working together to ensure sustainability
Head of Health Centre, Zigora Kebele

Zigora Kebele has 12 villages, comprising of 1,250 households. The total population is 6,839 people. Overall leadership in the Kebele is provided by a core team that is comprised of an elected chair, school principal, heads of departments for health and agriculture, the health extension worker, the Kebele manager (a government employee), and the community police. This team sets the priorities for the Kebele in consultation with the Este Woreda WASH team and the development units. The development units are made up of a cluster of about 30 households. Zigora Kebele has 45 development units and 211 1:5 networks. The leaders of the 45 development units form the Health Development Army.

Key findings & achievements

Within a year of triggering, the kebele has achieved yellow flag status. They have declared themselves ODF, with 99 per cent coverage of latrines. Of these toilets, 966 are improved (using Ethiopian definition, not SDG definition), 284 are unimproved and 45 are sharing. This has been achieved through a strong structure, good accountability and ownership of success at kebele level. The roles of WASH actors are clearly defined and they show strong commitment to their roles. Regular meetings are held with seven different government chair people from different parts of government. Monitoring and regular feedback are integrated into the programme. Social pressure is an effective mechanism for promoting change.

Challenges

- There is a single toilet block at the school for both males and females.
- Latrine coverage is high, but some latrines lack either a door or cover, a hand washing facility, or have poorly constructed walls or roofing.

Recommendations

- Enhance informed choice of toilet design at household level. There are national standards available but these do not seem to be informing design at household level.
- Separate toilet blocks for males and females at the school.
- Improve participation of the elderly.
- Upgrade toilets with no hand washing facility, no door or cover, poor walls or roofing, and those with pits too close to the door.

Testimony

Figure 15: Yimegn, left, with members of her network

Yimegn Ayalew: Leader of the 1:5 and 1:30 network of the Health Development Army, Amaga Village

Yimegn is and has been a model and a leader in her community. As some one who sends her children to school, keeps her house clean, cares for her family, animals and is good in agriculture, her friend nominated her to lead a 1:5 network. She started as part of the Health Development Army in 2013.

While it is a government directive, she sees "health" as being very important to her family and her community and is very passionate about her work as a volunteer. She leads 30 females and has five leaders in her network.

She received training from the health extension worker, she practices what she learned and she shares this with her network. Together, with the support of the health extension worker the network makes a plan every two weeks where they work together to achieve agreed "criteria". "We have assignments, we rank each other, and then we make the next assignment together so there is continuous improvement".

Monthly, there is meetings with the leaders as part of the HDA and they give support and inputs on how to encourage those that are lagging, for the elderly and those with less education.

She likes the focus on children's health, sending them to school, environmental cleanliness and the leadership opportunities. She feels the work is very important and there is a strong commitment: "we will continue". There is a strong linkage to government structures to all levels.

Her advice to others? Strong organisations and structures with follow-up every two weeks works well. The ranking of progress amongst the group also helped.

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Field Team 4: Gosh Beret Kebele

Figure 16: Group 4 with the Health Development Army at Gosh Beret Kebele.

"Women are the ones that worry the most about health, because they suffer the most, because they also suffer for their children."
Head of Health Development Army, Gosh Beret Kebele

Gosh Beret Kebele has 11 villages, comprising of 844 households. The total population is 4,616 people. There are 30 Development Units (1 to 30 networks) and 143 sub-development units (1 to 5 networks). Gosh Beret has nine institutions: one Kebele Office, one Health Station, three schools and four churches. The community was triggered in March 2017.

Key findings & achievements

Prior to triggering, 422 households practiced OD and 422 households had unimproved latrines. There were few hand washing stations and the WASH Steering Committee was not functioning. Following triggering by the Health Development Army, all households now have latrines - most have improved latrines – and all have hand washing stations. The community has mobilised to support 65 ultra poor households to also have their own latrine Communal latrines have been built and are maintained. All nine institutions have improved latrines. A school WASH club has been developed and meets every two weeks and every student is given a checklist to monitor household latrine use. They take the checklist home on Fridays and return it on Monday.

Challenges

- Some of the household hand-washing stations were missing soap or ash.
- None of the institutional or communal hand-washing stations had soap or ash

Recommendations

- Maintain the dynamic engagement of the Health Development Army and related Structures
- Maintain health engagement between School and Community for sanitation and hygiene Development
- Maintain the support provided by the Health Extension Workers
- Improve hand washing station with soap/ash to remove contamination (Tippy tap) at all levels
- Government to promote other latrine options including the ones for PLWDs and elderly
- Government and partners should invest in supply chain of sanitation options and materials
- Expand the establishment of communal latrines for people in transit
- Communal toilets to have male and female stances
- Consider Improving privacy and size of superstructure (height)

Testimony

Tadelu Yirdew is a 33-year-old woman, born and raised in the kebele of Gosh Beret, Ethiopia. She is a mother of 5 children, two boys and three girls. She is also the leader of the local Health Development Army, a group of 30 women that supports the health extension workers rolling out the national personal and environmental hygiene programme.

Tadelu is very aware of the importance of sanitation and hygiene for good health. Her interest was triggered during a community session delivered by the health extension workers. She also heard the same message at church and at her children's school. She saw that "dirty things like faeces attract flies and other bugs. They are full of diseases and transmit them from people to people. Women are the ones that worry the most about health, because they suffer the most, because they also suffer for their children".

When she first learned about the importance of sanitation and hygiene, Tadelu supported the women in the village to raise awareness in all households. They regularly visited them, explaining the need to have a toilet and a hand washing station with soap; they identified the people who struggled to construct latrines and organized community support to assist them. They went again and again, as many times as needed, until every household was mobilized.

Now all the households in the kebele have a toilet, the vast majority of these already improved. Soon the village will win the green flag that symbolizes 100 per cent improved sanitation access. Looking at this achievement, Tadelu said "this is our big reward: better health".

Tadelu can read and write a little bit, and sign her own name though she has never been to school herself. This has not prevented her from playing an active role in the development of her kebele. In addition to sanitation and hygiene activities, she is also supporting pre and post-natal care and immunization campaigns. Her biggest dream is to see her kebele green, clean and safe for everyone's health, when she'll see "all mothers and their children are healthy".

Field Team 5: Ginda Temem Kebele

Figure 17: Group 5 ready to set off for Ginda Temem Kebele.

"Good relationships between parents, teachers and pupils are the key to unlocking the potential of community sanitation."
Ginda Temem Primary School Head Kebele

Ginda Temem Kebele is home to 12 villages, with a population of 8,401 people in 1,583 households. There are 59 Development Units (1 to 30 networks) and 256 sub-development units (1 to 5 networks). Ginda Temem has 12 Institutions, including a health post, primary schools, and churches. The Kebele was triggered in November 2017 by the Health workers supported by schoolteachers and the Health Extension Workers, after they received a CLTS Training of Trainers intervention.

Key findings & achievements

The kebele currently has 98 per cent latrine coverage and has achieved yellow flag status. At the time of the field visit, they were anticipating ODF verification (green flag) within the next couple of weeks. Household latrines are ranked on a three-tier system A-C, where A is excellent, B is average and C is poor. The Health Post hosts a Sanitation marketing centre where Safi latrine options are displayed. Prices range from Birr 1,000 to 2,000 (€30 to €60). The kebele has an active WASH team and women play a central role in the networks, including leading the Health Development Army. Students are involved in monitoring household sanitation practices and a girls' club has been formed and trained in MHM.

Challenges

- Communal toilets at public places needs attention
- HWWS stations available but these are prone to contamination as spout hole is covered with a nail which user has to remove and put back
- VIP Toilets available at Health post but with no fly trap on vent pipe or no lid provided to cover hole

Recommendations

- Quality of latrines, need to invest in more affordable and durable latrine options with good finishing.
- Need to standardise size of superstructure to avoid creating space for other things e.g. being used as a storeroom.
- A good record system is in place which needs to be maintained
- Vent pipes for toilets to be fitted with fly traps or lid to be placed to cover the squat hole
- With investments in durable latrine options such as the Safi latrine, there is need to start considering FSM as some of these toilets can be emptied
- Need to separate animal accommodation from human to avoid zoonotic disease transmission)

Testimony

Madam Aleminesh Andualem is resident of Ginda Temem Kebele, a mother of four children and Head of 1 to 5 network. She joined the CLTSH triggering sessions last year in 2017. She narrates that six years ago before joining CLTSH triggering sessions, she had an unimproved latrine characterised of half super structure with inadequate privacy, pit full and with no hand washing facility. She explains that this type of latrine was a source of contamination due to flies contaminating utensils and causing smell nuisance. One of her children was affected with diarrhoea and serious vomiting. She took the boy at health facility and nurse informed her that the conditions being faced are caused by poor hygiene and sanitation practices in her household.

Her experience motivated her to join the CLTSH triggering sessions and she has consistently participated in the sessions, which are conducted each month. Through these sessions she obtained knowledge on challenges of unimproved latrine and advantages of improved latrine. It is then that she made a decision to change her status and that of her neighbours.

She admits that the CLTSH triggering sessions have been significant in improving her hygiene and sanitation standards by constructing an improved latrine and installing the hand washing facility near the latrine. This practice has contributed to controlling flies and bad smell. Since then none of her family members has suffered from diarrheal disease and intestinal worms. Not only CLTSH triggering sessions helped her to construct an improved latrine and installing HWF, she also learned about safe storage of kitchen utensils, constructing of modern cooking stove, sleeping under mosquito net, keeping the household surrounding clean and in general housekeeping. This can be observed when you visit her household.

Being a role model in the village and the burning desire that I have to take my kebele to attaining the white flag status "*I will continue using coffee ceremonies to sensitize and educate children and the entire community on how to improve their health and hygiene."*

Madam Aleminesh Andualem acknowledges that the Government of Ethiopia and SNV WASH program has contributed much in improving the hygiene and sanitation standards through initiating appropriate approaches that involve men in the process. However, her request to the government is to provide more support to other villages in other kebeles to improve their hygiene and sanitation.

Field Team 6: Makane Eyesus Kebele

Figure 18: Group 5 ready to set off for Makane Eyesus Kebele.

"We are ready to make the communal latrine system work!"
Head of 1 to 30 Network, Makane Eyesus Kebele

Makane Eyesus Kebele has four villages with a population 6,821 people and 1,588 households. The households are organised 46 development units under the leadership of the 1-to-30 networks. They have four institutions: one TEVT college, one school, one church and one Kebele Office for all sectors. The town has six public latrines.

Key findings & achievements

The community, with support form local government and SNV, has supported marginalised groups, including the ultra poor to be able to access communal sanitation facilities, including three latrines and one bathroom each for males and females. The communal facilities are managed and maintained by the 1 to 5 and 1 to 30 networks.

Sanitation marketing is in place, initiated by the WASH Technical Team, who learned about the safi-latrine on an international study tour. The WASH Team approached the Technical and Vocational Training institute, who provided training on how to build the safi-larine components to ten local artisans. One artisan has started his business alone, while the remaining artisans work in two collectives. The solo artisan has already trained three others to support production for his business.

Challenges

- Unimproved latrines are hard to clean and may be prone to collapse.
- The full safi-latrine set costs around USD30, which is beyond the reach of many households. Offering a variety of technologies at different price points my increase uptake

Recommendations

- ***Supply chain***: Quality of safi-latrine: some technical aspects need to be addressed; e.g. fly control; support box material optimisation; improve the quality of the finish of the slab, squat pan and ring cover
- ***BCC:*** Hygiene beyond HWWS to personal and child body hygiene- identify the trigger tools and message through the structures; Intensify BCC activities to reduce open defecation and increase access to HW facilities
- ***Governance*** Ultra poor facility could trigger shyness due to the proximity of doors; separate access such that they do not use same corridor
- Hygienic use and maintenance; consider a urinal for men

Testimony

Figure 19: Fekadu at Makane Eyesus Kebele 02

Fekadu, a 23-year-old physically challenged man has been living in the Makane Eyesus Kebele 02 for the past two years. He has no family and is being cared by an aged volunteer in the community. Fekadu, through support from the Social Welfare was trained as a sweater maker but due to limited capital he could not practice the skill acquired and he currently sustains himself on the money he receives from shoe polishing. His biggest dream is to be able to continue his education, in order to be seen as part of the community.

In February 2018, the WASH technical team of Makane Eyesus Kebele 02 in its quest to achieve ODF and improve standards of living collaborated with the Social Welfare office to identify Fekadu to benefit from an improved latrine facility for PLWDs.

According to Fekadu "I'm glad I was identified to benefit from this facility. It made me know I'm part of this community and this has increased my self-esteem. I am not in contact with any faecal matter as was the case previously and my dignity is gradually being restored. Initially, I had to be held by my aged host before I could use the latrine but now I can use the facility on my own".

Fekadu is determined with a fighting spirit to continue his education as he is gradually becoming part of Makane Eyesus Kebele 02 and hopes for a meaningful life (economic independency) for himself. He recommended, however, that wheels be placed under the toilet seat as it sometimes gets tired moving the seat.

Figure 20: A model latrine chair. Latrine chairs allow Fekadu and other PLWD to regain their independence and their dignity

X. Block III: Post-ODF

Why is this relevant?

What are the objectives of this block in terms of knowledge and learning outcomes?

- To plan for FSM in post ODF settings;
- To learn how to calculate the lifetime of a pit latrine;
- To discuss strategies for communicating information on pit lifetimes and safe FSM to their communities.

What was the process?

- An introductory presentation on FSM and the variables required to calculate the average pit lifetime in their communities.
- Presentations from Indonesia and Cambodia on SDG targets and post-ODF strategies.
- Country group work to calculate the average household pit lifetime in their communities and to discuss how to communicate this information and information on safe FSM to members of their community.
- Sharing and exchange of experiences: plenary discussion where each country presented their discussion.

Overview of Block 3

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands. Presentation available in Annex III.

When chasing the SDGs we want to go step-by-step to reach "safely managed". The ODF movement in many countries has become very strong. However, ODF is then often viewed as the finish line, with little thought given to what happens next. Without developing a post ODF strategy, it will not be possible to go beyond ODF, to climb the sanitation ladder and to maintain momentum: If a latrine is not well maintained they will become filthy and then people may return to OD because is seems cleaner and more hygienic. Truly safely managed sanitation looks beyond the installation of a structure.

National guidance on Post ODF

Often there is no clear national guidance beyond achieving ODF status. After the ODF celebration is complete, focus shifts to new areas. This is due, in part, to a lack of knowledge and understanding of what post-ODF is actually about. Is it

- Toilet cleaning, maintenance?
- Further hygiene behaviours?
- Pit emptying or replacement? (Better to give good guidance than to dig very deep pits to reduce danger of children falling in.)
- Other areas of sanitation, such as solid waste?

Level of ambition for Post ODF

As always, we need to be realistic in the type of change that can be expected. Initially, many projects and programmes used to count only improved toilets but this became very de-motivating for the community. It is important to acknowledge even small steps: moving from OD to a basic toilet is still a good step. The transition from ODF to safely managed may be too big to take in a single step: there are seven behaviours in Nepal's understanding of total sanitation, while Indonesia recognises five pillars. Ethiopia recognises primary and secondary ODF. Steps should not be too big, in order to allow communities to feel a sense of achievement and to maintain motivation, nor too small to allow meaningful change to occur within a reasonable timeframe.

Sustaining results and attaining new milestones are two separate activities that both require attention. Unlike CLTS, this cannot be done in "campaign mode". We need to unbundle services and behaviours. Services require continued oversight while behaviours need sustained attention and surveillance.

SDG WASH Target Strategies and Implementation in Indonesia.

Presented by Dr Riskiyana Sukhandhi Putra, Promotion and Community Empowerment, Government of Indonesia. Presentation available in Annex III.

Indonesia a huge and diverse nation: its population of over 260 million includes over 300 distinct ethnic groups, with more than 740 different languages and dialects spoken across the archipelago of more than 13 thousand islands. Naturally, this diversity creates some challenges when chasing the SDGs and ensuring equitable access to WASH services. Nonetheless, as of 2017, some 67.5 per cent of the population had access to minimum standard sanitation services, with a further 9.4 per cent accessing basic services. The target is to reach universal coverage of minimum standard services by 2020.

Indonesia's WASH programme is based on the concept of Community-Based Total Sanitation (STBM, Figure 21). The concept aims to improve public health through the reduction of diarrhoeal and environmental diseases by improving total sanitation. The concept employs four basic components – behaviour change, increased access to sustainable sanitation, sustainable community based management and creating and enabling environment – focused on five key "pillars":

1. Achieving ODF;
2. Hand-washing with soap;
3. Household water treatment and safe storage;
4. Solid waste management at household level; and
5. Domestic waste management at household level.

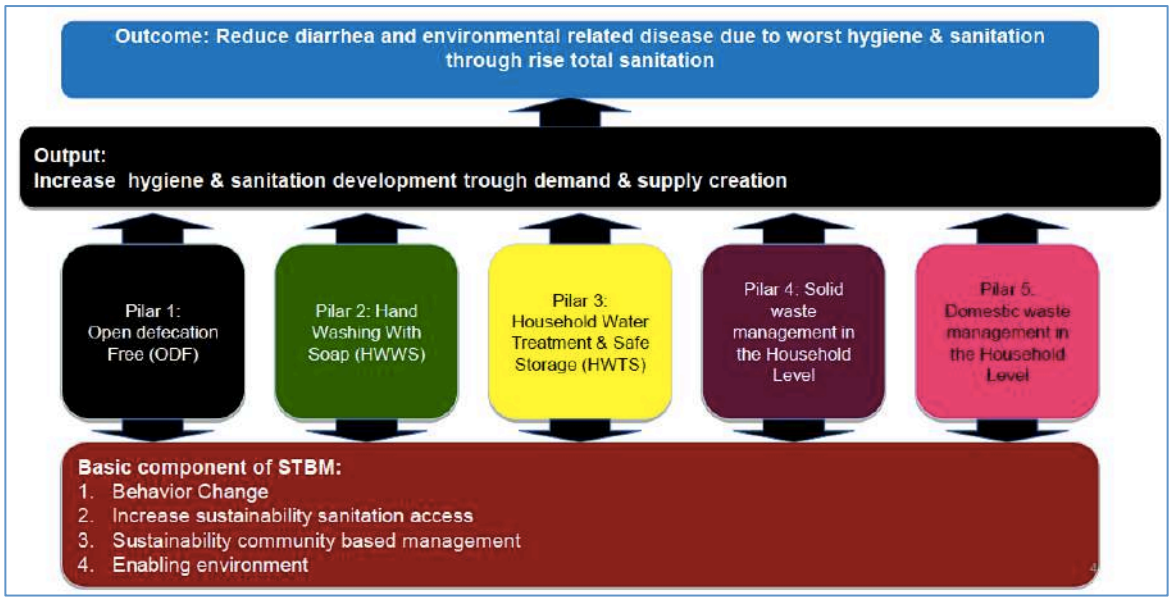

Figure 21: Indonesia's Community Based Total Sanitation (STBM) concept. Presented at SNV Learning Event, Ethiopia 2018.

To achieve the national goal of universal coverage by 2020, activities will include construction of on-site facilities including individual and communal septic tanks, provision of desludging trucks, and sludge treatment facilities in 409 cities and regencies. Off-site facilities will include communal, medium scale and citywide access for 34 million people across 438 regencies and cities. These activities will be supported through community awareness raising campaigns,

education and sanitation and hygiene promotion; advocacy for the involvement of local governments and parliaments; provision of technical assistance; review and updating of the existing strategy; and capacity building for all key implementing agencies. The strategy incorporates three interlinked components: Demand creation, supply improvement and an enabling environment. To achieve the SDG, each of these components needs to progress together.

STBM recognises that while the presence of a well-articulated strategy is important, in the end it is about commitment, not documents. The engagement of community champions is essential to effect sustained change. Dr Riskiyana urged each country to build with vision: to consider population growth and to ensure connections to treatment plants. He recommended a combination of "carrots and sticks", with a focus on behaviour change at local level for entire cities, including government departments, as well as paying more attention to the entire sanitation ladder, including post-ODF.

He concluded by noting the importance of having a functional and appropriate monitoring system in place to generate data for action to respond to both achievements and challenges and to develop sustainable business models, rather than relying on grants and subsidies.

SNV Cambodia: SSH4A Post ODF Phase – *Beyond the Finish Line*

Presented by Ms Gabrielle Halcrow, SNV SSH4A Regional Coordinator, Asia. Presentation available in Annex III.

Ms Halcrow began the presentation by observing that rural and hygiene in Cambodia has made significant progress from a very low baseline but still has one of the highest rates of OD in the region. Environmental factors including widespread annual flooding in the Mekong Delta has resulted in most families preferring to make a single investment, installing improved facilities from the outset: unimproved pit latrines simple do not last.

This has been facilitated through the participation of the private sector. Cambodia does not yet have a strong regulatory environment, which has allowed many private sector entities to compete in the development and supply of sanitation technologies. The concept of sanitation marketing emerged in Cambodia, as the concept of CLTS emerged from Bangladesh. The need for accessible improved facilities led to the development of the Ezy Latrine, which utilises modular construction, allowing mass production at a largely affordable price. The Ezy latrine is also simple and relatively inexpensive to install. Nonetheless, inequality in access to facilities in increasing: the Ezy Latrine is affordable for those in the upper and middle wealth quintiles but still out of reach for those in the lower quintiles (Figure 22).

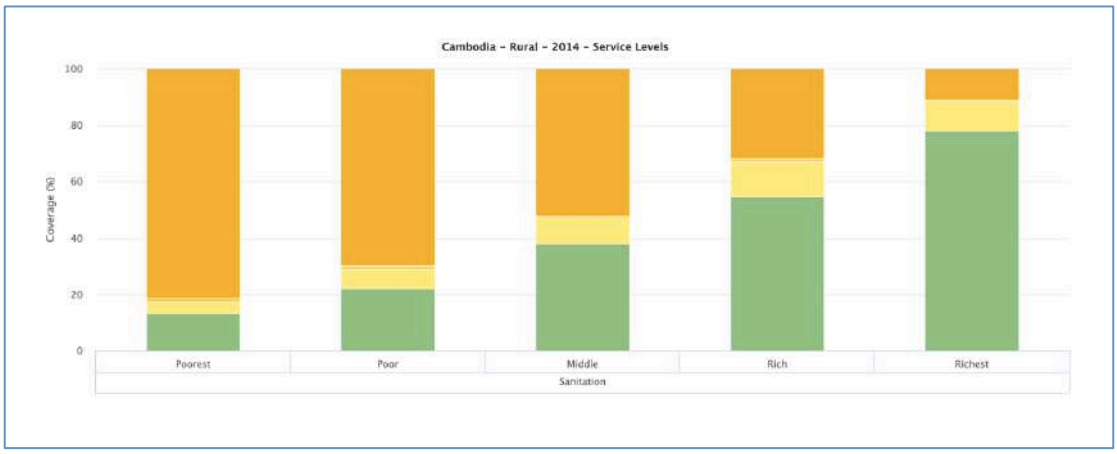

Figure 22: Rural sanitation service levels. Cambodia 2014. Presented at SNV Learning Event, Ethiopia 2018

Cambodia has a large number of small but active NGOs and other local actors in the WASH sector. Traditionally, the approach has been very piecemeal with each actor focusing on their own priorities with little coordination or harmonization among them. Over the past five years, the government has recognised the need for an integrated approach and has increased the priority of rural WASH, as evidenced through the development of the National Strategic Plan 2014-2025, National Action Plans 2014-2018 and Provincial Action Plans for all 25 Provinces. The government recognises the role of districts and provinces and is committed to decentralization as a conduit to achieving sustained access to safe water and sanitation facilities for all in rural communities by 2025. This process is still in its early stages and it remains to be seen if decentralization can be effectively implemented.

SSH4A Timeline

Since 2012, SNV's SSH4A has taken a phased district wide approach. Very good progress has been made (Figure 23) but, as in many situations, achieving the last mile has proved very challenging. In 2016, Bantaey Meas became the first SNV-supported district to become ODF. From a baseline of 16 per cent access in 2012, 69 per cent of households have basic level facilities (JMP) and 100 per cent of primary and secondary schools have access to sanitary toilets. This was realised through a lot of persistence and commitment from the local government. The district is still considered "early post ODF" with work still to be done around upgrading facilities and reducing sharing: additional behaviours are being introduced in stages.

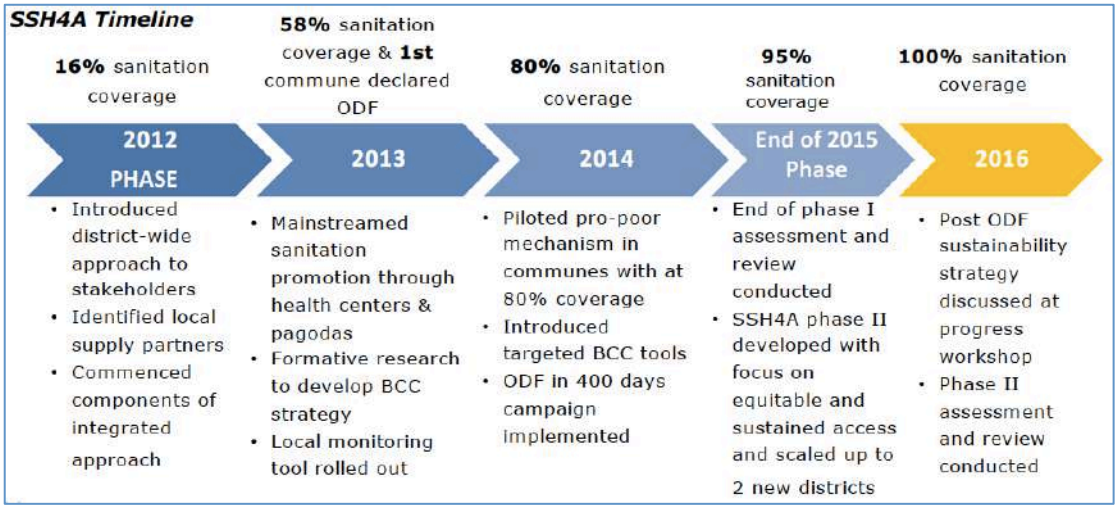

Figure 23: SSH4A Timeline in Cambodia. Presented at the SNV Learning Event, Ethiopia, 2018.

As districts achieve ODF status, the role of the government is changing from encouraging uptake of sanitation facilities to looking towards the provision of public services such as solid waste management and faecal sludge management as well as public compliance with standards and codes to ensure environmental health. This will require and new set of activities and a new range of actors. "Early post ODF" priorities include

- **Creating demand for a regulated and clean environment**, including 100 per cent access to universal improved sanitation, including for PWID who make up 6 per cent of Cambodia's population;
- **100 per cent hygienic use of toilets at all places** including oversight and maintenance of sanitation facilities at schools, health centres, health facilities and communities.
- **Responsive hygiene BCC**, including a district-wide Post ODF BCC strategy with a focus on HWWS at critical times and new behaviours such as MHM for women and girls, safe handling/emptying of faeces, and safe storage and handling of household drinking water.

- **Governance systems**: strengthening community guidelines, monitoring systems and local regulations; ensuring post ODF planning and implementation are included on the agenda of monthly commune council meetings; and developing budgeting systems at district and commune level, including pro-poor support mechanisms within commune budgets.
- **Safely managed services**: Currently, 80 per cent of toilets are less than five years old and 95 per cent have not yet become full. As toilets age, demand will increase and FSM is an increasing priority at national level.

Question & Answer

In terms of sanitation marketing, what was the role of the private sector?
In Cambodia, the market is unregulated, with many entrepreneurs. The government is working out how to engage with private sector for greater regulation but to date, the response is largely private sector driven.

The figure for unimproved facilities is very low: how did this happen?
In Southeast Asia, people rarely choose to install an unimproved model because it will not last in the environment; their aspirations are for an improved facility that will last through the flooding and wet seasons.

What is the plan for support for last mile?
Cambodia has history of subsidy, with the government now moving towards "smart subsidy". There is a clear government categorisation of "poor", known as IDpoor. The government has urged private sector vendors to sell to IDpoor households via a rebate system. This system, however, is quite expensive and not really creating an enabling environment.

Is private sector interested in pit emptying?
Not really at this stage – we are still working on that!

Presentation of Faecal Sludge Management, Post ODF

Presented by Antoinette Kome, Learning Event Facilitator, SNV Global. Presentation available in Annex III.

Along with setting new milestones and maintaining achievements, one very important aspect of post ODF is faecal sludge management. When households have decided to build a latrine, we should be able to give them some guidance on FSM, such as:

- What is the lifetime of the pit (i.e. when will it be full)?
- When full, should the pit be replaced or emptied?
- How should this be done safely, in terms of handling of faeces, stability of the ground, final disposal, and so on?

It is very important that the pit is emptied or replaced in a timely manner, before it becomes a health hazard. As such, it is useful for households and facilities to be able to estimate how long it will take before they need to address this issue, so that they can have the new pit dug or a plan to empty the pit in place before the old pit becomes critically full.

Country Team Group Work: Calculating the Lifetime of a Pit

Country teams were asked to calculate the pit of household in their area toilets and to discuss how they would communicate this with their community. They were asked to consider the types of safety guidelines they would give to their communities for both emptying the pit and closing and replacing it. For this exercise, teams were asked to consider only rural households.

The length of time it will take a pit to fill depends on a number of variables:

1. What accumulate? Only solids? Or both liquids and solids?
2. How many people are using the toilet?
3. What is the accumulation rate for the type of toilet?
4. What is the volume of the pit?

The calculation to determine pit life is quite simple. Not many studies, however, have been completed on accumulation rates, so it is difficult to develop good estimates for this variable. For this exercise, country teams were provided with the accumulation rate from Malaysian Water Safety, presented in Table 6. *Note*: If solid waste is thrown into the pit, this will reduce the pit life by approximately half. Ms Kome then discussed depth versus effective depth (Table 6): We do not want the pit to overflow, so we should reduce the height of the pit in our calculations by the depth of the freeboard, or the space remaining once the pit is effectively full (Figure 12).

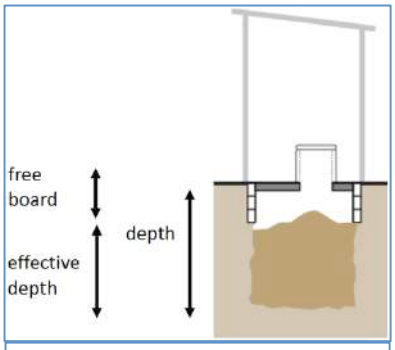

Figure 24: Depth vs Effective Depth. Presented at SNV Learning Event. Ethiopia 2018.

While country teams were asked to calculate pit life only for households in their communities, the same formula can be applied to latrines in schools, health clinics or other facilities:

- Effective size of pit = (depth-freeboard) x width x length →
- Accumulation rate x number of users = household production per year →
- Effective size of pit/household production = number of years before emptying.

Note If solid waste is dumped, divide the number of year by 2

* If **Type of toilet**	**Accumulation Rate (m^3/person/year)**	**Size (m^3)**	**Freeboard (cm)**	**Effective size (m^3)**
Single Pit	0.06	2	50	1.57
2 Pits	0.06	2	50	1.57
2 Alternating Pits	0.06	2	50	1.57
Single compartment	0.04	0.15	10	0.12
Double compartment	0.04	0.15	10	0.12
Tank, no effluent outlet	3.50	10	50	7.50
Tank with effluent outlet	0.08	10	50	7.50

Table 6: Accumulation rate from Malaysia Water Safety. Presented at SNV Learning Event, Ethiopia, 2018

There was substantial variation in pit life among the different countries (Figure 25). Fill time depended on a number of variables including the usual size and shape of the pit (circular pits vs. square pits), whether or not the pit was lined, whether or not it was also used for solid waste, and the size of the household. Country Teams were then grouped according to whether they promoted both emptying and replacement in their communities or

replacement only to discuss the guiding questions. The outcomes of this exercise are presented in Table 7.

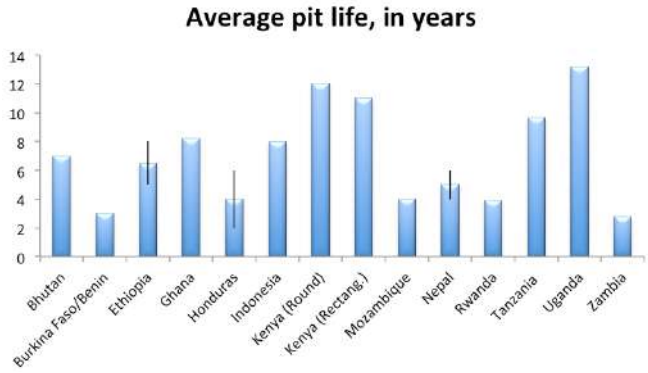

Figure 25: Average pit life in years for participating countries. Error bars indicate a range, if given. SNV Learning Event, Ethiopia 2018.

Country	Average pit life	Current situation	Suggested future guidance
Bhutan	7	Have not yet experienced full pits	Promote twin pits which can be safely emptied, following proper OHS, after 10 years and used as compost
Burkina Faso/Benin	3	Usually replacement	If full to freeboard: construct new latrine - Move slab - Fill the pit with soil and ash - After 2 years, use content as fertilizer or plant a tree on the pit
Ethiopia	6.5	Almost always use replacement	Fill the freeboard with mud, then leave to decompose for at least 2 years
Ghana	8.2	Almost always use replacement	Close the old pit following proper OHS and plant banana palms on top
Honduras	4	Almost always use replacement	Fill the freeboard with mud, then leave to decompose for at least 2 years
Indonesia	8	Depends if land is available. If yes, a new pit will be dug, if no it will be emptied. Rich people outsource the emptying, poor people do it themselves, with sludge often dumped in the river or elsewhere	Suggest should be emptied following proper OHS transported to treatment plant or buried safely in empty land If a second pit is built, don't touch the old one for 2 years.
Kenya (Round)	12	Usually recommend replacement to avoid faecal contamination, plus cost of emptying is higher than building a new pit. It is challenging to transport faecal matter to disposal sites as they are often far away	Need to integrate discussion of pit lifetime and FSM into household training
Kenya (Rectangle)	11		
Mozambique	4	Usually replacement	Recommend to close the old latrine, following proper OHS; burn the old wooden slab, fill in the freeboard with ash, salt and soil; plant a tree on top of the old latrine

Nepal	5	Replacement or emptying, depending on available space	Encourage alternating pits to be emptied after 2 years and can then be reused; Peri-urban areas can use mechanical emptying and then reuse the land
Rwanda	3.9	Contractor demolishes the old toilet and builds a new one	Suggest move to emptying by engaging the private sector
Tanzania	9.7	Usually replacement - pits are not often lined which makes emptying difficult	Close the old pit following proper OHS and plant banana palms on top
Uganda	13.2	Usually recommend replacement to avoid faecal contamination, plus cost of emptying is higher than building a new pit. It is challenging to transport faecal matter to disposal sites as they are often far away	-Use exclusively for faecal waste, not solid waste - Monitor where old latrines are so new ones are not built on top - Explain free board concept to households and help them calculate approximately how long their pit will last
Zambia	2.8	Usually build a new pit, but with VIP toilets, this cannot be done	Encourage twin pit with emptying after 4 years

Table 7: Outcomes of country and mixed country group work on pit life and faecal sludge management. SNV Learning Event, Ethiopia 2018.

Ms Kome noted that it is not always easy to move from replacement to emptying as simple, unlined latrines may collapse if they are emptied. However, even though replacement is often viewed as cheaper than emptying, it may not be if you consider the lifetime of the pit. She further noted that the advantage of twin pits is that it allows time for the direct pathogens (although not helminths) to die, which makes for safer handling. In concluding this block, Ms Kome reminded everyone to consider the height of the groundwater when considering whether to use replacement or emptying and to remember that FSM can be quite simple in rural areas, particularly when compared to urban FSM.

XI. Block IV: Building Blocks For Progress

Why is this relevant?

In order to continue making progress it is important to identify new milestones and to unpack these milestone to determine what are the key steps we need to take to reach those milestones: to identify the building blocks for the next phase.

What are the objectives of this block in terms of knowledge and learning outcomes?

- To develop milestones and building blocks around six different topics;
- To identify key take-home messages and tools.

What was the process?

- Introductory presentation on the concept of building blocks for progress;
- Mixed team group work to develop milestones and associated building blocks for their selected topic;
- Presentation to plenary by each group;
- World café: sharing of advice and guidance by mixed country 'consulting' groups to each country;
- Identification of key take-home messages and presentation of these messages to the plenary.

Overview of Block 4

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands. Presentation available in Annex III.

Ms Kome began the overview by revisiting the SDGs and their inter-relatedness. She reminded participants that they need to identify their contribution to the SDGs and be clear about what their role entails, while still knowing what other sectors are doing and how to work together.

She likened the SDGs to a puzzle, of which sanitation and hygiene are a vital piece: the puzzle is not always neat and we must develop our capacity to meaningfully connect people and processes in order to make progress. People often mention that 'the real problem' is 'XYZ' but no problem is more 'real' than any other. There are many interrelated issues and communities often get support from different agencies, which is why we need a holistic vision but specific roles. We need to sit with many stakeholders to create a vision and align activities. Our role, however, is not to bring everyone together and just say 'yes' but rather to promote critical reflection: What works? What doesn't? What can we improve?

Building blocks for progress

In order to maintain momentum and continue to progress, we need to unpack what type of progress we need in our individual setting. Is it to move up the sanitation ladder? Cambodia felt the need to move straight to improved toilets due to environmental reasons; other countries may find that an unimproved toilet feels sufficient to the community and does not present undue risk to public health.

Progress may also be reaching larger areas or addressing the needs of specific groups. It can be easy to focus on the most accessible groups and push them up the sanitation ladder but it important to recognise our responsibility to all. Some may choose to focus on schools and health facilities, while others feel it is important to institutionalise new responsibilities and quality control.

Next milestones and sustaining results

Ms Kome asked participants to consider what their next milestones might be based on their country-specific gaps, and how these milestones may be reached, recognising that not all work can be undertaken in campaign mode. She presented six possible milestones to consider:

1. Moving towards district wide coverage (ODF or basic sanitation) for households;
2. Get all schools up to standard for infrastructure and hygiene behaviours;
3. Get all health facilities up to standard for infrastructure and hygiene behaviours;
4. Ensure safe menstrual hygiene management in households and schools;
5. Ensure responsive behaviour change communication;
6. Set up environmental health surveillance and response.

DGroup Responses

During the DGroup discussions, participants were asked to consider some of the challenges around achieving district-wide ODF. Participants recognised the need to connect the different organisations and individuals with a mandate for those larger areas to sanitation as well as the need for the engagement and alignment of multiple stakeholders. To extending cost-effective messaging coverage, the suggestion was made to look for opportunities to integrate with other events – such as agricultural events – and leaders. Others recognised that while it is important to start in the village, we cannot assume that sanitation coverage will spread "naturally" and that we should try to avoid scattered islands of success.

Other participants raised the need to strengthen systems including district-wide sanitation plans and national M&E systems, and to avoid seeing sanitation as an (automatic) add-on to

water. It is hard to mitigate the fact that water is attractive and sanitation is not: sanitation usually gets smaller budget, less priority, fewer senior staff. Participants recognised the need to ensure an integrated sanitation approach – supply, demand, governance – and to address gaps proactively, with particular attention paid to the needs of less vocal or visible groups.

It is easy to get focused on numbers but it is essential to ensure quality for sustainability and also for demand creation/scale up. When discussing quality assurance during the DGroup, participants recognised that duty bearers sometimes have a limited understanding of their role and mandate in quality assurance. The quality of processes is important for scaling – it is important not to take shortcuts. In Laos, for example, the triggering process skipped many of the more challenging steps, such as engendering disgust, so (of course) it was not effective. We need a detailed understanding of the context-specific quality issues: one off training is not sufficient: teams need to return to see what is working, what messages have taken root. It is also important to understand what level of quality is necessary and attainable; setting unrealistic goals can be very demotivating. Long term engagement and responsive activities are needed for quality assurance (beyond campaigns) and we need to look at the results, not just the activities. Funding, however, is often tied to activities so it can be challenging if you realise that the funded activities are not actually what you need right now. A final point raised was that the WASH committees, central to many CLTS campaigns, might not actually be the long-term hygiene promotion channel.

Mix-country group work on building blocks for progress

Participants were asked to divide themselves into six groups to discuss the six possible milestones, presented above, and the building blocks required to achieve these milestones. Building blocks may be specific activities or ensuring that the necessary systems and protocols are in place, for example. They were asked to consider the following questions:

1. Describe the milestone situation in detail;
2. What would be an indicator of achievement?
3. What would be an appropriate process to reach there?
4. Which building blocks would you need to get there?
5. Who would/should take the lead?
6. How does it fit into current structures and work processes?

After initial discussion, participants were given the opportunity to "spy" on other groups to see what they had achieved and suggested and to bring those ideas back to their own group before their final discussion. The results of the group work are presented in Table 8, below. *Please note, given the time constraints, not all groups were able to fully respond to all six questions.*

Moving towards district wide coverage of ODF
Milestones
- Adopt ODF that is based on basic sanitation achievement; - Each country achieves one ODF district, based on basic sanitation achievement.
Indicators
- Use existing indicators for ODF but with basic sanitation achievement → - Number of districts that are ODF based on basic sanitation achievement.
Process
- Demand creation: standard toilet in place as basic sanitation; communicate benefits of basic sanitation - Enabling environment: agree on country standard for 'basic sanitation'; development of a checklist - Decide where to start: national or village level; - Focus on capacity building by →

- Integrating with other sectors: government, private sector, BCC

Building Blocks

- Adoption of basic sanitation;
- Scale from village level to district wide and ensure all partners and stakeholders are harmonised;
- Develop district road map and action plan, including standard tools (e.g. district sanitation investment plan);
- Develop technology options: new/existing pit latrine designs, prototypes;
- Private sector involvement: financing (loan models to community, businesses), supply chain, capacity building.

Critical Elements

- Get commitment from leaders;
- Have regulations in place that are enforceable;
- Develop a roadmap with associated budget;
- Get commitment and support from champions.

Leadership The district takes the lead: they mobilise the stakeholders' participation. The stakeholders develop an investment plan with budget and advocate for he government and development partners to commit to funding and implementing the plan. The district will identify champions/opinion leaders to lend support. The district will mobilise the private sector to participate.

Get all schools up to standard for infrastructure and hygiene behaviours

Milestones

- Adequate access to WASH facilities in schools;
- Adequate HWWS facilities in schools;
- Proper institutionalisation and maintenance of facilities;
- Menstrual hygiene management system;
- Adequate latrine meeting the set standards for toilet ratio;
- Trained school management and WASH club

Indicators

- Number of school with adequate facilities;
- Number of schools with adequate HWWS facilities;
- Number of schools that are properly utilising and maintaining their sanitary facilities;
- Number of schools with MHM facilities in place;
- Number of schools with latrines meeting the set standards of pupil toilet ratio.

Building Blocks

- Adequate budget allowance;
- Evidence based advocacy → political will
- Capacity building of teachers and key stakeholders;
- Enforcement of set standards;
- Development of M&E framework and system;
- Development of WASH implementation framework in schools & functional WASH Club;
- Roll-out of school-led total sanitation and hygiene (SLTSH);
- Establishment of WASH model schools;
- Development of low cost latrine design in schools.

Who takes the lead? Government takes the lead, specifically Ministry of Education. MOE, however, will need to work with other ministries, e.g. MOH.

How does it fit into existing structures? Intensification and scaling of school SLTSH, with greater focus and more commitment to prioritise WASH in schools.

Get all health facilities up to standard for infrastructure and hygiene behaviours

Milestones

- Infection prevention and control

a. Waste segregation and disposal (sharps, infectious waste, general waste);
b. Hand hygiene;
c. Infrastructure (e.g. ramps for PLWD).

Indicators

1. Hand hygiene: hand washing at different points of care; number of functional HWF in use.
2. Access to and use of safe water;
3. Basic sanitation.

Who should lead? Need management and commitment from the health sector. Policy-wise leadership needs to come from the top, down. Consider developing a steering committee to lead strategy implementation

Innovations

- Integrate sanitation and hygiene training into the training curriculum for those who want to work in health facilities;
- Encourage patient (and staff) feedback on level of service and cleanliness via a "TripAdvisor"-style app.

Ensure safe MHM in households and schools

Milestone MHM policy and guidelines supporting proper MHM information, behaviour and access to safe MHM facilities and products, including safe disposal.

Indicator Universal access to basic information and facilities (including safe pads, safe disposal, safe changing places, proper information/knowledge, including for boys & men, and enabling policies).

Building blocks

- Institutionalise a good, inclusive M&E system to monitor facilities, access and products;
- Competent and capable workforce with the capacity to break the silence around menstruation;
- Safe disposal facilities in place and in use;
- Create supportive domestic and institutional environment that enables normalisation of menstruation;
- Develop and activate multi-stakeholder approaches to MHM;
- Introduce low-cost, culturally appropriate menstrual hygiene supply chain;
- National guidelines for MHM

Innovations

- Breaking the silence: Use community champions, CSO or other local community organisations to break the silence; radio/TV; emotional triggering.
- Supply-induced universal demand: reduce cost; localise production; taxation cost-effectiveness advocacy; free availability of pads in schools.

Ensure responsive BCC

Milestones

This team identified many milestones reflecting the different stages that each country is at. From these, they selected 2 to focus on for the purpose of this exercise:

1. National BCC Campaign
2. Cascade the implementation to lower local government

Process for National BCC Campaign

- Consensus of stakeholders on motivations, barriers, and existing behaviours;
- Appreciation of existing capacities – capabilities and funds;
- Inventory/study of approaches and actors;
- Harmonisation/integration of existing approaches, structures, policies;
- M&E Framework

Building Blocks

- Clarity of institutional roles and responsibilities (MOH);

- Compendium of standards;
- Capacity building plan (expertise);
- Enabling environment (policy/political);
- Platform for review;
- Budget.

New Innovations

- Bottom-up consultation: local level to national
- Piloting elements of the BCC campaign before roll-out;
- Decentralisation of BCC messaging to account for diversity;
- Involvement of the private sector;

Lingering questions

- Using evidence to support BCC;
- Moving beyond the strategy on paper;
- Contextualising BCC;
- Reach (size, segmentation, vulnerable/marginalised groups);
- Local partnerships for sustainability;
- P2P: church, local partnerships.

Set up environmental health surveillance and response

Milestone institutionalisation and professionalization of WASH.

Process

- Strengthened and integrated environmental health systems & surveillance generating high quality, sound environmental health & WASH data;
- Linkages with HIM and outbreak data;
- Oversight and analysis of trends;
- Priority given to WASH related disease burden (?);
- Develop core indicators/environmental health parameters;
- Identify or develop relevant data collection tools;
- Create demand for surveillance through advocacy, sensitisation;
- Build capacity;
- Ensure the '5 Ms' are in place: materials, manpower, methods, machines, money.

What is surveillance, in this context? The collection of environmental health data expressly for health planning, control, prevention, and health promotion. It is an on-going process that includes timely analysis to generate clear and easily understood results to be disseminated as evidence for action. The surveillance system itself should be regularly reviewed, evaluated and improved.

Who should take the lead? Ministry of Health through the Environmental Health and Environmental Surveillance Departments. Need to strengthen quality assurance to ensure compliance with data collection guidelines.

Investing in health surveillance will solve all health issues.

Table 8: Outcomes of the Building Block multi-country group work. SNV Learning Event, Ethiopia 2018.

Each group was then asked to present their proposal for new milestones and the building blocks to achieve these milestones to participants role-playing as representatives from the Asia, Africa and Latin America Development Banks. The presentations were judged on the following criteria:

- Clear milestone?
- Realistic milestone?
- Does the process or building blocks consider the basic conditions?
- Is there something new, an innovation, to trigger change?
- Can it be integrated into current structures?

All teams gave very strong presentations, but in the end the team aiming for district-wide ODF were declared the winners!

World Café session

Based on the previous discussion, each Country Team was asked to prepare a brief on priority issues in their country. One or two people from each Country Team were then asked to remain as the country 'client', while the remaining participants were to form a pool of 'consultants'. The consultants were organised into mixed-country groups and were then instructed to visit some of the country clients to provide advice on the issues identified in the brief. Due to time constraints, each consulting group visited three countries only. Some country clients presented the same issue to each of the three consulting groups while others developed two or three briefs. These briefings were intended to help each country identify some 'take home' messages and tools to put in their 'shopping bag' (below).

Country Shopping Bag

An important objective of the learning event is for participants to take home a 'shopping bag' full of new or different ideas and learning to influence practice in their own countries. Documenting what participants placed in their shopping bags holds participants accountable for knowledge and learning they pledge to take back. It also allows SNV leaders a reference from which they may monitor progress over the upcoming months.

For most country teams, the shopping bag drew on information and ideas that had emerged throughout the workshop. For many, these ideas were distilled during the previous session. The shopping bags for each country and a hybrid from Netherlands/USA team are presented in Table 9

Country	Shopping Bag Content
Benin/Burkina Faso	- Guidance on new technologies for latrine construction - Methodology of FSM in rural areas - BCC approaches/strategies - Sustainability beyond the project implementation period - District ODF strategy to scale up - Consultancy/owner country role play
Bhutan	- Guidance on pit life and FSM - Role of schools (students) in monitoring sanitation and hygiene in communities - 1-5 network systems for follow up and monitoring
Ethiopia	- Woreda-wide ODF with basic facilities - Hygiene practice - Ensure affordable sanitation and hygiene products and services
Ghana	- Influence effective coordination and harmonisation between WASH institutions (MLR, MOE, MWSR, MOH), through for example, creation of a coordinating authority - Development of a government-owned framework/master plan/s with clear timelines for implementation - Effective regulations/standards for quality latrines (basic access) - Improve interactions with PLWD - Effective M&E structure: harmonized reporting to track progress of interventions; data management
Honduras	- Clarity, in that it is possible to promote sanitation and hygiene at low cost: in Honduras the technology is expensive - The escalation phases; for example, how we promote social cohesion. Involve the different sectors

	- Innovation and specialisation is what will make a difference in what we do - Monitoring systems from the ground up, which respond to give timely follow up to ensure optimal growth - Strengthen local bases to ensure the sustainability of the processes we develop
Indonesia	- Visions and inspirations from other countries - Moving from monitoring to heath surveillance (integrating different systems - More attention should be given to building the blocks towards post-ODF - FSM: anticipating and providing services - To merge and increase coherence of existing sanitation working groups - New ideas to promote behaviour change in rural areas
Kenya	- Use 1-10 network to achieve ODF: 'nyumba kumi'; M&E - Use school to scale up hand washing: children to take message home (BCC); linkages (community and schools) - Sectoral integration: Water, education, health, agriculture; steering committee at all levels - Informed choice materials: type of toilet (structure); type of pits (round vs. square); depth; lifetime
Mozambique	- Develop national BCC strategy for WASH - Develop strategy for engagement of the private sector - Revise the district-wide sanitation approach - Increase coordination between different sectors, including Ministry of Finance
Nepal	- Invite/engage MOF representative as NSHCC - Guidance on pit life and FSM - Strengthen role of FCHV as Health Development Army (BCC) - Engage Health Facility Centre as key WASH-related awareness centre
Rwanda	- Ethiopian structure: Implementation using existing government structure down to development unit; involvement of the school & students in WASH - Experience of Nepal: Incentives to private sector to invest in sanitation (tax incentives) - Different ways of defining 'improved' latrine according to local context, in addition to the JMP definition - Twin pit latrines for FSM solution in rural areas
Tanzania	- Set up the 1-5 and 1-30 networks, as observed in Ethiopia - Adopt school monitoring of sanitation progress - Adopt flag system for sanitation achievements - Ward-level ODF celebrations
Uganda	- Institutional coordination: reporting; data management - Supply chain and standards on ODF - District wide ODF: basic and improved (JMP) - PLWD and ultra poor sanitation needs - Monitoring through school children
Zambia	- Public toilets in rural areas - FSM: preparing communities and learning how to calculate pit life - Strengthening coordination units at sub-district level

	- Continuously monitor and evaluate BCC - Total sanitation package: households and institutions - Advocate government for increased commitment to sanitation and hygiene (including budget), through, for example, WASH NGO Forum and thematic working groups
USA/Netherlands	- Technical crash course, including trends and future goals - Better insight into the rural sanitation actors - Communication products and materials for external audiences

Table 9: Country Group Shopping Bags. SNV Learning Event, Ethiopia 2018.

Annex I: List of participants

(available for attending participants only)

Annex II: DGroup discussion summaries

"Chasing the SDGs: Scale, sustainability and new frontiers in rural sanitation and hygiene" Summary of Dgroup Discussion

6th March – 14th April 2018

SNV Netherlands Development Organisation

Introduction

An email discussion was held on SNVs Rural Sanitation and Hygiene Dgroup platform from 6th March until 14th April 2018 on the topic of *"Chasing the SDGs: scale, sustainability and new frontiers in rural sanitation and hygiene*". This document is a summary of the 49 contributions from participants in 15 countries from the Africa, Asia and Central America regions. The countries were Benin, Bhutan, Burkina Faso, Nepal, Tanzania, Australia, Nepal, Uganda, Zambia, Indonesia, Rwanda, Kenya, Mozambique, Honduras and Ethiopia.

The discussion covered the following three topics

- Topic 1 Priorities and realities in reaching the SDGs in rural sanitation and hygiene
- Topic 2 New frontiers in rural sanitation and hygiene
- Topic 3 Quality assurance and sustainability.

Topic 1: Priorities and realities in reaching the SDGs

For our first topic, *Priorities and Realities*, which ran from the 6th until the 16th March 2018 there were 17 contributions from individuals and combined teams from SNV and government partners across 12 countries from Africa, Central America and the South Asia regions.

Chasing the SDGs in rural sanitation, the SDG 6.2, puts the following challenge to us as a sector:

6.2 by 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

When looking at the indicators, this represents 3 challenges in one:

- End open defecation for all by 2030
- Use of basic sanitation for all by 2030
- Use of safely managed sanitation for all by 2030

And although not very explicit, there is in fact a 4th challenge:

- Hand washing with soap after defecation (for all?) (by 2030?)

Basically, the SDGs propose to climb the full sanitation ladder by 2030, and not only for households, but also for schools, health centres, work places, public places and so on. Of course, the SDGs are intended to be aspirational targets, each country sets its own priorities, and priorities need to be based on the local context. This is why this first topic focuses on the priorities and realities in rural sanitation and hygiene. We want to look at the reality of achievements, for example: "Are there ODF districts in the country already?" But also at the reality of our knowledge and capacity, for example: "Do we know how to ensure basic sanitation services for all health facilities in a sub-district?".

The guiding questions for the discussion of this first topic were:

1. Where does your country stand today with regard to progress towards SDG 6.2 for rural areas?
2. Where do you think our knowledge and capacity stands with regard to the ambitions of the SDG6?
3. What are your country's priorities for achievement in rural sanitation and hygiene by 2030?
4. What should be our priority for sector learning going forward?

Where do we stand today with regards to ambitions and progress towards SDG 6.2 for rural areas?

Across the examples shared by the participants from Zambia, Kenya, Uganda, Ethiopia, Bhutan, Mozambique, Honduras, Tanzania, Nepal, Burkina Faso, Rwanda, Benin

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- Countries have set context specific targets, including many with intermediary targets. At best, there are mixed levels of confidence about these 2030 targets given the current realities and projections - ranging from "challenges are enormous", "it is practically impossible" to "convinced".
- Countries with higher rates of open defecation (OD) are focused on lower service levels and have less confidence in what are felt to be unrealistic ODF targets
- Countries with (now) low rates of OD are challenged by increasing inequities, higher service level targets but have strongly engaged in mainstreaming the SDG agenda
- Mixed availability of data on hand washing and health care facility access, but common challenges in school toilet ratios.

Table 1. Snapshot of country level goals, realities and projections

National goals and priorities for 2030	Current realities	Projections
Zambia - ODF by 2030	3 out of 103 districts have attained ODF status to date, however intensive activities underway in majority Access to sanitation in 2017 was projected at 31.18%	Solomon Mbewe and Warren Simangolwa, SNV - given the current rates, "Zambia will only have attained a 100% access to basic sanitation by the year 2231". Whilst Given Mbita, MoH estimated 100% improved access by 2482" and made the target "is practically impossible" without a concerted effort.
Ethiopia - ODF by 2023, along with intermediary targets of 82% of people with basic hand washing by 2020 and 82% people with basic sanitation by 2020.	OD reduced from 90% in 2000 to 32% in 2015, but only 3 per cent progress in basic sanitation access rates. Health facilities relatively satisfactory compare to school toilet ratios.	Andualem Anteneh -estimated given current progress it will take another 8-12 years to eliminate open defecation and more than **480** years to ensure access to basic sanitation by all (households) in rural areas.
Mozambique - ODF by 2025, universal access to sanitation facilities for schools and health facilities by end of 2029 and universal access to drinking water and sanitation by end of 2030.	24% (basic) and Rural 12% (basic), whilst rural OD is reported at 48.5%.	Befekadu and team estimated it will require 99 years to achieve access basic sanitation for all.
Benin, - 75% coverage for access to basic sanitation and end open defecation by 2025	Household access to latrines is estimated at 46% in 2014 with high rates of open defecation,76% in rural areas. 20% have access to improved sanitation, with 7% living in rural areas.	
Tanzania - By 2030, 100% basic sanitation of which 13% will qualify for safely managed sanitation services. Basic hygiene will be practiced by 75% of the population. Open defecation free status by 2025	OD has been reduced to approx. 5% and basic sanitation access has increased from 25% in 2013 to 55.1% in 2017 due to the National Sanitation Campaign program. Currently only 27% of schools meet the required standards and data on health care facilities is scanty.	Jackson felt the government is convinced that the SDG goals will be attained by 2030 as long as the current momentum is sustained, and that this was justifiable.
Burkina Faso - 100% of villages ODF, 100% for access to adequate sanitation and 100% of population with good practices	232 /8435 villages ODF to date, CLTS is used both with and without subsidy	Aminata Bara – Country will have to realize about 150 000 latrines each year from 2016 to 2030. Till now only 45 000 latrines are made yearly; 70% of the population continue to practice open defecation.
Rwanda –100% access to basic sanitation by 2020 and 100% access to safely managed water and sanitation services by 2030		
Kenya - ODF by 2020, and by 2030, the target is to attain universal access to improved sanitation.	ODF Vision of 2013 was revised to 2020. To date 1 of the 47 counties has been certified ODF. JMP figures for OD in 2015 reported 12% but it is potentially lower.	Fanuel Nyaboro - Provision of sanitation and hygiene services became a devolved function in Kenya in 2013, need to return to campaign mode
Nepal – ODF by 2018. By 2030, achieve total sanitation throughout the country (aligned with SDGs).	47 out of 77 districts have achieved 100% access and declared ODF. Basic sanitation coverage is estimated at 96% in 2018, from 30% in 2000. Government has been committed to total sanitation since 2011 and has been mainstreaming the SDGs at the government level	Ratan and Chiranjibi, SNV Nepal - Major challenge of federalisation process, as state restructuring underway and the 7 Provinces and 753 Metropolis, Sub-metropolis, Municipalities and Rural Municipalities have just been established and will each have to commit to the SDGs and total sanitation agenda.

Bhutan – Aligned with the SDGs, >95% access to improved sanitation facilities by 2023 90 per cent access to hand washing with soap practices by all by 2023.	Basic sanitation service levels is 63% and steadily increasing, 4% open defecation, no data on safely managed. SDGs basic service levels for hygiene is 80%. Schools have 76% access to basic sanitation service levels.	Rinchen Wangdi and team - Confident progress, but challenges in target setting without a national baseline for safely managed sanitation and inequities.

Knowledge and capacity gaps

Data, definitions and indicator alignment

Within countries, there are multiple data sources, with differing definitions and terminology (including the JMP figures) which poses challenges for alignment and sense-making. For example,

- Several are facing issues at the national level with safely managed sanitation indicators, baselines and definitions. As Warren and Solomon shared in Zambia, *there is not sufficient information on excreta management to allow for safely managed sanitation classification"*. Kumbulani added further that in Zambia, indicators are currently not oriented towards safely managed sanitation but improved sanitation (now Basic in SDGs) and ODF definitions are orientated at the household/village level and exclude for example schools and public places. Whilst in Bhutan, Rinchen Wandi, MoH reflected that their "*most common issue identified was the absence of reliable national baseline data for WASH to track the SDG 2030 targets*" which has seriously impeded the setting of National Targets for safely managed sanitation and handwashing with soap in line with the SDGs. In Nepal, Nadira shared that at the national level "*the challenge for SDG 6.2 lies in having a clear and contextualised definition for safely managed sanitation that can be monitored*". This was an exercise which the National Planning Commission and line ministry have been working on but would take time to finalise and align all stakeholders accordingly.
- Several participants struggled to find meaningful data on handwashing, access in health care facilities or reference to indicators in sector documents. Data for schools was more readily available, focused primarily on service levels and ratios.
- Jackson, Getachew and Nabasirye Lillian each reflected on more general issues with data quality, reporting and timeliness. They felt that in their respective country contexts there were needs for timely, efficient and structured monitoring tools or systems that improved data quality and reporting.

Disparities, inequities and use by all

Participants from multiple countries reflected on the potential and increasing disparities in access and usage between groups, limitations in data and tools to monitor this, the need for more nuanced solutions and the suitability of technology options to meet the needs of all - if we are to leave no-one behind.

- In Bhutan**,** disparities in access to sanitation and hygiene facilities and services were related to income, gender, disability and geographic factors, and were often interrelated. Rinchen, MoH shared that the poorest households' access to improved sanitation (32%) is three times less compared with the richest households (95 %). In Ethiopia, service levels for the ultra-poor and people with disability were significantly lower.
- Linked to the limitations of data and monitoring tools, Given, MoH Zambia raised the concern that the national monitoring tool used on sanitation does not include indicators for measuring sanitation data by wealth quintile, sanitation data for people with special needs such as elderly people, people living with disabilities and women.
- Regionally in Africa, Anne felt there were gaps in involvement for people with disabilities, women and the poorest wealth quintiles beyond looking at technology options. She felt that

in relation to limited involvement of socially excluded groups, we may be lacking information on who they are, what they do, their aspirations to safe sanitation and services and other such challenges.

- Nadira, SNV Nepal shared that even though almost all households, health facilities, and schools may have built a toilet as part of the sanitation campaign, there are people who are still facing challenges in having safe and comfortable access to sanitation and hygiene especially people with disabilities, the elderly or people with temporary difficulties.
- Finally, Jackson in Tanzania raised the issue of sustainability and how to ensure adequate access to sanitation for the poorest, most vulnerable and hardest to reach. He shared that the country had no clear mechanisms for reaching the vulnerable groups with speed and relies on community coping mechanisms.

Inadequate attention to sector financing and (re)organising

- Whilst many countries shared progress at the national levels with commitments to strategies, targeting setting and reforms they also shared that these had not be in many cases backed up with sector financing reforms. As Anne Mutta shared currently for many countries in sub Saharan Africa, the financing of the sector is donor dependent.
- Solomon and Warren in Zambia reflected that the sector generally has not met the ambitions and determinations registered in policy and strategy with an equal weight of sector financing. Whilst Given reflected on an over dependence on partners. In Ethiopia, Andualem shared that there is no operational cost allocated by the government specifically for hygiene and sanitation from regular budgets.
- Patricia Solórzano, SNV Honduras shared an example of urban municipal level citizens being invited to participate in planning and service delivery discussions, including proposing how to invest budgets. However, such practice is not yet applied systematically or throughout the country.
- There is a need for re-organising and approaching the financing barriers. In Bhutan, Rinchen and team shared that they were looking to develop ways to motivate local government authorities to prioritise sanitation and hygiene programme and allocate adequate budget. In Mozambique, the team questioned how to make government more accountable for results and progress when interventions are left to NGOs/INGOs and CBOs. In Tanzania, Jackson raised the priority was to mobilise sufficient financial investments and for the country to set aside enough funds for the sector to implement. Yet, to date sanitation has been financed mainly by partners and what is available is not sufficient.

Ongoing sustainability and supply chain challenges

Finally, Jackson in Tanzania, Ousmane in Benin, Getachew in Rwanda, Fanuel in Kenya and Aminata in Burkina Faso shared concerns for limited capacity and knowledge on how to address the issue of sustainability, including specifically tackling slippage and reversion to OD and the need for supply chain innovations to provide affordable (yet quality) options. In Zambia, contributors were concerned not only about the quality and durability of toilets but also about hand washing stations.

Topic 2: New Frontiers in rural sanitation and hygiene

For our second topic, *New frontiers in rural sanitation and hygiene*, which ran from the 19th - 28th March 2018 there were 18 contributions from individuals and combined teams from SNV and government partners across 11 countries from the Africa and the South Asia regions.

During the first block, a number of country sector priorities and learning priorities emerged. In this second block, we sort to zoom in on three of these and explore what this would mean in practice in your countries. The following were the three "frontiers":

A. Achieving a 100% basic sanitation in an entire district, this means leaving no-one behind
B. Providing post-ODF direction (targets, priorities) as well as support
C. Reducing dependency on donor budgets for reaching rural sanitation and hygiene targets

The guiding questions for each of these were:

- How this could be organized (better)?
- What would need to change and be learned to achieve this?

A. Achieving a 100% basic sanitation in an entire district, this means leaving no-one behind

Models for outreach and scale

- Given, MoH, Zambia, reflected on the importance of the linkage between leadership, outreach and mandate. She used the example of the need for MoH who has both the mandate and the outreach structure to lead sanitation.
- Osman Yiha, SNV Ethiopia first shared the strong outreach structures (1 to 30 development units and 1 to 5 networks) that are tapped in to in achieving rural sanitation and hygiene targets. Osman reflected though that whilst there had been many ODF declared wards as yet there had not been districts. Therefore, it will would be important to increase the priority on declaring ODF at district level, building momentum and economies of scale than to continue targeting small units of wards/villages.
- Befekadu, SNV Mozambique urged actors to consider long term intervention in specific geographic area and avoid scattered "islands of success
- Ousmane, SNV Benin however felt there was a need to start in a village and spread from there, involving neighbouring villages in the progress.
- Bendy, Kenya shared the idea of integrating messages within agricultural events which draws big crowds.

Strengthening systems, including monitoring ones

- Pius, Rwanda shared the example of developing the Zero Open defecation (ZOD) Protocol which included ZOD verification and certification to strengthen the existing government process
- Given, Zambia felt there was a strong need to strengthen the systems and the management – for example around district total sanitation plans, committees and capacities.
- Getachew reflected that whilst the government of Rwanda is now better organized to achieve 100% basic sanitation in an entire district, a separate sanitation policy and strategic guidance was needed to avoid it being seen as an add-on to water supply only.
- Gabrielle, Raj in Bhutan and Salvata, MoH Tanzania all raised the need to strengthen national monitoring systems, including for example of intra-household measures.

Working with multiple levels and stakeholders

- Osman, Ethiopia and Befekadu, Mozambique felt there was a need for broader multi-sector engagement – beyond the health sector alone.
- Given, MoH, Zambia saw the value in bringing together the key stakeholders being those with technical knowledge, the local/traditional leaders and civic leaders who have elective power and influence on electorates. This would form a power influence triangle.

- Bendy, Kenya saw that to achieve full coverage we would need to mobilise the stakeholders at all levels to maximise the outreach.
- Befekadu, Mozambique focused on the need for strengthened partnership and collaboration and potential through integrated approaches.
- Ousmane, Benin raised the need to work at 3 inter-related levels (community, local and national), which all should have the relevant competences.

What would need to change and be learned to achieve 100% district-wide basic sanitation access?

Tailoring approaches and support mechanisms and addressing "gaps"

- Nadira, SNV Nepal reflected that whilst achieving district-wide ODF in Nepal was well organized, gaps remained, including whether everyone within the household can use the toilet at all times, whether they are all motivated to use the toilets or were some people still defecating outside at times
- Gabrielle shared examples across Asia and Africa in which to achieve district wide approaches to reach all a "mix" of tailored approaches (11) were being used in SSH4A programmes, yet further learning and evidence was needed to understand how, when and where to use these approaches.
- Salvata, Tanzania felt indications were that the community support mechanisms alone were not sufficient and that deliberate support mechanisms to augment the community support systems were needed.
- Raj, Bhutan also raised the need for further attention to vulnerable groups, through identifying, tailoring support and engaging them in the process.

Improved efforts for harmonising approaches

- Ousmane, Benin felt that partners should frame their interventions in a logic of complementarity and synergy and not competitiveness/conflicting. This meant ensure a single approach by district, be it "without subsidy" or "with subsidy".
- Bridgit, SNV Kenya felt local governments needed to better coordinate partner involvement to minimize duplicating of efforts and harmonize approaches to reduce conflicts and propel villages towards achieving ODF status
- Aminata, SNV Burkina Faso felt efforts were need to improve the institutional context to encourage people to self-build and address the reality of conflicting approaches (eg subsidy) within areas.

Look beyond household access

- Nadira, Nepal questioned whether there were enough numbers of well-functioning toilets at health facilities, schools, and public places and whether they catered to the needs of all and have provisions for basic hygiene (hand washing with soap and MHM). She also raised the potential *safety* issues faced by transgender people in accessing public toilets.
- Raj, Bhutan also highlighted the need for further focus on both schools and monastic institutions.

Finally, many felt that all of this would require stronger and broader definitions of leadership (eg church leaders, community). Salvata, Tanzania shared the efforts of the sector in "rallying the leadership" to ensure sanitation progress is one of the agendas in high level decision meetings.

B. Providing post-ODF direction (targets, priorities) and support

- How could Post-ODF direction and services be organized (better)?
- What would need to change and be learned to provide Post-ODF direction and services?

Post ODF or Total Sanitation Guidelines, protocols and road maps

Several examples were shared from contexts where the was no clear Post-ODF guidance. For example, Ousmane, shared that in Benin there was a need for a post ODF policy and strategy that

defines the approach, the content, the activities, the targets and the expected outcomes. Befekadu raised the need for the national sanitation strategy to provide a clear strategic roadmap for organized post ODF support mechanisms in Mozambique and options of incentivizing progress. Salvata, in Tanzania felt that a clear strategy, with priorities and targets was lacking and that more knowledge was also needed.

In contexts where there was experience or guidance these were either in development, or developed but not yet fully implemented. Chiranjibi shared that in Nepal, where work has been underway for some time, Total Sanitation Guidelines were anticipated this year, in a follow-up to the National Sanitation and Hygiene strategy of 2011. However, as Nadira shared, given the complexities of the challenge the focus of the guidance has shifted from "achieving" total sanitation to going "towards" total sanitation. Osman shared that the post ODF national guidelines in Ethiopia to achieve and sustain ODF and declare secondary ODF had been developed, but much was needed to be done for them to be implemented.

Phasing and its focus

Participants shared from contexts at different stages of post-ODF efforts. Nadira and Ratan shared the experiences of Nepal, and the observation that moving towards total sanitation is not the same as sustaining what exists, the latter though should be integrated better. In turn, sustaining behaviours is not the same as sustaining facilities and services and there is a need to "un-bundle" services and behaviours. In phased approaches such as the total sanitation phase in Nepal, the "second" phase which builds on the momentum of the ODF drive involves multiple behaviours, indicators and sub-indicators. This has required time and capacity to work at the local level to phase or prioritise efforts.

Salvata, in Tanzania felt the focus and resources of post-ODF phases should not be directed only at monitoring ODF, community surveillances and enforcement of community by laws. It should also be on broader behavior change, including hygienic use and maintenance of toilets if they are to sustain ODF and encourage moving up the ladder.

In Ethiopia, Osman shared that in the national approach and guidance there are two phases of ODF - primary and secondary, both with indicators. Primary ODF is focused on ending OD and at least unimproved access to sanitation and hygiene facilities at all households, public institutions and public gathering places and handwashing facilities. Secondary ODF expands to the use of improved toilets, basic handwashing facilities and safe water management at household level including total elimination of open defecation practice. There are so many primary ODF declared wards, but so far, the only secondary declared wards are within 6 of the SSH4A program area. As such, maintaining primary ODF is a challenge, moving to secondary ODF is also important.

C. Reducing dependency on donor budgets for reaching rural sanitation and hygiene targets

Advocate to make it a political priority

- Most contributors, including Befekadu, Osman and Kumbulani focused on the need to raise the priority of sanitation amongst political leadership and to increase advocacy efforts for earmarked budgets. As Kumbulani reflected, political announcements are not matched with resourcing and concerted advocacy and lobbying efforts are needed, including for example by the Zambia NGO WASH Forum.
- Others felt that the need was for "better" advocacy. For example, Bridgit in Kenya felt that for timely advocacy, there was a need for CSOs to better understand government budget cycle and for the "glamorization" of sanitation to profile it and give motivation.
- Fanuel, also in Kenya felt that it was not seen as national issue of concern as advocates hadn't been able to make a good case on allocating budget. More emphasis should be given to the economic benefits compared to economically productive.

Manage existing resources better

- Befekadu and Osman felt that part of the issues was how countries have been utilizing and managing the existing resources for the intended purposes.
- Bridgit, Kenya felt resources should not be allocated on subsidies but could be used instead to encourage existing common interest.
- Pius in Rwanda felt that with technical guidance social structures could be used better to mobilise local resources.
- Brian in Kenya felt more should be done to source alternative homegrown solutions of mobilizing funds.

Working with financing mechanisms and institutional arrangements

- Salvata, Osman, Aminata and Given felt that clear or improved mechanisms were needed. For example, in Tanzania financial policy could be changed to allow basic sanitation services to receive funds from Central Government along with motivations for increased use of local government budgets.
- Given felt that with the institutionalization of sanitation programme within key line ministries, there would be increased prioritizing and allocation of funds reflected in their main action plans. A deliberate policy should be in place to ensure that all the action plans formulated by key ministries have a budget line for sanitation for it to be approved by the government of the Zambia.
- Raj shared in Bhutan that with decentralization, there was now increased allocation and devolution of authority to local government. With advocacy, districts and sub-districts were now able to prioritise and include WASH targets in planning and budgeting processes.
- Getachew, Rwanda considered opportunity through government readiness to apply **cost** recovery and financial sustainability mechanisms along with polluter-pays and user-pays principles to be applied in sewerage and waste management.

Topic 3: Quality assurance and sustainability

For our final topic, *Quality Assurance and Sustainability*, which ran from the 29th March until the 14th April 2018 there were 14 contributions from individuals and combined teams from SNV and government partners across 11 countries – Benin, Bhutan, Indonesia, Ethiopia, Mozambique, Zambia, Tanzania, Honduras, Rwanda, Nepal and Burkina Faso.

The following were the guiding questions.

1. Quality assurance in rural sanitation, what does it mean in practice for your country?
2. How to make the sustainability of behavioural change a mainstream responsibility in your public service (system)?
3. What do you dare to dream for your country about the phases towards achieving full quality and sustainability of rural sanitation and hygiene?

Quality assurance in rural sanitation

Quality assurance in rural sanitation (and hygiene) can be about many things:

- It can be about the **quality of the sanitation facilities/ toilets themselves**. As the Ethiopian team (Osman, Michael and Andualem) wrote, there is a challenge in maintaining ODF status due to the poor quality of latrines which are at risk of damage during the rainy season.
- It can be about reaching **all households** and **all villages** in an area.
- It can be about the **use and maintenance of toilets**
- Or about the **use by all** people in the household, and whether it's suitable for use by all
- Several hygiene practices by all…

In many countries, there is a moment for quality checks, during an ODF verification, but it is unclear how quality is assured over time. There may also be changes in what is considered a good (enough) quality of toilet, hence quality standards may change over time. The Ethiopian team shared that they have "primary ODF" (access to unimproved toilets, no OD, hand washing stations), as well as "secondary ODF" (access to improved toilets, safe household water management etc). Hence their standard is rising over time.

The question is what quality assurance in rural sanitation (beyond the ODF verification moment), means in your country. **How it works in practice, who sets the standards, and, last but not least, is there any action if quality is not good enough?**

Firstly, it is not just about the ***quality of the sanitation facilities***. Participants from a range of country contexts (eg Zambia, Benin, Ethiopia, Mozambique, Indonesia, Nepal) shared examples of government set criteria for the quality of sanitation facilities and the need for durability. But, the same group then reflected that linked to ODF certification (and Post-ODF phases) it is more than that. They shared the inclusion of broader parameters or standards including for handwashing facilities, hygienic maintenance, and consideration for broader aspects such as use by all, risk of contamination of water sources and privacy. If that was not yet the reality in their context, they felt it should be as Salvata Silayo from the MoH in Tanzania shared "quality assurance ought to be directed at functionality and durability of the toilets, reaching all households and risk associated with toilets contamination of the environment and in particular water sources".

Ratan Budhathoki, Nepal shared that the focus shifts relating to the phase. For example in pre-ODF it is about the quality of materials and construction along with reaching all. But in Post-ODF the focus shifts to hygienic use and maintenance and ensuring use by all, all the time. Maria Carreiro, SNV Indonesia considered the importance of incremental progress beyond ODF and infrastructure and shared the example of Indonesia's 5 pillar programme (STBM) that in addition to ODF and hand washing also includes the safe management of domestic liquid waste, solid waste and safe handling of drinking water and food.

Both Befekadu Kassahun, SNV Mozambique and Phurpa Thinley, LNW in Bhutan reflected on the need to think about ***quality assurance of the "process"*** (eg approaches, tools, guidance and needed skills) from the onset rather than only for the end point of quality latrines or ODF certification. The end point itself should be more broadly seen as including informed choice, being accessible to all, people prioritizing sanitation and hygiene and ultimately providing the desired services and intended uses. Informed choice was a point also highlighted by Getachew Belaineh with SNV Rwanda.

Warren Simangolwa and Solomon Mbewe, SNV Zambia reflected on the need for a "new era, being one that endeavours to attain ODF with quality and not with 'just latrines' regardless of the quality". It will reveal the gaps in sector financing, technology innovations, systems linkages, community participation, sector workforce and sanitation monitoring.

Several contributors shared examples of government processes for monitoring or "checks".

- Ousman Ibrahim, SNV Benin, shared that the municipalities are responsible for the promotion and management of hygiene and basic sanitation within their territory and carry out checks of the services of facilitators and service providers (NGOs, consulting firms, companies) in the field and ensure the quality of the services provided.
- Andualem Anteneh, SNV Ethiopia shared a recent initiative in that every district health office has started an inventory of sanitation facilities twice a year through its sectoral structure to ensure the quality of toilets reported by their administrative reports every month. Feedback is shared to the relevant stakeholders to take corrective measures including the development partners engaged.
- Maria reflected that quality assurance according to the governments standards in Indonesia should be guaranteed through compliance with official Building Development Standards Permits, overseen by the Ministry of Public Works (MPW) staff in the rural areas. However, the quality assurance practice varies substantially across Indonesia's 415 districts related to the level of coordination, consistency of inspections and enforcement, the availability of affordable options and the motivations by households to invest.

The ***enabling environment*** was further discussed by participants from Rwanda, Bhutan and Tanzania. Salvata shared that in general, the guidelines, protocols and the standards are in place but what needs strengthening is regular monitoring, quality reporting and enforcements. Ugyen Rinzin, SNV Bhutan felt similarly that the tools and guidance are increasingly in place at the national level but that they need to be applied systematically, including to better capture data on accessibility issues and use by all. Further, quality assurances of the services also need the ability and capacity ***to evolve, engage and adapt*** to changing or emerging needs of different communities, societies and individuals.

How to make the sustainability of behavioural change a mainstream responsibility in your public service (system)?

As mentioned above, quality assurance in sanitation can be about many different things. To ensure sustainability of a sanitation facility (toilet) and services, may require another type of effort than ensuring sustainability of individual hygiene behaviours.

If we look closely at those individual hygiene behaviours, these are often addressed in specialised campaigns. Yet sustained behavioural change requires long term engagement and follow up, and not a one-off campaign. several of you mention the importance of embedding responsibilities in the mainstream work of those who have good outreach to the people. The team from Tanzania (Salvata, Jackson, Olivier and Saul), mentioned outreach model in their country with the 10-cell leaders (in charge of 10 households). In Zambia, areas with reduced sustainability are those where district WASH committees and other local structures are less active.

In many countries, there are public service workers (health, education) that have such outreach among the population. However, sanitation related behaviours are not part of their mandate, not their priority, and very often there is no budget. Is there an opportunity to assign the role of sustainable behaviour change more clearly in any of such services in your country?

Mainstreaming and mobilizing beyond the health sector structures was a strong focus of discussions.

Andualem in Ethiopia, shared the example that even though hygiene and sanitation is the health sectors mandate, the federal government recognised that it couldn't be achieved through the efforts of health sector alone. It established WASH coordination offices (National, region) and WASH Technical and Steering Committees (each level) to mainstream the responsibility among these committee sectors based on MOUs and WASH Implementation Frameworks. The WASH committees are from sectors of health, water, education, agriculture, finance, administration and women & children affairs and most have well established structures at community level. The opportunity lies in *revitalising these structures* and mainstream responsibilities.

Warren and Solomon, Zambia felt that the national structure governing sanitation and hygiene behavioral change was too small to accommodate the diversity it needs and lacked sufficient BCC expertise or staffing at national, provincial, district and sub district levels. They felt the focus must be on strengthening synergies between government departments with different diverse community outreach mechanisms.

Befekadu, Mozambique felt solutions lay in the government integrating and mainstreaming it as a key development agenda in any development business – liberating it from WASH programming alone.

Given Mbita, MoH, Zambia also advocated for mainstreaming behavioural change and communication activities in normal routine activities by key ministries (Ministry of Health, Ministry of Education, Ministry of Local Government and Housing, Ministry of Resource Development, Water supply and sanitation, Ministry of community development and social welfares etc) rather than leaving it for specialized campaigns.

Linked to the discussions about the need to work with multiple stakeholders, Maria, Indonesia, Patricia Solórzano Leiva, SNV Honduras and Aminata Bara, SNV Burkina Faso felt that given the number of line agencies action involved in sanitation and hygiene there was a need for stronger political leadership, improved coordination with shared visions, realistic targets and clear roles and responsibilities. Further, as Maria shared, whilst political leadership is critical it is the institutional embeddedness (in regulations, programmes, planning and budgeting processes) that will secure sustainability beyond the initial "hype".

When the ***health sector was still the primary outreach model*****,** contributions focused on the use of cascade models but linked to local governance. Salvata, Tanzania shared the example of the MoH adopting a cascaded approach led by a limited number of technical staff at the apex (national and regional) who equip district staff with knowledge which is then transferred to local staff (community/village health workers) who are in daily contact with the community. Mentoring and supportive supervision is part of this. But in parallel it was also important to mainstream priorities in the village level agendas, supported by informed community level health staff. Ugyen, Bhutan shared a similar process from the national level to the community based health staff along with the need for enhanced engagement with the local governments to ensure targets in their annual plans and key performance agreements.

Prioritising sanitation and hygiene within the health sector

Reflecting discussions in earlier blocks about the need for sanitation and hygiene to be better prioritized Befekadu, Mozambique, Warren, Solomon and Given in Zambia advocated for further efforts. However a key part of the challenge was ensuring it was a priority within the health sector (and staff) itself.

- Warren and Solomon in Zambia felt that behavior change has not had sufficient policy orientation and as such the strategy remains in draft - "we are still wrestling with what constitutes behavioural change, what indicators should be considered, what should be measured for progress, who should measure it and at which stages need it be measured."

- Given, MoH Zambia shared that whilst the establishment of health promotion officers at district level is a positive development, experience has shown that WASH related behaviors struggle to be prioritized alongside other health promotion activities (eg HIV/AIDS). A dedicated and resourced social Behavioural Change and communication framework /strategy would improve this.
- Ugyen, Bhutan shared the example in which the Health Promotion Division, MoH is the national lead agency for promotion of health and hygiene in the country but with multiple programmes their involvement in sanitation and hygiene is very limited. As such, Public Health Engineering Division is mandated in planning and developing evidence based innovative WASH behavioural change interventions.
- Warren and Solomon, Zambia also shared the need to ensure availability of community health assistants whose 80% of their day to day activities is on public and environmental health.

Finally, what did we dare to dream for country phases towards achieving full quality and sustainability of rural sanitation and hygiene?

Many contributors, including Andualem, Ethiopia, Warren and Solomon, Zambia and Befekadu, Mozambique wished for adequate funding, strengthened WASH structures and increased commitment and priority to be placed on sanitation and hygiene. Maria, Indonesia added to this that she hoped that hygiene would have equal standard alongside sanitation.

Broad range of visions was shared including

- Warren and Solomon, Zambia - "As passionate WASH practitioners, (with only 3 of the 103 districts as ODF) we dare to dream of a Zambia where every person alive has access to a toilet infrastructure that meets their needs and does not in any way harm the environment nor contribute to their poor health and that of their communities". Added, aspirations included a sanitation think tank that provides advocacy and evidenced based policy for the country.
- Getachew, Rwanda, "In order to achieve universal access to sanitation, Rwanda shall improve, replace or build every year almost 500,000 (mostly individual) sanitation facilities. In addition, fecal sludge management for rural household toilets seems very remote so that I dream that could happen in the country".
- Maria, Indonesia hoped for many things, but was underpinned by the wish for the inspiring dynamics that have created the nations enabling environment to translate into provincial and district governments across Indonesia acknowledging the importance of sanitation and common visions and that behavior change led, demand and market driven sanitation and hygiene are the approach by default. Further, that ODF is seen as milestone in a longer term vision for universal and high quality service provision; post ODF sanitation and hygiene services are anticipated from the onset and regulation, gender and social inclusion is part of this.
- Salvata and Kiberiti spoke from the current governments goals and reflected on learning to date in Tanzania. For Salvata, it is very possible that if all stakeholders will maintain high level commitment and passion we shall reach the SDGs target but it will need high level advocacy and collective efforts.
- Ugyen, Bhutan reflected that PHED's ultimate goal beyond the upcoming five year plan is to have full national capacity in maintaining the quality and sustainability of rural sanitation and hygiene in the country.

Annex III: Presentations

A copy of each of the presentations included in the Learning Event is available at https://www.dropbox.com/sh/sd9k9q7hq4lp1f6/AABScaWbB2mvnxE05nGSlXj0a?dl=0

Annex IV: Field Work Deliverable

The fieldwork deliverables for each of the six groups are available at https://www.dropbox.com/sh/cfqq1p0t3f8lg7y/AABOnHY1BMmNq6mJgfo2mIAIa?dl=0