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

Making the Invisible, Visible! Increasing Effective Implementation of Behavioural Change Communication in Rural Sanitation and Hygiene.

Fort Portal, Uganda, September 17th -22nd 2017

This report documents the activities and proceedings of SNV Netherlands Development Organisation's Learning Event, held in Fort Portal, Kabarole District, Uganda from 18-21 September, as part of the Knowledge and Learning component of the Sustainable Sanitation for All (SSH4A) programme.

The event was attended by 45 participants from 10 countries and focussed on design, implementation and monitoring of behaviour change communication (BCC) activities to promote sanitation and hygiene.

This report has been prepared by Sarah-Jane Clarke, MSc Epidemiology: Any errors or omissions are the sole responsibility of the author.

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List of Acronyms and Abbreviations

BCC	Behaviour change communication
CLTS	Community-led total sanitation
DFID	UK Department for International Development
HH	Household
HWWS	Hand washing with soap
IEC	Information, education, communication
MoH	Ministry of Health
MoWS	Ministry of Water Supply and Sanitation
NGO	Non-government organisation
OD	Open defecation
ODF	Open defecation-free
SBCC	Social behaviour change communication
SI5	Sustainable indicator 5
SNV	Netherlands Development Organisation
SSH4A	Sustainable Sanitation For All
SSH4A-RP	Sustainable Sanitation For All Results Programme
URDT	Uganda Rural Development and Training Programme
VHT	Village health team

I. Background

Sustainable Sanitation and Hygiene for All

The Learning Event was conducted through SNV's Sustainable Sanitation and Hygiene for All (SSH4A) programme. SNV runs SSH4A in two regions of Uganda: Western and West Nile. Challenges in reaching the West Nile region made it impossible to hold the event there and for that, among other reasons, the event was held at Fort Portal, Kabarole District in the Western Region of Uganda.

The SSH4A programme was introduced in 2009 and now reaches over 10 million people in 12 countries across Africa and Asia. SSH4A is a collaboration between SNV, national governments and line agencies and knowledge partners. The SSH4A Results Programme (SSH4A-RP) is an innovative partnership with the UK Department for International Aid (DFID). It covers eight countries (each represented at the Learning Event) and has been extended until 2020. SSH4A-RP follows the SSH4A framework and is tailored to each country, with shared indicators for outcome and sustainability. The framework consists for five 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-RP Learning activities

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

i. Preparatory DGroup Discussion. These discussions took place between August and September in 2017. The purpose and outcomes of these discussions are articulated in sections VIII, IX and XI of this report.
ii. Learning Event Workshop. This was held in Fort Portal, Kabarole District, Western Region, and Uganda from 18-21 September 2017. This report articulates the proceedings and outcomes of this event.
iii. In country -follow up (depending on country priorities).

Learning Event Attendees

The participants for this Learning Event were from eight countries that are currently implementing SNV's SSH4A-RP – Ethiopia, Ghana, Kenya, Mozambique, Nepal, Tanzania, and the host-country Uganda – as well as from Rwanda. While SNV is not currently implementing SSH4A in Rwanda, the country is implementing other sustainable sanitation initiatives that are supported through other funding sources. Relevant government representatives from the programme countries were also in attendance.

Preparatory DGroup Discussions

A series of DGroup discussions were held between 24 August and 13 September 2017, in preparation for the Learning Event and following the same theme of *Making the Invisible, Visible: Increasing effective implementation of behavioural change communication 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 2.

II. Scheduled Program

Programme		
Day	*Time*	*Activity*
Monday	8.30	Registration
	9.00	Official opening by the Chief Administrative Officer of Kabarole
		Round of introductions by participants
		Presentation of the programme
	10.00	Block 1: Stock taking of behavioural change communication
		Introduction to block 1
	10.30	BREAK
	11:00	Putting a BCC mirror in front of us
	13:00	LUNCH
	14:00	Sharing of BCC mirrors
	14:45	Block 2: Ugandan National Hand Washing Campaign
		Introduction to the Ugandan National Hand Washing Campaign
	15.15	BREAK
	15.30	Explanation and preparation of the field assignment
	17.00	Closure
Tuesday	7:00-17:00	Field assignment
Wednesday	8.30	Good morning
		Consolidation of findings
	11.00	Presentation of findings and feedback from stakeholders
	13:00	LUNCH
	14:00	Block 3: Effective behavioural change designs and messages
		Introduction to block 3
		Presentation of behavioural change communication outside our sector
	15.00	BREAK
	15.15	Presentation of sequencing of behavioural change interventions
		Debating game
	17.00	Closure for the day
Thursday		Block 4: Closing the monitoring cycle
	8.30	Programme of the day and introduction to block 4
		Presentation on the hygiene effectiveness study
		Presentation on the RWSSP monitoring exercise (of BCC)
		Country group work on information, analysis and action regarding BCC
	10:30	BREAK
	11:00	Peer-feedback and sharing of IAA routines
	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 address of Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands

Ms Kome welcomed everyone to the Learning Event. She observed that the "hygiene" in water, sanitation and hygiene programmes is an essential component and yet perhaps also the most challenging. It is easier to focus on tangible outcomes – such as water and sanitation infrastructure but changing behaviours towards improved hygiene practices at community and higher levels is always very challenging. She stated that one of the goals of this Learning Event was to discuss how to make hygiene visible as well as to explore ways to ensure sustainable change.

She expressed a hope to see what is working at all levels – including dialogue with government and other agencies - in each of the eight countries that are implementing SNV's SSH4A programme, as well as in Rwanda that is implementing a sustained sanitation and hygiene programme funded through other donors. She acknowledged the challenges in measuring behaviour change and hoped that this event would inspire all present to continue to work on promoting change and to ensure that change is sustainable. She noted that the sharing of knowledge and experiences makes each country team stronger.

Ms Kome then invited Mr Michael O'Mahony, the Country Director of SNV Uganda to present his opening address.

Opening address of Michael J.F. O'Mahony, Country Director, SNV Uganda

Mr O'Mahony warmly welcomed everyone to the event. He noted how wonderful it was to have such a wide range of expertise represented at the event, including government partners and implementing agencies and noted that it spoke to SNV processes as well as to everyone's desire to engage partners at all levels in promoting behaviour change towards improved hygiene practices. He expressed his hope that all present would be able to take key lessons on board, in interact and engage with partners and to identify strategies to support their work towards sustainable results. He also expressed his hope that everyone would enjoy the activities included in the Learning Event.

IV. Official Opening

Presented by The Honourable Margaret Kihika, Vice Chairperson of Kabarole District, Western Region, Uganda

The Honourable Margaret Kihika welcomed all participants to Kabarole District. She noted that participants came from many parts of the world but largely from Africa. She stated that she and her government partners very much appreciated the work of SNV and that the results of SNV programmes were visible on the ground. She further appreciated the focus on *sustainable* hygiene for *all*. Ms Kihika noted that there has been some progress in changing attitudes and behaviours in Uganda towards hygiene: Since 2000, the rate of children dying of preventable diseases has reduced in Uganda and some of this reduction is attributable to SNV programmes. She observed that change is something that has to be gradual and that development cannot be achieved until the human and financial cost of preventable disease is reduced.

Ms Kihika noted that there are challenges, particularly if people cannot afford the equipment for good hygiene practices, such as containers for water or soap. National water and sewerage is a focus of the government to help ensure that people can access clean water. Coverage has improved but has not yet reached 100 per cent. She noted that the government has approved budget to continue extending this coverage.

In addition, she stated that the government also focuses on food hygiene and safety and that SNV has been instrumental in supporting these initiatives. The Government of Uganda appreciates and supports SNV efforts. Ms Kihika concluded her remarks with an appeal to SNV to continue supporting improvements towards reducing childhood deaths attributable to water, sanitation and hygiene.

Ms Kome thanked Ms Kihika and the Government of Uganda for their on-going commitment.

Ms Kome then introduced two representatives from the Ministry of Water and Environment (Sanitation Coordination Unit) – Ms Martha Naigaga & Ms Namyala Cate – who also extended their warm welcome to all participants.

V. Introduction to the Learning Event, 2017

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands.

Ms Kome began this presentation by explaining that the intention of this event was to explore Behaviour Change Communication and how to make the invisible components of these activities, visible. The text below captures a summary of her presentation:

Orienting the Learning Event

The Learning Event is part of SNV's Sustainable Sanitation and Hygiene for All (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 and to facilitate an exchange of ideas and to deepen our understanding of the topic.

Hygiene promotion has been around for more than 100 years and yet is still presents a great many challenges. Initially, hygiene promotion was delivered through social re-education. The approach was often very prescriptive and judgmental, which may not have created a very fertile environment for the message to take root. In addition, many messages were delivered at once, which was overwhelming and confusing.

Learning from this approach, a new approach of information and education campaigns (IEC) was developed. While they appeared more fun and friendly on the surface, the underlying messages remained quite prescriptive.

In the 1970s, hygiene promotion began to focus more on empowerment. Efforts were made to lead communities through a reflective process and let them set their priorities. Unfortunately, hygiene promotion was almost never raised as a priority.

Behaviour change communication (BCC) is another name for hygiene promotion but comes from the perspective of selling the importance of hygiene promotion. It looks for "triggers" or "motivations" such as saving money or improving status. The trigger will differ between communities and will be influenced by cultural and other factors. Once the motivation is identified a message can be created around the motivation and various channels – such as mass media (TV and/or radio), demonstrations and rallies, and one-on-one meetings – can be selected to deliver the message. In recent years, marketing agents have become involved in BCC. The approach is very similar and they have experience in delivery persuasive messages.

Ms Kome concluded this section of the presentation by observing that more than 100 years after the issue was first raised we are still talking about and trying to address the challenges of hygiene promotion.

Objectives of the Workshop

Ms Kome the proceeded to introduce the four objectives of the workshop, namely:

1. To take stock and reflect on progress of BCC;

2. To develop deeper understanding of the BCC design processes and feedback loops;
3. To analyse institutional embedding of BCC responsibilities; and
4. To share experiences.

She reintroduced the three DGroup discussion topics and highlighted that the discussions revealed that not enough monitoring and evaluation of BCC activities and outcomes was currently being undertaken, and that there is a need for all countries to develop a set routine to collect, analyse and use the data to improve BCC interventions.

Learning Event programme by day

The Learning Event was organised into five blocks:

Block I	Stock taking of BCC
Block II	Ugandan National Hand Washing Campaign
Block III	Effective designs and messaging
Block IV	Closing the monitoring cycle
Block V	Country group session and wrap up.

These blocks follow a logic, moving from self-reflection and stock taking of past and current BCC interventions in each of the participating countries in Block I to an introduction of the Ugandan National Hand Washing Campaign in Block II. The field assignment is a component of Block II and aims to learn about the context and experience in Uganda, analyse how the National Campaign has been rolled out and to reflect upon discuss the strengths and weaknesses of the challenges as identified by multi-level stakeholders (government, households and other stakeholders) as well as to develop a set of recommendations for the District Health Inspectors.

Block III spotlights effective BCC designs and messaging, drawing on experiences from outside the WASH sector. Block IV will address strategies to close the monitoring cycle: an issue universally identified during the DGroup discussions.

The Learning Event concludes with Country Team sessions including reflections on the messages, strategies and feedback that each country will take home in their "shopping bag".

The proceedings of each block are described in detail in sections VII through XI of this report. The daily programme is presented in Figure 2.

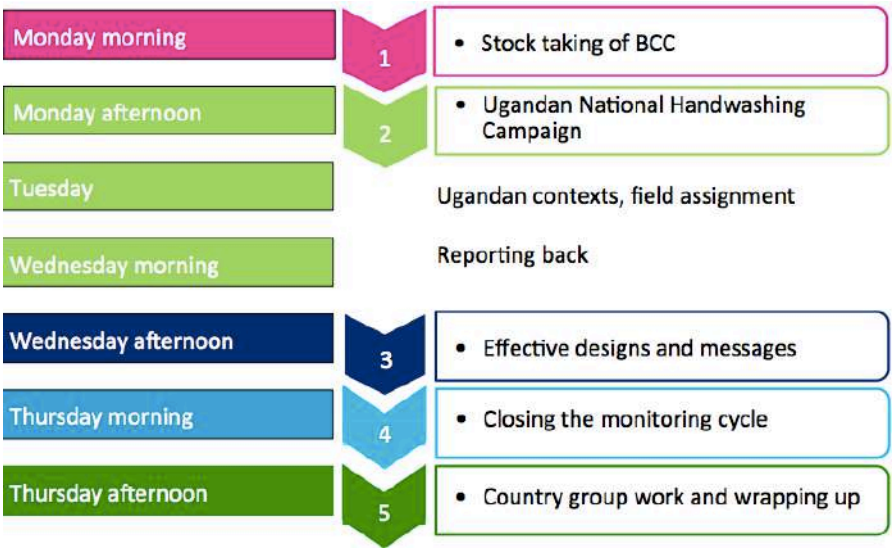


Figure 2: Daily programme of the Uganda Learning Event, 2017.

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 2, below.

Country	Expectations
Ethiopia	1. To learn from other countries how to better deliver interventions to bring sustained BC in rural areas; 2. How to better design BCC strategies to help reduce rates of preventable disease, particularly among children.
Ghana	1. To come out with a formidable and effective BCC strategy to achieve the national targets; 2. To learn success stories from other countries effective BCC strategies and messages.
Kenya	1. To learn what is the best practice for institutionalisation of BCC 2. BCC is a process so what is best practice for design, monitoring and evaluation of the process?
Mozambique	1. To learn effective monitoring and reporting systems for hygiene promotion; 2. To learn what is the best practice and scale up approach for our country; 3. To learn how to create a mechanism for accountability for hygiene promotion and ensure credibility of outcomes.
Nepal	1. To learn best practice on BCC from other countries; 2. To learn how to better track and monitor the results of BCC campaigns.
Rwanda	1. Learning from other countries approaches and strategies for WASH BCC; 2. To share our experiences of working with different stakeholders in our programmes.
Tanzania	1. To learn new ways to run BCC campaigns; 2. To share our experiences on how to run effective BCC campaigns.
Uganda	1. To learn lessons from other countries on BCC; 2. To learn how to better track the impact of BCC campaigns.
Zambia	1. To share knowledge and experiences on effective BCC campaign design and messaging; 2. To learn more on how to effectively implement and sustain BCC activities on the ground.

Table 1: Expectations of the Learning Event, by participating country. Fort Portal Uganda 2017.

VII. Introduction to Blocks I & II

Presented by Antoinette Kome, Learning Event Facilitator, SNV Netherlands.

Ms Kome commenced the introduction by highlighting the need to agree on certain concepts. By definition, BCC seeks to see changes in behaviour, such as moving towards regular hand washing with soap at a variety of critical points. In order to change a behaviour we need to change "something". These "somethings" are often described as motivators. Motivators may be knowledge (with greater knowledge people will understand the importance of washing their hands with soap) or facilities (with easier access to improved facilities people may find it

easier to wash their hands regularly), beliefs (some people may have beliefs that act as a barrier to hand washing), and others.

When creating a BCC campaign, we need to understand what "triggers" a person to change behaviour and to recognise that what works in one situation may not work in another. For example, shame and pride are effective motivators for Community Led Total Sanitation (CLTS) initiatives to reduce open defecation. These motivators are less effective, however, for hand washing, which is a more private, less collective activity.

The motivators to convince people to regularly wash hands and, importantly to not slip back, will depend on a variety of factors including cultural norms, geographic location and so on.

Example Motivator is knowledge. From an understanding of what knowledge is missing, we need to create a message to impart that knowledge to help people change their behaviour. Once the message has been crafted, we then need to think about how to make sure that message reaches the intended audience.

The message may be disseminated through a variety of channels: radio, TV, video, demonstrations, rallies/events, or door-to-door visits. Each of these channels will be more or less effective depending on both the context and the message. Each channel also has a financial cost so it is important to select the most effective channel for the situation. It is rare that a single channel will be fully effective on its own which is why it is important to develop a campaign – using all suitable channels to deliver the message over a sustained period of time.

Once the campaign is designed, it is time for the outreach. For effective outreach, it is essential that the target audience sees the message and that the message is relevant and understandable. In countries with many language groups this may be additionally challenging. The choice of words is very important: keep the message clear and concise. Ensure that it is culturally appropriate and tailored towards your target audience, or they may not recognise that the message applies to them. Deliver the message in a tone and style that makes it accessible and allows people to actually "hear it" for example, not as prescriptive and paternalistic as earlier social re-education messaging.

Effective BCC campaigns work on three levels (Figure 3):

i. Behaviour objective (are people now washing their hands?);
ii. Communication/campaign objective (have people changed their attitude to hand washing); and
iii. Outreach (have people heard your message?)

If any one of these levels is ineffective, then the behaviour change does not occur.

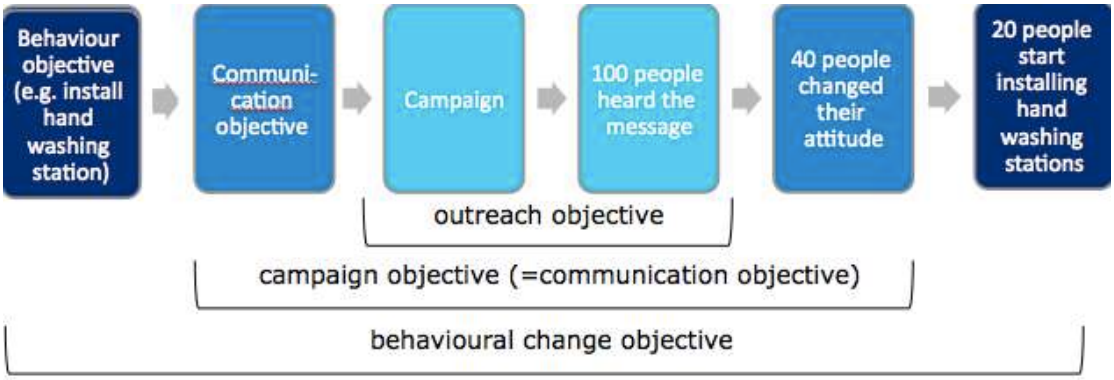


Figure 3: An illustration of the three levels of BCC Campaigns. Source: SNV Learning Event presentation, Uganda 2017.

DGroup discussion overview

The DGroup discussions talked about implementation, design and institutions. They revealed that hygiene promotion has very low priority on many countries. People and governments tend to focus on "visible" outcomes, such as increased number of water points and so on. These visible outcomes are also easier to sell politically. As such, the budget for invisible interventions, such as BCC, is frequently low and is easy to cut. In addition, hygiene promotion is not often viewed as a priority for households who have many competing and more tangible demands.

So how is it possible to create demand for something that people do not want? Two key strategies were articulated within the DGroup discussions:

i. More attention needs to be given to build political buy-in and engagement of officials with hygiene campaigns; and
ii. To influence the importance given by communities and hygiene promoters themselves.

The discussions also raised some key issues including:

Some governments like to see many messages: they think it is faster and more cost effective to bundle BCC messaging, feeling they receive "2 for the price of 1". Too many messages however just make noise and rarely effect lasting change. An emphasis should be placed on sequencing messaging: ensuring that one change has been effected and embedded before introducing the next step.

The capacity and performance of front line hygiene promoters was also identified as a key limitation. Many hygiene workers are expected to undertake a challenging job for low pay and with low capacity. They are given multiple responsibilities but often receive low recognition with few tangible results, leading to high turnover. Interpersonal and small group interaction is key: relying on TV and other mass media is not effective to induce behaviour change but critical if we are working towards mass awareness.

Training should take into account who the frontline workers are and what is the outreach structure that has been designed. How are they trained? Relying on single training-of trainer events is a little like "Chinese Whispers": the information and instruction given at the front end may become diluted and distorted over time; reflection and coaching is an essential component of training. Consideration should be give to the influence of language and culture: sometimes trainers from within the cultural group may not be as effective as using external people. In addition, it is important that training focuses on results-orientation, rather than "tick the box" implementation

Audience segmentation is essential but challenging: No one size fits all. It is imperative to return continuously to the data and make sure that everybody in target group is being reached, especially given that some sections of target group may be in a "blind spot", for example, mothers or caregivers for people with disabilities.

Following this introduction Ms Kome provided a brief overview of the content and process for Blocks I and II. The outcomes of these blocks are described in the following sections (VIII and IX).

VIII. Block 1: Stocktaking of Behavioural Change Communication

Overview of Block 1

Why is this relevant?

Reflection on the results of past BCC initiatives allows country teams to analyse what it working well and where the challenges lie; it allows them to learn from the experiences of other country teams and to share lessons learned their own experiences in return. The analysis of data from the household surveys and the sustainability indicators provides evidence for action to strengthen current campaigns and to design more effective and sustainable future campaigns.

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

- To review data (aggregated and disaggregated by country) collected through the annual household survey and through a survey of sustainability indicators, with a focus on Sustainability Indicator 5 (SI5), which measures the roll out progress of BCC strategies.
- To reflect upon their own data and how this may be used to strengthen future campaigns.
- To learn from other countries' strengths and weaknesses in designing and implementing BCC campaigns.
- To use this knowledge to improve BCC campaign design and implementation in their own countries.

What was the process?

- An introductory presentation of the aggregate data from both the household survey and SI5
- Country group work to review the data from their country and to reflect upon and answer the following questions:
    1. What is the data telling you about your country?
    2. What needs to change to improve the current results?
    3. What needs to change to ensure sustainability of progress achieved?
- Sharing and exchange of experiences: plenary discussion where each country presented the answers to the questions as well as showed some of the BCC materials they had developed in previous campaigns.

Country Team Group Work: Putting a BCC Mirror in Front of Us

Presented by Ms Anne Mutta, SSH4A PMU, Kenya

The objectives of Ms Mutta's presentation was to present and discuss the data collected through the annual Household survey as well as data collected for Sustainability Indicator 5, which measures the progress of roll out progress of BCC strategies. She commenced by noting that many campaigns had been rolled out across the various countries and that many different BCC tools and strategies had been employed. She noted the difference between one-off BCC events, such as World Toilet Day and Sanitation Week, which are important awareness raising events but are not a "campaign". A BCC campaign should employ many different channels, all presenting the same message in different ways – a blizzard of information that is impossible to avoid. She emphasised the need for an over-arching BCC strategy to ensure that the message does not become fragmented. If different agencies are following a different group the message may become muddied and confusing: a shared strategy is much more effective.

Ms Mutta then presented the aggregate results for the 10 sub-indicators for SI5, the Household Survey as well for critical points for hand washing with soap (HWWS) from the Household Survey. She noted that the results had not been weighted and thus may not be truly representative but still gave a good overview.

Results of the 10 sub-indicators for Sustainable Indicator 5

The aggregate result of the 10 sub-indicators for SI5 showed good overall progress (Figure 4). The greatest improvements were shown in sub-indicators 1-7, which relate to the presence of a BCC strategy. These measurements relate to the first intervention of the programme and at this stage most countries lacked a working document especially at the sub national level. This is also evident in the programme extension. The greatest improvement was shown in sub-indicator 7: *Uses communication methods based on adult learning principles*, which, it is assumed, may have been driven by the SNV hygiene promotion campaigns in 2015.

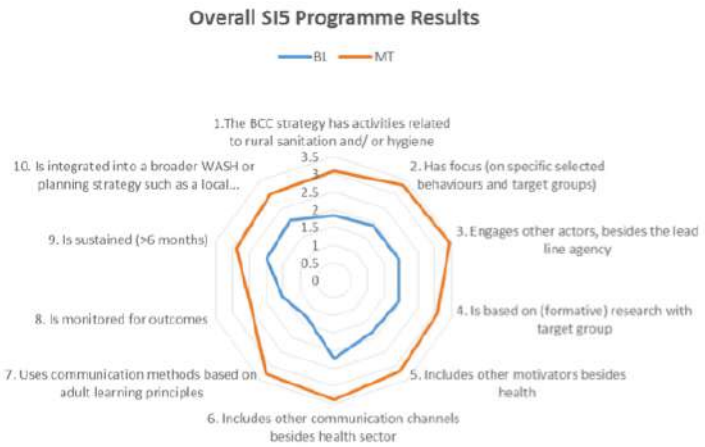


Figure 4: Aggregate Sustainable Indicator 5 Programme Results. Source: Presentation at the SNV Learning Event, Uganda 2017.

Despite the general overall improvement, the data revealed a need to intensify efforts in monitoring and targeted outreach. Monitoring and evaluation efforts remain an area of improvement for all the country programmes. We need to better monitor the impact of current efforts in order to determine what is working and what needs improvement.

Results of the 2016 Annual Household Survey: Critical Moments for HWWS

The various household surveys conducted after the programme baseline revealed that knowledge went high during the campaign period (2015) and has ben reducing in subsequent years Figure 5).

Knowledge around some critical moments – notably before breast feeding or feeding a child, after cleaning a potty or toilet, and after cleaning a child that has defecated or changing a nappy – did not decrease. It was posited that this might be due to information coming from other complementary campaigns, such as maternal nutrition supporting HWWS before breast-feeding.

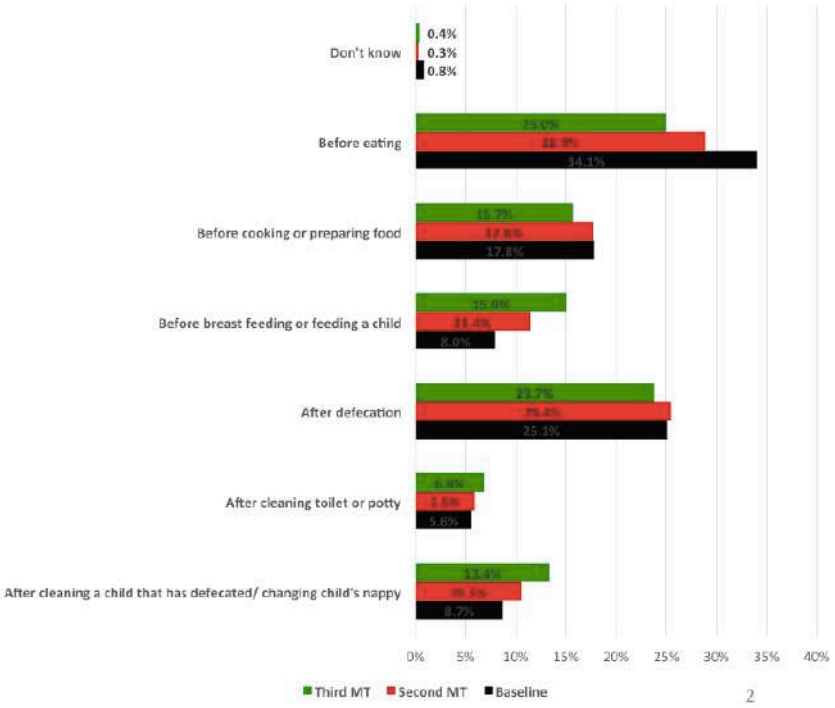


Figure 5: Aggregate results from the 2016 Household Survey, Critical moments in HWWS. Source: Presentation given during the Learning Event, Uganda 2017.

It is hard to quantify how much is spent on BCC but it is clear that results are dependent on the amount of resources – both time and money – committed to these interventions. For many countries, the key barrier to improving rates of HWWS at critical moments appears to be technological. We should question, however, whether this is truly correct or if it is easy to say BCC is not working because the facilities are not there. If BCC is truly effective, people will find a way to create these facilities or demand their implementation/provisions. It is important that we also investigate the HWWS using socio cultural practises. This could be helpful in investigating further if the limitation to HWWS is because of lack of physical facilities.

Preparation for Country Team Group Work

Ms Mutta then raised the following questions for each Country Team to reflect upon during the upcoming group work session:

Each Country Team was given the following questions to guide their discussion:

1. What is the data telling you about your country?
2. What needs to change to improve the current results
3. What needs to change to ensure sustainability of progress achieved?

If the teams felt that nothing needed to change for questions two and/or three, the teams were asked to provide reasons why.

Because we are measuring practice on the left and on the right, we are measuring only one motivation (knowledge) but no measurement of other motivators – did the focus on other motivators decrease the focus on knowledge?

If the facilities for HWWS have increased and practice has increased, how do we reconcile this with the observed reduction of knowledge of for e.g. hand washing after defecation? Each country should interrogate this further.

In closing, Ms Mutta highlighted the fact that there is still a very large proportion (>60%) of people in the programme areas who are still lacking hand-washing facilities. Country Teams were guided to focus on the most problematic critical points – and/or most appropriate (e.g.

breastfeeding only in households with infants/small children). Ms Mutta emphasised that the initial programme was coming towards its end and that there is now a need to work on and exit strategy; to develop a way to ensure that the achievements and progress of the programme can be sustained and draw lessons from our current work to inform the extension phase of the programme to 2020.

Country Team Group Work Results

Each of the eight SNV countries brought a selection of their BCC materials. For each country, BCC materials had been designed to reach a particular target audience and were presented in an appropriate language. For example, a selection of the materials from Ethiopia focused on the elderly and disabled. In addition, they had developed a calendar with ideas for suggestions on how to improve hygiene, as well as materials on feminine hygiene management, particularly focused on schoolgirls. Ghana's BCC materials were aimed at the whole community and focused on techniques for effective hand washing and critical moments. The BCC materials from Kenya included flip charts to initiate discussions around sanitation and hygiene, while those from Nepal aimed to make the invisible visible by showing people that even clean-looking hands can be covered in bacteria that can cause illnesses. Tanzania and Zambia's materials focused on washing hands at certain critical points such as before breastfeeding and before preparing food. BCC in Uganda included posters with a message that HWWS and improved hygiene results in savings in both time and money due to fewer hospital visits.

The results of the Country Team guiding questions are presented in Table 2, below.

Country	What is the data telling you about your country?	What needs to change to improve the current results?	What needs to change to ensure sustainability of progress achieved?
Ethiopia	Good achievement in the most critical moment for HWWS Need to focus on (i) before eating and (ii) before cooking Significant investment in HW station increase for 1.7% to 89.8% Running water increased from 0.09% to 4.79% SI5: good progress from 1.4 (BL) to 3.8/4 (MT 2017), except sub-indicator 8: Monitoring outcomes & 10: Integration into broader WASH or planning strategy	Focus on improvement of sustaining and continuing coaching (HAD, Development Unit, HEW, School WASH clubs etc.)	Strengthen Government ownership: as for DSP & ODF, Hygiene should be included as an agenda Follow up on DSP & ODF plans Link with new National BCC strategy Need to advocate for the structure of water schemes
Ghana	Some progress has been made Change is possible but	Intensify and sustain BCC structures Monitor and evaluate	Require the buy-in and support of the government and use of

	more work needs to be done	to determine the most effective BCC strategies to use	government structures to plan, budget and implement effective BCC campaigns Address communication challenges e.g. illiteracy
Kenya	Some issues with implementation e.g. some HW facilities became mosquito breeding grounds therefore people see it as a public health risk rather than a benefit 74% of the programme beneficiaries still do not have HWFs Of the 26% that do, only 2% practice HWWS	Targeted interventions for children Meaningful participation and involvement of the beneficiaries	Evidence based advocacy for BCC for full institutionalisation by the Government: show government that it is more expensive to prevent rather than treat preventable diseases. Targeted messages for different audiences: need to get BC to habit level. Incorporate BCC into primary school curriculum
Mozambique	In general knowledge at critical moments of HWWS are very low, specifically: after cleaning the toilet or potty (7.7%), after cleaning a child that has defecated (12%), before breast feeding or feeding a child (12.5%)	The programme should continue to focus on the three behaviours mentioned and specific target groups Develop innovative messages Involve community and local leaders on the design of the message Broaden communication channels	Involve all stakeholders in hygiene promotion activities Advocate for the development of a national sanitation strategy Empower local community chiefs on BCC Ensure the local leaders commitment to hygiene promotion
Nepal	Need critical review – knowledge as significantly decreased on critical points – Before eating, before cooking, after defecation Increased knowledge (success of campaign) Before breastfeeding, after cleaning the toilet or potty, after cleaning	Intensive campaign focusing on increasing knowledge, esp. around Before eating, before cooking, after defecation Promote & establish hand washing stations Upgrade level 2 & 1 to 3 & 4	Lack of monitoring system at government level – need to introduce regular monitoring of outcomes Advocacy for broader strategies Engage multiple partners Develop a national plan of action with resource

	a child that has defected/changing the child's nappy.		allocation
Tanzania	Data shows that the proportion of places with no HWWS points was high during the baseline. Following intervention, this proportion decreased but then increased again due to: (i) HHs were afraid of children drinking the water at some points (ii) Regular stealing of containers for recycling (iii) Insufficient water to fill the containers (iv) Lack of continued push to install and use HWWS points	Keep involving communities in BCC, particularly with regard to sanitation Enforcement of laws, guidelines and standards on HWWS Bring in more political leaders to the BCC campaign Focus on emotional triggering because other approaches have not been successful	Knowledge is high during campaigns but seems to drop off very quickly when the campaign stopped; to ensure sustainability we need to: (i) Have a sustainable campaign to remind people of the importance of HWWS (ii) Government to institutionalise BCC from the grassroots (iii) Leaders to be role models in sustaining HWWS campaigns (iv) Emphasise community coaching and mentorship (v) Increased monitoring
Uganda	The data reflects the reality of Uganda Given the 50/50 male/female split of respondents, knowledge on critical times, likely skewed down because males tend to have lower knowledge There is abundant knowledge on HWWS. However the practice is not yet embedded in social norms. One vessel is used for many purposes so if you do not come at the time that it is being used for HW, you may not recognise that it is present. Proxy indicator	Integration of on-going HWWS campaigns into other programmes The roles of monitoring of local structures & political engagement need to be emphasised in the communication process Do not have a sustained campaign for HWWS after defecation Before breastfeeding going up because of complementary campaigns	Intensive and sustainable campaigns to promote HWWS

	may not be available all the time Men and youth need to be better targeted in the campaign		
Zambia	Knowledge on HW after defecation increased in each survey from baseline to the second midterm and again to the third midterm. Knowledge increased for other critical moments increased from baseline to the second midterm survey but *decreased* by the third midterm survey. Similarly, the presence of facilities increased from baseline to the second midterm survey but *decreased* by the third midterm survey.	Strengthening the sub-district structure and orientation on BCC to include coaching to ensure that CCS and hygiene promoters are well guided → tend to focus only a few critical areas at the detriment of others Improve M&E structure to include traditional leadership at sub-district level BCC campaign to focus on other critical moments for HW	Increase the allocation of resources: currently limited by lack of funds Increase the number of hygiene promoters Conduct effective (MOH and Council) Improve coaching of hygiene promoters and conduct follow-up sessions.

Table 2: Results of the Country Team Group Work: A BCC Mirror. Uganda 2017.

IX. Block 2: Ugandan National Hand Washing Campaign – Field Assignments

Overview of Block 2

Why is this relevant?

Uganda is unique among the represented countries in that it has a national level hand washing with soap campaign. This block aimed to better understand this campaign 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 National Hand Washing Campaign in Uganda is structured and implemented.
- To visit five counties in the Western Region to observe the impact of this campaign on the administration at county and sub-country level, as well as in the villages themselves.
- To provide feedback to the different counties on what is working well and recommendations to address observed challenges.

What was the process?

- A presentation providing an overview of the key actors in Uganda's water and sanitation sector as well as those focusing on rural sanitation and hygiene in particular.
- Field trips to Kabarole, Kamwenge, Kyegegwa, Kyenjojo and Mubende counties in the Western Region of Uganda.
- Presentations by each group on the results of their field trip including observations

Presentation on the Uganda National Hand Washing Campaign

Presented by Ms Martha Naigaga, Sanitation Coordination Unit, Ministry of Water and Environment, Uganda

Ms Naigaga began her presentation by providing some context for the National Hand Washing Campaign, including an overview of the Water, Environment and Sanitation Institutional Framework (Figure 6). Then Ministry of Water and Sanitation (the Ministry) links directly with local government offices as well as with community based organisations. It operates at all levels with the national and regional levels focusing largely on developing and disseminating guidelines. Implementation takes place at community level.

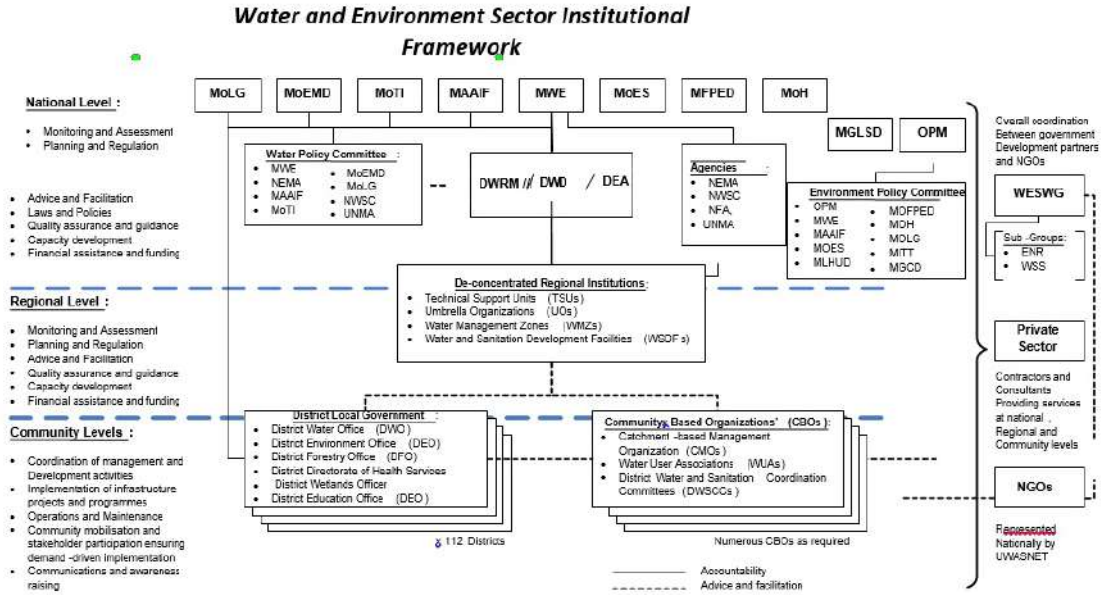


Figure 6: Uganda Water and Environment Sector Institutional Framework. Source: Ministry of Water and Sanitation, Uganda. 2017.

There are many different partners in rural sanitation and hygiene in Uganda (Figure 7). Regular inter-district meetings are held to share information and experiences. Technical support units at regional level provide support to district-level local government to implement the various initiatives.

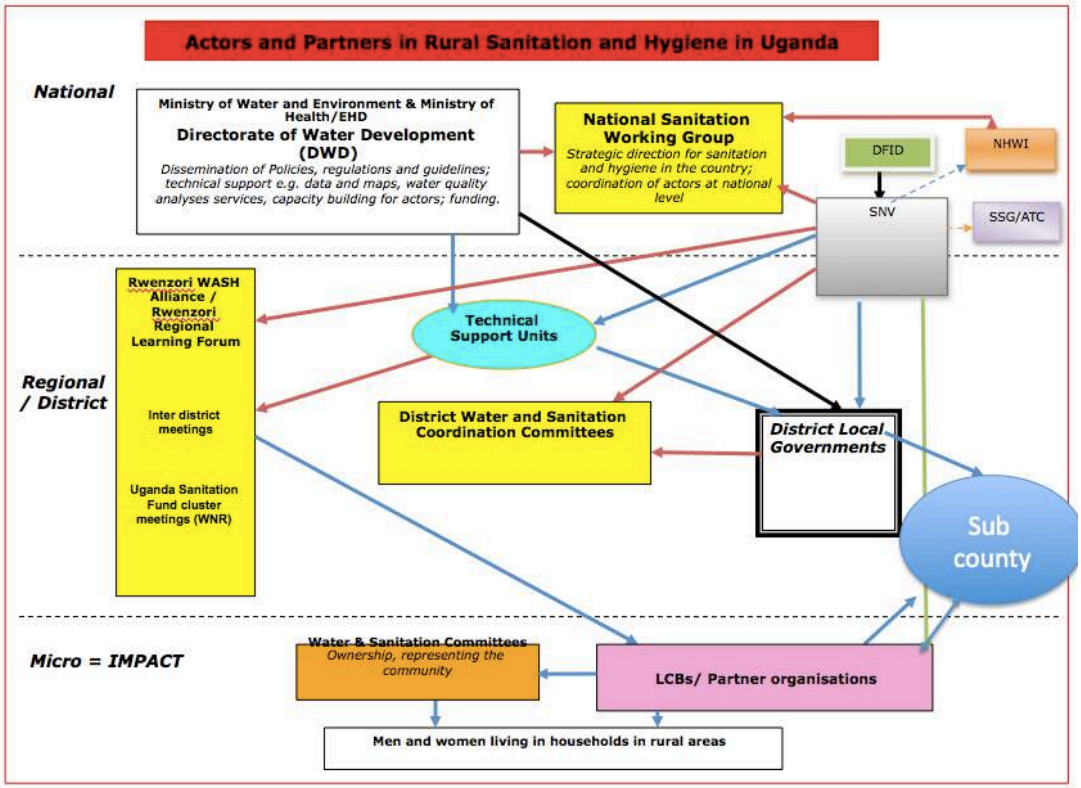


Figure 7: Actors and Partners in Rural Sanitation and Hygiene in Uganda. Source: Ministry of Water and Environment. 2017.

History of the Uganda National Hand Washing Campaign

In 2003, the government of Uganda adopted sector-wide approach and started moving away from a more project-based approach. The Water and Sanitation Working Group was formed, as was the National Sanitation Working Group. In 2005, an ad hoc committee of the National Sanitation Working Group was formed, in part to support hygiene promotion.

At inception, little was known of the actual rate of HWWS or what motivated or prevented the behaviour in Uganda. In 2006, it was estimated that only 6 percent of the population regularly practiced hand washing with soap after defecation. Within this same survey, 95 percent of households had soap. After prompting, many respondents reported using soap at least intermittently. Key motivators for HWWS included disgust, wishing to nurture their families, and to ensure good health. Barriers included being too busy, forgetfulness, and the perceived high cost of soap: many households had soap but used it only sparingly. A follow up study in 2012 revealed that the motivations and barriers remained the same.

The National Hand Washing Initiative was introduced in 2007 and aimed to engage all levels of government as well as the community. To date, three campaigns have been implemented:

1. *Mama the power is in your hands* (2007): Five pilot districts. This was intended to empower women but many women felt condemned and men felt threatened; men felt excluded and women also felt men should be more involved
2. *Hands to be Proud Of*: 2010-2012. Learned that you cannot sustain campaign on its own
3. *Wash Your Hands & Save Time, Money and Unnecessary Hospital Bills*: 2015-ongoing

Rates of hand washing have increased from around 14 percent in 2007 but remain low at approximately 37 percent. Several challenges in increasing the rate of hand washing have been identified throughout these initiatives, including:

- Limited and intermittent funding
- Trivialisation on hand washing
- Low prioritisation of use of soap for HWWS at HH level
- Technological limitations – tippy-taps
- Challenge of sustaining behaviour change
- Indicators for critical moments: issues with data collection
- Pegging of HWWS promotions to disease outbreak undermines essence of BCC: HWWS needs to become a habit, not behaviour that is undertaken only when there is a disease outbreak
- Capacity gaps, especially at implementation level

Question & Answer

What was the timeline between each campaign (sequence)? Do you think this had any effect in terms of behaviour change?

Campaigns ran for about three months at a time so were not really sustained, largely due to lack of funds.

Have you seen any coordination challenges during the campaigns?

Not so much at national level: we have national level working groups to guide coordination. At lower levels, however, some actors are not so active. This may depend on individuals and may not really be an institutional issue.

When Uganda implemented the "Mama" campaign, what channels did you use for BCC?

Posters, radio, t-shirts, and door-to door-visits.

Were there any issues in trying to generalise campaign at the grassroots level?

We had Health Worker Ambassadors who helped with this. These ambassadors were unpaid volunteers.

We would like to know more about the integration at all levels: who was the "champion"? Many different working groups are made but sometimes in practice they send junior staff and nothing is actually done. How did you manage to bring everyone together effectively?
Integration and cooperation is still not 100 percent but we do have some high level engagement. The initiative is spearheaded by Ministry of Water and Sanitation and the anchoring organization is the National Sanitation Working Group. Every year, there are sector undertakings. During the transition from integration to implementation, all the different sectors were engaged in designing what the national HW campaign would look like. This made it a multi-stakeholder venture, including Ministries, non-government organisations (NGOs), private sector and others.

Coverage was going up and down between 2007 and 2017. But between 2010 & 2015 there appears to be a steady improvement. To what do you attribute this steady improvement?
It is difficult to say for sure but it is likely that it is due to spillover from other, complementary health campaigns, such as those focusing on maternal and infant nutrition.

Preparation for Field Assignments

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands.

Explanation of field assignment

The purpose of the Field Assignment was fourfold:

i. Learn about the context and experience in Uganda on HWWS;
ii. Analyse how the National Hand Washing Campaign has been rolled out;
iii. Reflect and discuss the strengths, challenges; and
iv. Develop recommendations for the District Health Inspectors.

Ms Kome emphasised the fact that these assignments were to be not only about receiving information but also an opportunity for participants to share their own experiences and to provide feedback and recommendations.

Participants were split into five groups, with a mix of representatives from different countries in each group. Each group was assigned a different district to visit within the Western Region: A. Kabarole, B. Kamwenge, C. Kyegegwa, D. Kyenjojo, and E. Mubende (Figure 8). All of the districts are in the SSH4A programme area. Within each district, teams were to visit district and sub-country officials, as well as one village.

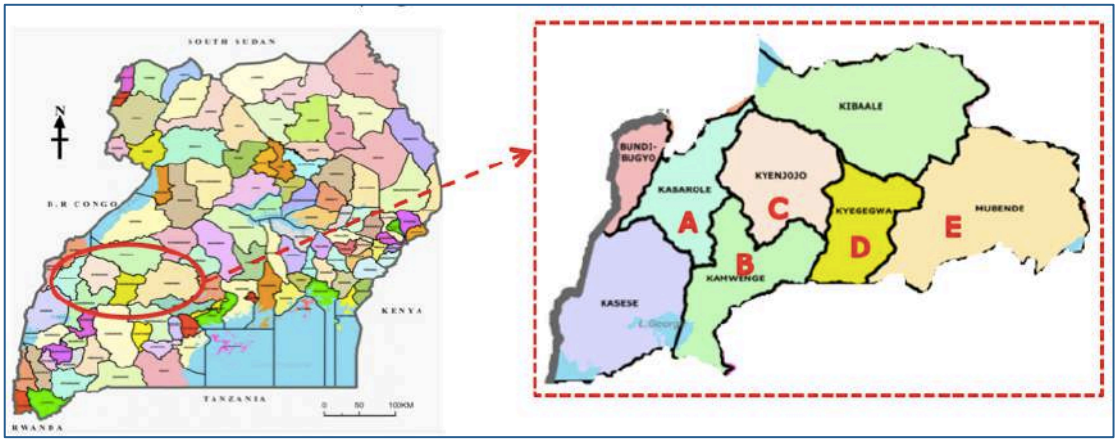


Figure 8: Map of Uganda, highlighting Field Assignment counties.

To allow for different styles of learning and communication, several outputs were requested:

- Photo diary;
- Testimony;
- Case Study;
- Quotes; and
- Recommendations.

Teams were asked to divide the responsibilities amongst themselves to ensure that everyone was involved and that all tasks were completed.

Presentation of Findings from Field Assignments

Key findings, recommendations and an extract from the testimonials presented by each Field Team are presented below. Case studies, full testimonial text and photo journals are in Annex 3.

Field Team A: Haragongo Sub-County, Kabarole District

Figure 9: Field Team A with Haragongo Sub County government representatives in Kabarole district. 2017.

> *"Investment in sanitation and hygiene comes from the heart, not money"*
> Disabled widow from Kibende Village, Bunyangabu District.

Haragongo Sub-County has a population of approximately 24,780 people. The main economic activity is farming: largely tea and motoke (plantain).

At the sub-country level, the Field Team elected to focus on implementation of the Obulamu? Campaign at the Nyantaboma Parish Health Centre. "Obulamu?" is a common greeting and means "how is life?" The campaign is anchored in a social-ecological model and designs health-centred BCC messaging for USAID implementers. Messaging is organised around different life stages:

Lovers' life stage	"How is your love life?"
Couple life stage	"How is your pregnancy?"
Caregivers & family life stage	Nutrition & WASH
Adolescent life stage	"What's up?"

Implementation of the programme is headed by a midwife based at the Nyantaboma Health Centre, with support from the County Health Team. A variety of channels are used to deliver the BCC messaging, including door-to-door visits by the village health team, radio, television, billboards, posters and stickers. The main hygiene messages focus on caregivers and those at the family stage of life and include hand washing with soap before cooking, after visiting the latrine, before eating and after changing a baby's nappy.

Key achievements

Latrine coverage has increased from 30% in 2015 to 75% in 2017. This has led to a reduction in the number of sanitation-related diseases. For example, 13 cases of diarrhoea were reported in June 2016; in April 2017 there were only two cases reported.

Challenges

- Sustainability of the interventions once external funding is no longer available;
- Integrated model results in too many messages being broadcast at the same time
- The donor determines the key health areas for focus and for in this area, family planning and malaria are the areas of main interest;
- There is a gap in data collection, analysis an presentation
- There is limited access to hygiene promotion materials.
- The integrated model does not give WASH interventions prominence, reducing the effectiveness of the campaign

Recommendations

- Investment in WASH-specific interventions should be improved, particularly at local government level in order to sustain the achievements
- The Health Department should develop a system to reward Village Health Teachers
- Data collection, analysis, interpretation and dissemination should be strengthened.

Testimony

The Field Team also visited Kibende Village in Bunyangabu District, just to the south of Kabarole District. At the village they solicited a testimony from a disabled widow. The woman owned a two-stance latrine with drop holes and wooden drop hole covers. The latrine had a nicely woven banana-fibre door. Near the latrine, a tippy-tap hand washing facility with soap had been installed. Pit excavation for the latrine had been outsourced and was paid for by the sale of plantain; the woman herself undertook wall smearing and floor maintenance.

Figure 10: A well built latrine with HWWS facility in Kibende village, 2017.

Figure 11: Field Team B's informant, Kibende village, 2017.

The woman was responsible for taking care of her orphaned grandchild. She testified to numerous incidents of diarrhoea before the latrine and hand washing facility were installed. Since then, she claims there have been no incidents within the household, which confirms that her neighbours have also ceased to dispose of faeces in the open and suggests that the community is or is close to ODF.

Field Team B: Kasule Sub-County, Kyegegwa District

Figure 12: Field Team B with the government representatives, village Head Woman, VHT Coordinator and VHTs at Bubalebwera Village, Kyegegwa District. 2017

"The most triggering moment for having latrine and HWWS facilities was use of drama."
Village Health Teacher, Bubalebwera Village

Kyegegwa district is one of the eight districts implementing SSH4A Project in the Rwenzori region with a total population of 277,379. Kasule Sub County is one of the eight rural Sub Counties of Kyegegwa district and one of four that has been implementing the SSH4A programme. SSH4A commenced in this district in 2014.

Hygiene promotion in this area is implemented through several agencies and actors including the Sub Country Health Authority, the Parish Village Health Teacher (VHT) Coordinator, the Village Sanitation Committees including the VHT, and URDT NGO. Several communication channels are used including posters, radio spots, DJ mentions, jingles, house-to-house visits and dramas performed in the villages.

Findings & key achievements

The Sub County is employing the CLTS approach to hygiene and sanitation. SNV/URDT partnership with Kasule Sub Country LG has enabled the area to move from 7% latrine coverage to 94% and rates of hand washing with soap to increase from 11% to 54%.

At village level, good HWWS facilities in the Bubalebwera village. The community had made innovative use of local materials to fashion doors and drop hole covers for the latrine, as well as anal cleansing materials. The village has 76 households, of which 68 (89.5%) have a good latrine with HWWS facilities.

Challenges

- Limited finance to effectively reach the community (Only UGX100,000 is provided per quarter provided for a health assistant to reach the community)
- Limited human resources: there was only one health assistant (HA) to follow-up actions in the villages (five parishes, 49 villages)
- The National HWWS initiative is not well cascaded from the district to the Sub County and then village
- Water supply is perceived as a challenge in the area to practice HWWS

- The directive has been issued that requires every household to install a pit latrine by 01 October 2017 or risk arrest and sentencing to community service. However, clear implementation modalities ought to be worked out.
- The URDT has ceased functioning, however the role is well assumed by the different level sub-county, parish and village leaders.
- Sanitation is well anchored at community level; for instance when a latrine is filled up or has failed due to rain the community digs a new one. This has occurred on at least three occasions to date.

Recommendations

- Allocate adequate finance to effectively reach the community
- Assign adequate human resources (HA and VHT) to follow-up actions in the villages
- Optimise cascade from the national HWWS initiative from the district to the Sub County and then village levels
- To prioritize access to water to the village
- Exert effort to improve and sustain existing latrine facilities

Testimony

Figure 13: A village health worker from Bubalebwera demonstrates the tippy tap with soap. 2017.

In the village of Bubalebwera, the Field Team solicited testimony from one of the Village Health Teachers (VHT). The woman was a mother of three, grandmother of one and had been working as a VHT for 15 years. She has been inspired by the tremendous changes that she has seen since 2014, when URDT started supporting the village: increased toilet coverage, doors and drop hole covers made from local materials, and greater focus on HWWS. Enforcement also contributed to a sharp increase in latrine coverage.

While she loves her work, it is not without challenges: she has met abuse and hatred from people who are not ready or do not to hear the messages she has. Despite this she has learned how to cope and handle these challenges well. She has learned to create time for her work as a VHT.

“What keeps me going is to fulfil the task that the community selected and entrusted me with. I also feel that I benefit from the exposure and training that I receive. To fellow VHTs I have this to say: Commit to do what the community selected you to do. By loving the people you serve, they will love you return.”

Figure 14: Innovative use of local materials

Field Team C: Kisojo Sub County, Kyenjojo District

Figure 15: Field Team C ready to roll to Kyarusula Village, Kyenjojo District. 2017.

"I am so happy that I don't spend my money on sanitation diseases anymore"
Household Head, Kyarusula Village

Kyenjojo is a district with a population of approximately 256,610 people. It is comprised of 15 rural sub counties, of which four – including Kisojo - are implementing the SSH4A programme. The main approach to sanitation and hygiene at the moment is CLTS. Partner engagement is focused on areas with low service coverage and high rates of disease prevalence.

Findings & key achievements

At district level, there is a Five Year Development Plan at district level as well as sector-specific plans. The National Hand Washing Initiative guides hygiene promotion and there is increased recognition of the importance of hygiene behaviour change. Implementation partners align with the government plan. Despite a low budget (not clear exactly what the budget is but S&H is certainly <1% of national budget), sustainability is being promoted through regular visits by the VHT (at least three visits within the past six months) leading to good knowledge of HW at critical moments among the villagers.

All the households had functional latrines, although some households were sharing latrines. The latrines had drop hole covers in place and there were some local innovations to help older people and people with disabilities.

Challenges

- District sanitation and hygiene budget is very low
- High dependence on donor funding
- Sub-district VHTs are burdened with too many responsibilities which runs the risk of sanitation and hygiene being de-prioritized
- Village level facilities are still at the unimproved stage and run the risk of falling into disuse if they collapse
- There is a perceived scarcity of water to sustain HWWS
- Many latrines are shared between two or more families
- Poor sanitation management at the church

Recommendations

- Decentralize BCC message development and campaign
- Advocate budget allocation from government treasury for sanitation and hygiene activities to ensure sustainability.
- VHTs are overwhelmed with too much work. They give priority to messages from partners who pay higher allowances. Either the government should pay regular salary or increase the number of VHTs.
- Link the village with partner interested to implement water supply project to sustain the hand washing practice.

Testimony

Women leader LCI

The community of Kyarusula used to experience a high number of diarrhoea cases. The health worker from the sub-county became concerned and visited the community. He facilitated the formation of the Sanitation Committee in 2015. In 2016, SNV came in to support the area with WASH activities. The community was motivated to construct latrines and demonstration on how to erect tippy-taps was conducted so that the community members could easily wash hands. Currently the cases of diarrhoea have decreased and this can be confirmed by the VHT.

Figure 16: Tippy-taps in place … but too low for comfort

Figure 17: An improved facility with drop hole cover

Community member

In the past the latrines were in a bad state as they were not properly maintained and most of the community members avoided the use of the latrines. With the intensification of hygiene education and follow-ups from the sanitation committee the latrines are now being cleaned and the community members can comfortably use them.

Field Team D: Nyabbani Sub-County, Kamwenge District

Figure 18: Team D with Kamwenge district-level government representatives

"Sanitation cannot be reached without integration"

Health Inspector at Kamwenge District

Kamwenge District is home to a rural and urban population of some 329,100 people. The main occupation is farming (maize and tea) and raising of livestock. Group D visited the district during the planting season. SNV is currently implementing the SSH4A programme in three out of 15 sub-counties: Nyabbani, Kamwenge and Ntara.

Findings & key achievements

Water supply total coverage is 79% access (rural 78%; urban 95%) based on at least one well per village within one kilometre in rural areas and within 200m in urban areas. There is currently little legislation in place governing sanitation and hygiene, with weak enforcement at sub-county level. In addition, there are few health inspectors (HI) in the area. Sanitation and hygiene planning tends to occur from the grassroots up, with sub-district areas finding their won budget for interventions. Currently, sanitation and hygiene interventions implemented in partnership with KALI and KDC.

Challenges

- Critical shortage of HI to facilitate village modelling
- Poverty that limits community members to carry out sanitation and hygiene initiatives
- Influx of refugees (about 60,000) limits council efforts
- Farmers/peasants rarely prioritize sanitation and hygiene at the home
- Most broken tippy taps are not repaired
- Sanitation and hygiene at schools are cumbersome with less priority given
- Sludge emptying have never been planned for especially in small growing towns
- Meagre funding is allocated for sanitation and hygiene, usually from unreliable own sources
- Weak coordination on sanitation and hygiene activities

Recommendations

For Kamwenge District Council

- Strengthen Team working on sanitation and hygiene activities
- Reallocate Health Inspectors/ Assist to areas of need
- Allocate more funding to sanitation and hygiene activities

- Strengthen structures at village level to improve sanitation and hygiene activities

For Nyabbani B Village

- Improve the size and use of tippy taps
- Install permanent doors to latrines for assured privacy
- VSLA to market cement for improved latrine floors
- Sustain the promotion group by reaching more people with S+H messages

Testimony

The interviewee lives in Nyabbani B village, Rwenkubebe Parish, Nyabbani Sub County in Kamwenge District and is a member of the Nyabbani Bakyala Twimukye VSLA Group. She is married to a mason who builds toilets and houses and she has six children. Upon been asked on what led her to begin practicing hand washing at critical moments her story was that in the past before the intervention by an NGO called Community Connector which came on board in 2014 the men in her region were prohibiting their wives from attending community meetings organized by outsiders due to various suspicions. The woman narrated that when this NGO came in the area it encouraged women attending meetings and the men gradually began to see the benefits from their wives participation in these meetings and eventually they became willing and gave their blessing towards the cause.

The woman further narrated that the NGO has taught her a number of things to do with farming and she and her family has now changed from only cultivating crops for family consumption as she is now growing cash crops where she gets part of her income to manage the home and send children to school. She added that she has also acquired the knowledge on how to store her crop produce, of which it was not the case previously and she would sell the remains of her produce so fast and then would later find herself buying from her colleagues at a higher price in no time.

She also testified how the NGO led to her learning of improved farming methods and practices and she then built separate structures for storing food as well as for rearing her animals, as previously her family did not live separately from the livestock and crop produce.

The NGO also did a lot of sensitization on the importance of hand washing and use of toilets as well as good sanitation and boiling of water for drinking, which proved to be very beneficial for her and her family when they adopted the behaviour as previously the family would experience a lot of stomach complications as well as diarrheal diseases especially with the children. She added she is now happy, as the family is able to save money and time to carry out other economic activities.

Figure 19: Two residents of Nyabbani B village using a tippy-tap

Figure 20: SATO pan installed in a village household latrine

Field Team E: Muleete Village, Mubende District

Figure 21: Team E with Mubende district officials at the end of their field visit.

"Do what I do, because it is good. I did it and I never have infections within my household"
VHT, Muleete Village, Mubende District

Mubende is a district approximately 150 km from Kampala. It has a population of just over 700,000 people, of those around 51% are female. The main ethnic group is Bantu and the common language is Luganda. There are 18 rural sub-counties, four of which have been implementing SSH4A since 2014 and 11 of which have been included in the SSH4A extension programme since 2017.

Findings & key achievements

Sanitation coverage is estimated at around 83% with access to hand washing facilities much lower, at just over 20%. The team met with the Honourable Vice Chairperson of the district, the Sub-country chief and two health assistants and in Muleete Village, with the village Chairperson, the Parish Councillor, opinion leaders and the VHTs.

Muleete Village had been selected as a pilot village early in the SSH4A programme. At sub-country level, local leadership had been sensitised and triggered to provide support and opinion and natural leaders had been identified in the village and among the VHT. The team clustered households in the village and used them as agents of change.

Challenges

- Staffing is not sufficient: only two health assistants covering all villages in the area sub-county (62 villages).
- Inadequate budget affects follow up (no transport).
- Monitoring and evaluation not comprehensive
- Culture- there are areas e.g. the pastoralists who are nomadic and difficult to reach with the interventions
- Enforcement of the by-law and fines of UGX 50,000 may be a concern.

Recommendations

- There is a technical planning committee at sub county level that looks like a good avenue to strengthen planning and review of the BCC interventions. They noted that this is where targets are set and progress on the same is reviewed.
- The political class has been triggered. They are able to drive the agenda if there is some momentum maintained. Regular review and reward/appreciation will be key in keeping this up.
- There are leaders at parish level (councillor) and village level (Chairperson LC1) who can drive the process. District & sub county can be role models- have HW stations at their offices
- There is revenue generated at the sub county level. This can be used for sanitation.

Testimony

Figure 22: VHT from Muleete Village, Mubende District.

It is a pleasure to share with you my experience regarding the hygiene messages and campaign that reached the village, especially because I am now a member of the village health team.

Before the sanitation promoters came, other household members and I got sick with diarrhoea-related diseases frequently. A member of the village health team would always give us drugs and zinc tablets. Right after the sanitation promoters came into my household we improved our sanitation related behaviours and facilities. For example we had a toilet before, but this was not a good one.

With the new toilet we also constructed a tippy tap, to chase the diseases away. We do not even use the drugs and zinc tablets anymore. Small children can even use these tippy taps and I am always reminding them to do so. The children also receive sanitation education at school once a week given by me as village health team member.

As a member of the village health team I go from house to house to demonstrate the facilities and good practices to the head of the households. And right now there are no households without a latrine and also a good number of households have a hand washing facility. For the disabled people, the community members give contributions to provide materials and they dig a pit and related facilities. We also trained a blind man on how to use a tippy tap.

I am facing some challenges however, with being a member of the village health team. It is hard work and I get really tired, I also get abused sometimes. But this does not stop me from promoting hygiene. Therefore my message for others is: 'do what I do, because it is good. I did it and I never have infections within my household'.

Figure 23 Tippy tap near a kitchen. Muleete Village, Mubende District.

Response from government representatives

Ms Martha Naigaga, Sanitation Coordination Unit, Ministry of Water and Environment, Uganda Ms Naigaga stated that she found the presentations quite enriching, and liked that the stories were picked up from real beneficiaries. She noted that the issue of sustainability seemed to be a recurring theme and that she sees the need to continue the campaigns. The national team needs to look at this and see how we can provide support. She thanked the respective local government staff for their efforts and support and noted that WASH funding is still limited and that there is still a need to advocate for increased government budget for these activities. Nonetheless, she went on to emphasise that it is not just a matter of money but that it is also important to work together to get the most out of the existing budget.

Cato Mamyaho, Environment Health Officer, Rural Water and Sanitation department, Ministry of Water and Environment Ms Mamyaho agreed that the presentations were very good. To address the issue of water scarcity raised in several of the presentations, she wanted to make sure that everyone is aware of the Presidential Directive that every village have a safe water source.

Peter Opwanya, Water and Sanitation Specialist (Technical Support Unit, western region), Ministry of Water and Environment Mr Opwanya welcomed the recommendations that the teams had made. He noted that some districts are not yet benefitting from donor-funded projects and that these recommendations could help to extend initiatives to these districts. He noted that the ministry is encouraging districts to increase staffing for water and sanitation initiatives. In addition, they are encouraging participating districts to plan to sustain their achievements. He noted that some districts are water stressed due to either a lack of ground water and/or impaired quality of water. In response to comments within the presentations regarding the lack of availability of hygiene promotional materials, he noted that the Ministry of Water and Environment is continuing to work to make sure that these are available at all levels.

X. Block 3: Effective Behavioural Change Designs and Messaging

Overview of Block 3

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands.

The third block in the Learning Event focused on effective design and messaging for BCC campaigns. Ms Kome introduced a simplified logic of BCC design (Figure 24) and summarised the DGroup discussions.

Figure 24: Simplified logic of BCC campaign design. Source: SNV Netherlands 2017.

Target groups

Ms Kome noted that while 66% of DGroup respondents referred to specific target groups, the remainder talked about communities in general or "everybody". Some countries, including Kenya, had considered primary and secondary target groups, and then the wider community (Error! Reference source not found.). Most countries focused on women, women with children under five years of age, and caregivers. Some countries noted the importance of considering fathers. Participants were reminded that some sections of a target group may be more hidden and more difficult to reach and that it is important not to miss these people. In addition, it was noted that reaching opinion leaders and ensuring political buy-in is essential for an effective BCC campaign.

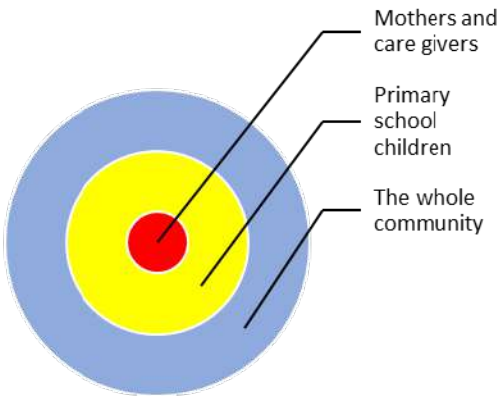


Figure 25 Primary, secondary and wider community target groups. Source: SNV Kenya, 2017.

Behaviours

The various countries were working to engender a number of specific behaviours through their campaigns. A majority were aiming for HWWS at all critical moments while others focused on specific critical moments - such as after defecation, after cleaning a child, before food preparation, and before eating – that had been identified as particularly problematic.

Motivators (behavioural determinants)

While most countries spoke generally about "knowledge, beliefs, attitudes" or "traditions", some 40% had identified specific motivators (behavioural determinants). Cambodia was focusing on linking HWWS to defecation while Nepal targeted the management of hand washing facilities. In Bhutan, they noted that while most households had soap, the soap was often moved from the hand washing facility. In response and to ensure that the soap was in the right place and available for hand washing, they developed reminder stickers for the hand washing facilities stating that "the soap lives here". The team from Ethiopia noted the challenges presented by different understandings of cleanliness and dirt: spiritual cleanliness, visible versus non-visible dirt, and the fact that babies are often perceived as clean - including their faeces.

Messages

There were many different motivators identified behind the messages (Error! Reference source not found.), with nearly a third of the messages focusing on providing guidance and improving knowledge (30%). Other key motivators included honour and pride (17%), comfort (11%), responsibility (11%) and time and financial savings (11%).

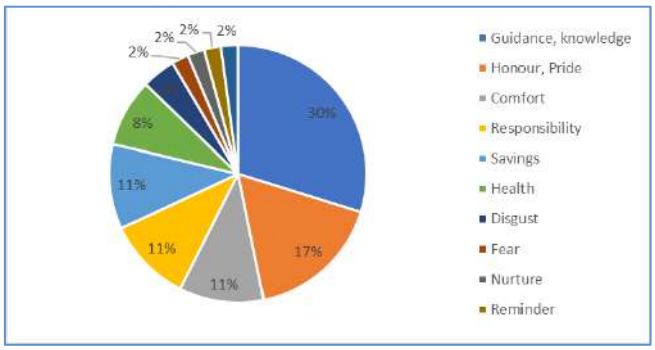


Figure 26: Apparent motivators behind the BCC messages. Source: SNV Netherlands, 2017

Communication channels

All countries were using multiple channels to deliver their messaging, with a range of four to nine different channels being used. Most agreed that face-to-face interaction was an essential component, although it was recognised that this approach is quite costly to implement. Ms Kome noted that there had been little to no research done on the effectiveness versus cost of different communication channels and that this presented a gap in current knowledge.

All participants recognised the importance of using appropriate language and culturally resonant messaging and that this may differ from place to place, particularly in countries with diverse ethnic groups.

Presentation by FHI360

Presented by Mr Emmanuel Kayarogo, Social Behaviour Change Communication Advisor, FHI360.

With a view to learning from the experience of BCC campaigns from outside the WASH sector, Mr Kayarogo, a social behaviour change communication (SBCC) advisor from FHI360 was invited to discuss the current "Obulamu?" health communication campaign. Obulamu? Is a popular greeting meaning "how is life?" and is part of the Communication for Health Communities (CHC) programme. CHC is a five year US Government that supports the Government of Uganda and US implementing partners to design and implement quality health communication interventions that contribute to reduction in HIV infections, total fertility, maternal and child mortality reduction, malnutrition, malaria and tuberculosis.

FHI360 works with the National BCC working group, relevant technical working groups, USG implementing partners, Districts level government and audiences to develop standardized materials, tools and IP guides to ensure consistent and harmonized implementation of health communication interventions. They use relevant SBCC theories and data to identify and tackle key barriers to uptake of services or adoption of recommended behaviours and provide on-going technical assistance to the Government of Uganda and USG implementing partners to enhance targeted mobilization, at the correct intensity and saturation required to achieve results.

At the commencement of the campaign, an audit was carried out to assess the status of current health communication interventions. The audit revealed the following:

- Limited implementation & scale-up of health communications;
- Fragmented implementation of interventions;
- Diseases-focused messaging, resulting in many concurrent messages;
- Health messaging competing with other messaging include advertising, political messaging, messaging from the church and others;
- Audience fatigue with instructive messages; and
- Disconnect between mass media and interpersonal communications.

Design and analytical framework

The campaign was grounded in the socio-ecological framework, and considers the following aspects:

1. *Information; knowledge*: How much does the audience know about the desired behaviour?
2. *Motivation, beliefs about outcomes*: What does the audience believe in relation to the behaviour? Do they believe that adopting the behaviour will result in something they want?
3. *Skills and self-efficacy*: Does the audience believe they can do it?
4. *Practices*: What are they currently doing?

5. *Self-efficacy*: Does the audience consider the practice easy and convenient?
6. *Ability to act, access, enabling environment*: Is the audience's environment/home set up to make the behaviour easy?
7. *Perception of social norms*: Audience perceives the practice as the new norm. Are there any social and gender norms that affect uptake of the behaviour?

The campaign took an audience centred, life-stage approach, developing different messages for audiences in each of four life-stages: adolescence, young adults in relationships, pregnant couples, and caretakers of children under five years of age.

Development process

The development process included many stages, including inter-personal meetings and technical working groups (TWG) to identify health care needs. This was supported through extensive desk research with an emphasis on health information management systems (HMIS), the Uganda AIDS indicator survey (UAIS), the Uganda Demographic and Health Surveys (UDHS), and local research. Formative research was undertaken with representatives from all target audiences.

Once the concepts were drafted, the concepts were tested with the relevant target audience as well as reviewed by sector TWGs. The concepts were then further refined based on the results of testing and review. The revised materials were field tested among target audiences and once they received audience acceptance, were submitted to the MOH and UAC for approval.

The implementation and outcomes were monitored periodically throughout the life of the campaign, and "special campaigns" were developed to respond to identified issues, such as incidence of malaria in children under five years of age.

Standardised Packages

A series of standardised packages for different communication channels were developed. These standardised packages were then tailored for different communities taking language and cultural differences into account. The interventions were designed to (i) address the barriers to adoption of behaviour change and uptake of services and (ii) for implementation in a variety of locations where the target audiences would be most easily reached, including homes, drinking venues, markets, water sources, schools and churches, among others. While a standardised package was developed for social media, some challenges were noted with this channel, including the fact that the message is weakened when people criticize it online. Key elements of each of the IPC and mass media standardised packages are detailed, below:

Standardised interpersonal communication packages

Use of Community Champions

- VHTs and Peers who work with IPs
- Platform champions e.g. religious leaders, Journalists
- Organized groups e.g. Women, SACCOs, youth

Targeted mobilization strategies

- Community shows for audiences above 25 years
- KADANKEs for adolescents & younger audiences
- Home Visits for vulnerable audiences
- Small Group Discussions – Men Only, Women Only
- Children's clinic focusing on WASH
- Community debates

Standardised mass media package

Radio and TV products

- Radio and TV Spots
- Radio TV Magazines
- OBULAMU Moments (DJ discussions)
- DJ Mentions
- Talk shows
- Community Radio Debates

Monitoring, evaluation and learning

Monitoring, evaluation and learning (ME&L) activities were recognised as an essential component of the campaign and was included in the implementation strategy from the beginning. Key ME&L activities included:

- *Quarterly audience listening surveys*
  - Conducted in at least 20 districts across the country, representing nine CGC programme regions
  - Tracks exposure to the campaign interventions, intention to act and action/ change in behaviour among target audiences
- *Quarterly HMIS and IP data analysis*
  - Used as a proxy to measure effect of the campaign interventions on service uptake
- *Monitoring of 45 model facilities and sub-counties (continuous quality improvement)*
  - Monitoring tools include client exit interviews & health facility observations
  - Monitor & document changes in client knowledge & satisfaction, service uptake, provider customer care & counselling skills
- *Evaluative survey of an integrated health communication campaign in Uganda*
  - Result of Observation 2 to be compared with results of Observation 1

In conclusion, Mr Kayarogo returned to the six steps of communication effects: exposed to the message, understand the message, approve of or agree with the message, intend to act and then actually act. He emphasised the importance of reaching as many of the target audience as possible, noting that the campaign will lose people at each at each stage (Figure 27), so the greater the number of people exposed to the message, the greater the number of people who act on the message.

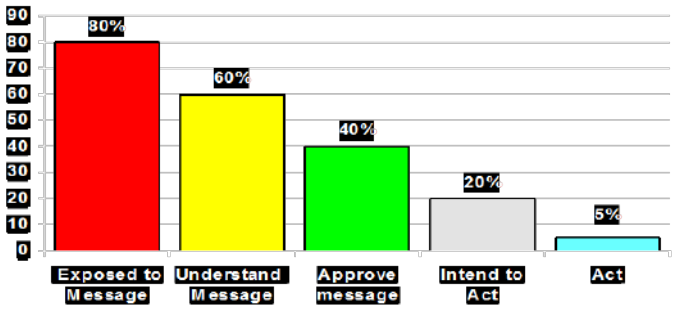


Figure 27: Hierarchy of communication effect. Source: FHI360, 2017.

Presentation by Fideli

Presented by Mr Waninda Joseph, Creative Designer, Fideli.

Mr Waninda Joseph was invited to explain the role of creative design within social behaviour change communication (SBCC) campaigns and to provide an overview of the creative design process. He commenced by explaining that SBCC are unique in that they deal with complex social issues relating to knowledge, attitudes, beliefs and norms. As such, they require tested and proven standard implementation procedures, guidelines, and approaches to tackle them.

Over the past 50 years, researchers, implementers and the development world have generated a considerable body of knowledge to inform the design and implementation of effective SBCC interventions. There is now a wealth of information and experience to learn from: there is no need for speculation or guesswork!

> *"If You get objectives right, a lieutenant can write the strategy!"*
> Gen. George C. Marshall, U.S Secretary of State, Nobel Prize, 1953

Ten characteristics of good SBCC campaigns

Mr Joseph then proceeded to articulate ten characteristics that exemplify a good SBCC campaign, namely:

1. *Process not event based*: SBCC campaigns are not one-off events; they follow a systematic, tried, tested and proven process.
2. *Evidence-based*: Informed by evidence/research.
3. *Audience-centred*: Developed by and for the target audience.
4. *Targeted and focused*: they are designed to reach a clearly defined audience.
5. *Highly participatory*: Involve multiple stakeholders.
6. *Campaign based*: Involve a series of interventions using multiple communication channels, not just posters or just radio talk shows, for example.
7. *Strategic and grounded in theory*: SBCC campaigns should be grounded in a defined theory of change as part of the wider strategy that ties different components together.
8. *Correct intensity*: Balances *reach* and *frequency* to obtain the correct intensity required to evince behaviour change
9. *Takes a great deal of time*: The process cannot be rushed. It takes a great deal of time to persuade people to change their behaviours and, in particular, to make this behaviour change a habit.
10. *Requires the right skills/expertise*.

SBCC campaign planning process

There are five key steps in the planning process:

1. Analysis

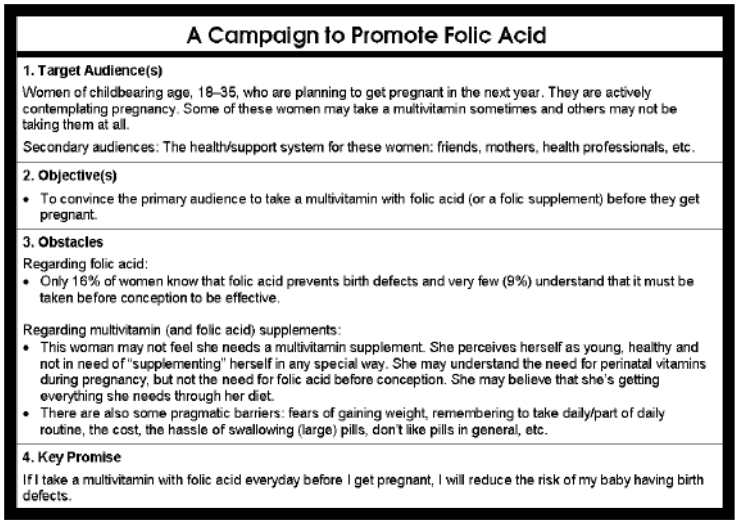
   Without a clear understanding of the current situation, based on robust data, it is not possible to design an effective SBCC campaign. For the Obulamu campaign, the analysis included audience analysis using relevant models, a review and audit of existing BCC materials and other resources, a strengths-weaknesses-opportunities-threats analysis, desk review of existing health data, and formative research with target audiences to identify gaps and start to consider ways to address them.

   The analysis revealed that livelihood and wealth generation were prioritised over health; that health messaging were highly medicalized and boring; that prescriptive messaging make people "switch off"; and that audiences were fatigued by the clutter of messages that they received every day.

   In response, the team decided to focus on de-medicalization of the messaging: life is sexy … health is not. They decided on using "Obulamu?" as the central message. A common greeting in many parts of Uganda, it was viewed as a way to break through the message fatigue and instead invite people to join the conversation about their health.

2. Strategic Design

At this stage of development, it is important to develop a strategy with clear objectives, to determine the appropriate approaches, channels and positioning for the message, to develop the work plan and budget and to develop and M&E plan. In addition, it is important for the client (programme donor/ planner, manager and/or implementer) to develop a creative brief to help guide the creative team in developing appropriate SBCC materials for the target audience/s. The creative team is usually comprised of graphic designers and illustrators, spots producers, film producers, music and jingle composers, and scriptwriters. An example of a creative brief is shown in Figure 28.



A Campaign to Promote Folic Acid

1. Target Audience(s)

Women of childbearing age, 18–35, who are planning to get pregnant in the next year. They are actively contemplating pregnancy. Some of these women may take a multivitamin sometimes and others may not be taking them at all.

Secondary audiences: The health/support system for these women: friends, mothers, health professionals, etc.

2. Objective(s)

- To convince the primary audience to take a multivitamin with folic acid (or a folic supplement) before they get pregnant.

3. Obstacles

Regarding folic acid:

- Only 16% of women know that folic acid prevents birth defects and very few (9%) understand that it must be taken before conception to be effective.

Regarding multivitamin (and folic acid) supplements:

- This woman may not feel she needs a multivitamin supplement. She perceives herself as young, healthy and not in need of "supplementing" herself in any special way. She may understand the need for perinatal vitamins during pregnancy, but not the need for folic acid before conception. She may believe that she's getting everything she needs through her diet.
- There are also some pragmatic barriers: fears of gaining weight, remembering to take daily/part of daily routine, the cost, the hassle of swallowing (large) pills, don't like pills in general, etc.

4. Key Promise

If I take a multivitamin with folic acid everyday before I get pregnant, I will reduce the risk of my baby having birth defects.

Figure 28: Sample creative brief. Source Fideli, 2017

3. Development and testing

A strong creative team is vital to develop attention-grabbing, memorable and persuasive behaviour change communication materials. Materials need to be developed with the audience in the forefront: they should be active participants in the design process, not just consulted in an ad-hoc manner. Equally, the design process should involve the client and other key stakeholders.

Message development cannot take a "one-size fits all" approach. As such, pre-testing is an essential step to ensure that the materials resonate with the audience and are, in fact, sending the correct message. It is a tactical, iterative process of refining and customizing the message to suit the audience. Materials should be tested among both the audience and the client, with a balance struck between the reviews of all.

Deigning effective SBCC tools is a blend of science and art: materials and messages are created based on evidence in a systematic, tested and proven process (science) but must also be able to evoke emotions and to motivate people to lastingly change their behaviour (art). Strong SBCC materials should have a clear emotion being addressed; in SBCC emotion is the most powerful behaviour change tool.

4. Implementation & Monitoring

Implementation is a participatory process. Prior to release it is important to provide orientation and trainings for partners, health workers, VHTs, among others to ensure that they fully understand the materials and how to deliver them.

Implementation incudes mobilizing the dissemination of all SBCC materials following a clear dissemination plan in line with the campaign strategy, detailing clear roles and responsibilities for all stakeholders. It includes regular monitoring of service statistics, mass media ratings, materials distributed, number of people reached or trained. The results of this monitoring should be shared with key stakeholders for reflection and learning – they provide evidence from which to identify lessons learned and future opportunities, where follow-up is needed, how results may be scaled up, and allows mid-course corrections to be made.

Mobilization should take a 360° approach (figure), balancing reach and frequency. Reach builds momentum and triggers word of mouth; frequency ensures message penetration. Effective SBCC requires both reach and frequency and it is important to design a campaign that will achieve optimal reach and frequency while still staying within your budget.

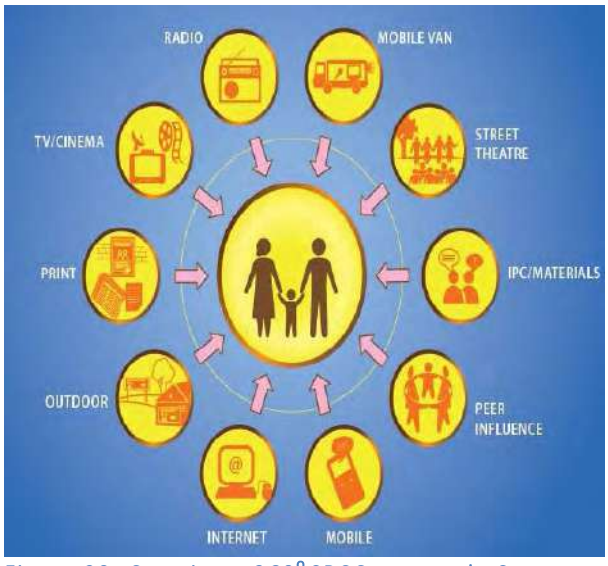


Figure 29: Creating a 360° SBCC approach. Source: Fideli, 2017

5. Evaluation & Re-planning

Periodic evaluation of the campaign allows you to determine how well your programme is achieving its objectives and to identify any unintended consequences. Outcomes may be measured and impact assessed through surveys and other evaluation techniques. Pre-post design is usually measured through baseline, midterm and end line evaluations. Experimental designs usually employ intervention-control studies. Results should again be shared with key stakeholders for reflection and learning and to identify ways in which future or next phase implementation may be improved.

Question and Answer Session for FHI360 and Fideli

*All the channels are somewhat effective – has any research been done to determine which is the **most** effective?* When you design a campaign, there are many different levels. For example, to promote toilet use: focus on the home, the wider community, health care workers and so on. Each channel is effective at different levels and work in concert. IPC gives a particular level of personal interaction and direct communication to clarify and misconceptions but it is very expensive. We need to use a variety of channels to balance reach, frequency and budget. Repetition is important – BCC is a process.

Instruction vs. call to action? Foundational analysis showed people are becoming more democratic in Uganda. If someone is sharing their story, this can challenge people to reflect on their own behaviour (… 'What about you?").

I have realised that the issue of WASH is not brought up properly – you never see posters of WASH – much greater focus on HIV. Still one year of the campaign left … perhaps greater focus could be given to WASH in the coming year? Over 70% of the budget for this campaign

is for HIV therefore it is the most visible. Hygiene is also tackled more through IPC as we find it is the most effective approach for this issue.

Has any analysis been done on the limitations of this campaign? For most of the health areas, at least 80% the people have been reached. Exceeded the expected 5% change – in some cases up to 15% change. The final analysis and results will be done at the end of the project campaign. The campaign is trying something new. For people still hiding their diseases, we need to reposition health facilities as source of information not just a centre for treatment.

This is clearly an expensive campaign. In hygiene we are dealing with very, very limited budgets. How can this type of campaign be adapted to be implemented at lower cost but still effectively? Look for small things that stick: e.g. message branded jerry cans that stay in the community. Need to balance the budget between reach, frequency and the most effective channel for your message. For example, running a TV spot costs around USD 5,000 per year - but then money also needs to be spent on designing the message. You need to work through the structures and find a balance between design of materials and budget for roll out. Also important to work together as stakeholders to pool our resources – technical and financial – for a wider reach and impact.

Campaigns can achieve results – but how can we sustain after the campaign? Have you developed any exit strategy with the government to help sustain the progress once the campaign ends? Throughout the campaign, we worked with MOH and other agencies, so the skills have been left at national and district level. People outside the health sector are copying the communication approach of these campaigns – this means that it has been effective!

How are you able to do the sequencing for BCC campaign? This is actually very difficult. For example, in our pregnancy campaign we had the same concepts on poster, TV, radio, IPC. Don't roll out the campaign until all channels are ready. In general roll it all out in a synchronised fashion – and then feed to other implementers.

You talked of working within local structures, as you exit, are these integrated into their operational plans. Issues around the veracity of data, which may lead to a focus on the wrong, or at least less pressing issues. Quality of data is a big issue. Training taking place among DHS regarding use of data for decision making; training these health service staff to look at the data and really identify where the issues are before making a decision about which actions to take.

Posters are found in many government offices, and in local drinking places, even on schoolbooks. So many posters – posted over each other, so many messages! Are we really able to measure the effectiveness of messaging through posters? When running out campaign and have oriented partners at district and down to the facility, we then decide: where should we place the posters? Where will it have the greatest impact? This discussion creates ownership among partners of the posters and the message. Aim to saturate the target area with messaging. Also refresh them periodically with new messages on same theme. In addition, we need to appeal to leaders to ensure that posters are displayed outside – not just taken home for them and their families.

Presentation of Sequencing of Behavioural Change Interventions (Nepal)

Presented by Ratan Budhathoki, Programme Leader, SSH4A, SNV Nepal.

Mr Budhathoki was invited to deliver a presentation on the *Application of evidence-based behaviour change communication in the SSH4A programme in Nepal*. The presentation was organised into two parts:

1. BCC programme development for two behaviours;
2. Applying BCC at different stages of sanitation coverage.

Part 1: BCC programme development for two behaviours; HWWS and hygienic use of toilets

The basis of the Nepal Country Team's work follows the BCC cycle:

1. Conduct research on motivating factors and barriers for a behaviour
2. Prioritize the most important factors and develop communication objectives.
3. Develop district BCC strategy identifying the audience, communication objectives and related messages and channels
4. Do a communications audit on existing materials to see which ones meet district strategy (messages) AND are effective in giving message (e.g. language, cultural context- people/dresses shown)
5. Develop new materials if needed based on messages and channels identified in strategy
6. Implement campaign using the materials developed and channels identified in strategy
7. Monitor outreach and impact

In 2014, in their earlier work in the SSH4A programme, the team in Nepal had started working with the BCC development cycle. They conducted formative research for hill and mountain areas and developed districts strategies based on the findings. However, they did not implement BCC campaigns based on the strategy; rather they used the traditional IEC materials already developed by the water supply and sanitation department to do house-to-house visits; and street drama based on known health factors. Following 2014 and up to the current campaigns, the focus has been on using BCC strategy as the basis for campaign implementation in the VDCs. Other WASH stakeholders have also adopted this campaign.

Mr Budhathoki then presented an example from the Terai Southern Belt: an area new SNV project area.

Formative research was undertaken, including consultation workshops with D-WASH-CC and fieldwork for data collection (with government participation in one district). The results were presented and verified with D-WASH-CC as part of the strategy development.

Development of communication objectives and district strategy. Based on the formative research, and in consultation with D-WASH-CC, a set of communication objectives and an implementation strategy was developed for each of the programme districts. An extract of the strategic development process from Saptari District is presented in Table 3:

Finding	Determinant	Com. Objective	Message
Lack of knowledge about the need for soap for truly clean hands Belief that soap is only needed if hands look dirty, feel greasy or smell	Ability: Knowledge Motivational: Belief	**Know/believe** that clean looking and non-smelly hands are still contaminated.	Only water is not sufficient for clean hands (free of germs) so use water and soap.
Lack of social support from mothers-in-law who criticise caretakers for using "too much" soap	Ability: social support Motivational: outcome	Family members **support** HWWS to keep children healthy	HW with soap is not "over-doing", but it is way to remain healthy and keeping children healthy. So support your daughter

Wanting to keep children healthy	expectation		and daughter-in-law for HWWS practice

Table 3: Extract of Saptari communication and district strategy. Source: Nepal SSH4A programme, 2017.

Once the strategy was developed an audit of existing BCC materials was conducted. These were found to be contextually inappropriate in terms of language, dress and the people represented. In addition, they focused only on knowledge determinants (HWWS junctures). New, more culturally appropriate tools were developed based on the communication objectives identified during the strategic design phase. These included jingles, leaflets, posters, flex charts, billboards, drama scripts, wall painting, demonstrations and a movie. All new materials were tested among the target audience and other key stakeholders before being finalized.

Campaign implementation was rigorous: it included multiple channels, using multiple tools and activities. In addition, it was synergized with other projects and programmes in the village to maximize messaging.

Part 2: BCC application at different stages of sanitation coverage

Mr Budhathoki commenced Part 2 with an overview of the sanitation status in the SSH4A programme area. At project commencement, districts and working VDCs (cluster of villages) were at different stages of sanitation coverage (**Error! Reference source not found.**). Some areas and their VDC were ODF or almost ODF. Other areas had medium sanitation coverage and some had low sanitation coverage. The programme focused largely on remote VDCs with medium and low sanitation coverage.

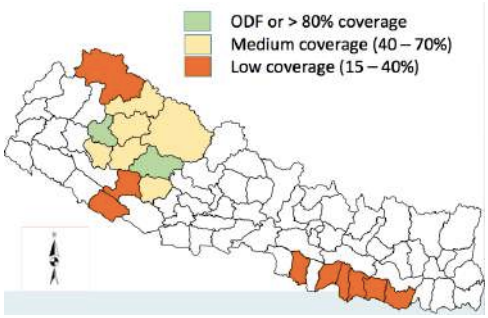


Figure 30: Sanitation coverage at programme commencement. Source: SSH4A programme. Nepal, 2017

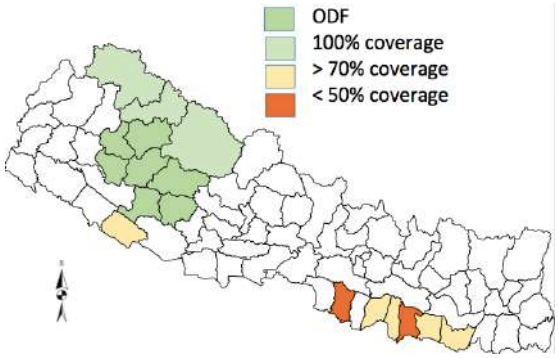


Figure 31: Sanitation coverage 2017. Source: SSH4A programme. Nepal 2017.

Following programme implementation, sanitation coverage is as shown in figure x. The green districts are either ODF or have 100% coverage but have not yet been formally declared ODF, those in yellow are on a good track while those in orange still have low sanitation coverage. As such, the team in Nepal is still working with districts and VDCs at different stages of sanitation.

How does BCC fit into the different stages of sanitation? There are different messages for VDC moving towards ODF, for those that are post-ODF and for those working towards total sanitation.

BCC to complement ODF activities These are used soon after triggering to motivate households to start using the newly constructed toilets and to wash their hands with soap after using the toilet.

BCC as post-ODF intervention These are used to focus on "use by all, at all times". They address structural issues that may prevent people from using the facilities all the time (e.g. distance to the toilet, pan levelling and position, ensuring that children can reach the hand washing facilities) and may require facility upgrading. In addition, this stage tries to identify any target sub-populations that may have been overlooked in the previous phase of the campaign, such as disabled people. In Nepal, this included "informed choice" information, providing some suggestions on how to use local materials to modify toilets to make them more accessible for people with disabilities.

BCC as part of total sanitation interventions These are designed to enable communities and individuals to achieve the six indicators of total sanitation:

1. Hygienic use of toilets;
2. Personal hygiene (including hand washing with soap);
3. Use of safe water;
4. Use of safe food;
5. Clean house & yard;
6. Sanitized community.

The first two indicators were prioritized to help the community focus during the transition to total sanitation. In addition, the campaign continued targeting "use by all, all the time", as for post-ODF areas.

The BCC messaging was delivered largely through local women's groups and also through house-to-house campaigns.

Separate from but complementary to the household campaign, SNV Nepal developed a partnership with Unilever under CSR to implement Unilever's Schools of 5 Campaign in some districts. This campaign is also based on research and motivators: disgust, nurture, affiliation, routine and habit and different tools have been used, such as glow balls, pledges, awards, and diaries.

Impact of BCC

Mr Budhathoki concluded his presentation by providing an overview of the achievements of the Nepal BCC campaign targeting increased toilet use, as well as some recommendations. Campaign outcome was measured at household level, using a progressive indicator ladder from *no toilet/toilet not in use* to *toilet is functional, clean, and provides privacy.* From baseline 2014 to mid-term assessment in 2017, the proportion of households that had function, clean toilets that provided privacy increased from 1% to 73% in the selected target area (Table 4). It was further estimated that the campaign reached 520,00 people and of those 350,00 are now practising hand washing with soap.

Level	Indicator Hygienic Use of Toilet (RBF 1 districts)	Baseline (Jul. 2014)	MTM (Dec 2016)
		%	%
0	No toilet/toilet not in use	75	14
1	Toilet is *used* as a toilet	4	2
2	Toilet is *functional*	10	10
3	Toilet is functional and *clean*	10	1
4	Toilet is functional, clean and *provides privacy*	1	73
	Total	100	100

Table 4: Impact of BCC on toilet use. Source: SSH4A programme. Nepal, 2017.

Key recommendations

- Evidence-based BCC and "rigorous" multi-channel implementation is critical for ensuring sustained adoption of behaviours
- Focus within BCC changes at different stages of community sanitation status from:
  - Emphasizing critical behaviours for community (HWWS, toilet use) (ODF)
  - Focus on behaviour for all people and address bottlenecks (post-ODF)
  - Widening scope to other behaviours important for community (total sanitation)
- Strengthen capacity of district line agency, stakeholders, and community social mobilisers on the changing needs

Resource recommendations

- Nguyen, N. K. & Gurung, H. "Barriers and facilitators to hygienic use and maintenance of latrines and hand washing with soap in Sarlahi, Mahottari, Sirah, Saptari districts of the terai, Nepal".

- SNV Behaviour Change Communication Guidelines: http://www.snv.org/public/cms/sites/default/files/explore/download/snv_behaviour_change_communication_guidelines_-_april_2016.pdf
- Mini film on two hygienic behaviours in Nepali – Swosthakar Bani Byabaha, Su-Swasthako Adhar: https://www.youtube.com/watch?v=yBnuPkON6K0
- DWSS (2016), "Options on Household Toilet Facilities for People with Disabilities and Difficulties".

Debating Game

The final activity of Day 3 of the Learning Event was an informal debate, intended as an engaging, participatory way to get all participants thinking about where the responsibility for designing BCC campaigns should lie.

Participants were randomly divided into two teams to debate the statement *BCC design is best done at central level*. There were three tightly timed rounds to the debate, with teams allotted a total of 10 minutes of presentation time each, interspersed with time to retreat to reorganise their arguments and to discuss refutes to the opposing team's arguments.

A panel of three judges assessed the arguments of each team in terms of consistency, coherence, persuasion, and refutation of the opposing team's arguments. In the end, the affirmative side was declared the winner due to their clear definition of both *BCC* and *national level*, as well as focusing on many aspects of the campaign: design, mandate, accountability, and resource availability at central level. They also, presented new arguments each round in contrast to the negative team, which tended to repeat their arguments and to focus largely on implementation rather than design.

Key arguments are summarised in Table 5, below

BCC design is best done at central level	
Arguments for the affirmative	**Arguments for the negative**
Defining BCC: Interactive process – catch communities, talk to individuals to develop tailored messages and to work out how to deliver the message effectively towards a sustainable outcome. Central authorities are in a better position to design the policy, ensure it cascades through lower level; Can ensure political acceptance and buy-in towards a more effective and sustainable campaign; Central level has holistic view and can help mobilise all actors at all levels; Cultural knowledge is known at national level; Campaign will be in line with national strategies; Can be used to inform the BCC strategy that can be done at local level – acts as a road map. BCC is very complex, trying to change people's behaviour and requires a level of expertise that is not found in the villages; It requires proper resourcing – will not have sustainability without sufficient budget. Resource allocation is best done at central level because that is where the key decision makers are;	Defining BCC: Process of determining the context, the channels the audience and the expected outcomes. Defining central level: topmost tier of any country where developmental decision are made. Most of the BCC messages are pitched to people at the grassroots, as such we need to make sure that the messages are accessible to them, this is best done with their involvement, not at a national level; Will promote sustainability as grassroots are involved in every stage from deigning to implementation; BCC needs to take cultural norms, language, political norms etc. into account; At central level, political issues that come ahead of other priorities, comes down to fulfilling political obligations, need to identify the grassroots priorities; Instructive messages from national level are not not effective, need to engender motivation: this needs to come from the grassroots; Programmes designed at central level have not resulted in change – we have this evidence. Data comes from the grassroots, so should design solutions at this level; Recognise the BCC targets grassroots, designing and

Need to work with the decision makers so that they are able to ensure that the resources are provided: government exist for the well-being of the people; Design does not mean implementation – it is laying the framework for how it should be done, what is the framework. It does not mean that the lower level are not involved during formative studies and so on; "Only a fool starts a journey without doing an assessment": Cannot begin BCC unless you understand the context – that is why you need expertise from higher levels to go down to local levels to fully understand the context; Do not confuse design and implementation – at the central level they have many priorities and are able to design a strategic plan, with complementary campaigns working in concert; Strength of a nation comes from combining resources together, to implement an effective BCC campaign; we need to pool our resources; Need to move as one nation towards changing specific behaviours. **Refutations** Which level are the negative team focusing on? Household level? Surely won't be BCC coming out of it? Do they dispute the fact that you do formative research in communities as part of the design? If that is the case, they are disputing the work that we are doing. We are all gathered here because BCC is lacking at community level. To design a package that helps to push through what you want to achieve, this should be done at national level.	disseminating takes a lot of time when it takes place at central level – at lower levels, it is a quicker, more direct process and uses fewer resources; Government has no money – relies on taxes from the local levels. Even foreign donors raise money through taxes – that is from the local level again; Cannot start designing without understanding the context – if you do not involve the people at local level you cannot fully understand the context; Understanding the need of the audience, we struggle to get BCC approved because they do not resonate with higher levels even though they test well with target audiences; "There is nothing that can be done for us without us": BCC is not a prescription that can be done in closed doors and boardrooms and pushed on to people.

Table 5: Key arguments from the debate. SNV Learning Event, Uganda 2017.

XI. Block 4: Closing the Monitoring Cycle

Overview of Block 4

Presented by Ms Antoinette Kome, Learning Event Facilitator, SNV Netherlands.

Ms Kome began here presentation by recognising that hygiene promotion tends to be expensive but without good results: there is a need to try to develop campaigns that have long term results *and* that are cost effective.

She then explored the content and outcomes of the third DGroup discussion: Institutional embedding of BCC. Key questions to guide the discussion included:

- In your context, who is responsible and/or should take the responsibility for long-term hygiene promotion?
- Should hygiene promotion campaigns be led and designed nationally or locally?
- What can be done to monitor effectiveness and ensure learning &innovation in hygiene promotion?

Responsibility for BCC

In the D-group, all contributors were of the opinion that the responsibility for long-term hygiene promotion lies with the government, but there are differences between:

- Whether it should be national or sub-national responsibility, and how responsibilities cascade down.
- Whether there is a shared or multi-stakeholder responsibility between Health, Water and Education (and sometimes Local Development) and,
- In the cases where there is a multi-stakeholder responsibility, there are differences at which level of government this integration happens.

In many countries the responsibilities have already been defined legally, though in others, it is less clear where the responsibility for (WASH related) hygiene promotion lies. Ensuring clarity on this issue is the first and most important step for institutional embedding of hygiene promotion. Other differences relate to the outreach structure of the responsible ministry, and of course the need (or not) to engage other ministries.

In many countries the Ministry of Health has a good outreach structure from national level down to village and even household level. This very useful outreach structure, however, is utilised by anyone and everyone who wants to disseminate health messaging: disease-specific messaging, curative and/preventative medicine messaging, family planning advice and so much more. Village health teams and their recipients become over burdened. For sanitation and hygiene messaging, it may be more effective to engage other structures or agents, such as local chiefs.

BCC campaigns may be rolled out through a single agency, such as the Ministry of Health, or they may be implemented through strategic partnerships with one specific implementer. Many BCC campaigns are the implemented through multi-party alliances with many actors (e.g. Health, Water, Education) working in concert, while some may become a social movement with engagement and involvement at the lower levels, as well (Figure 32).

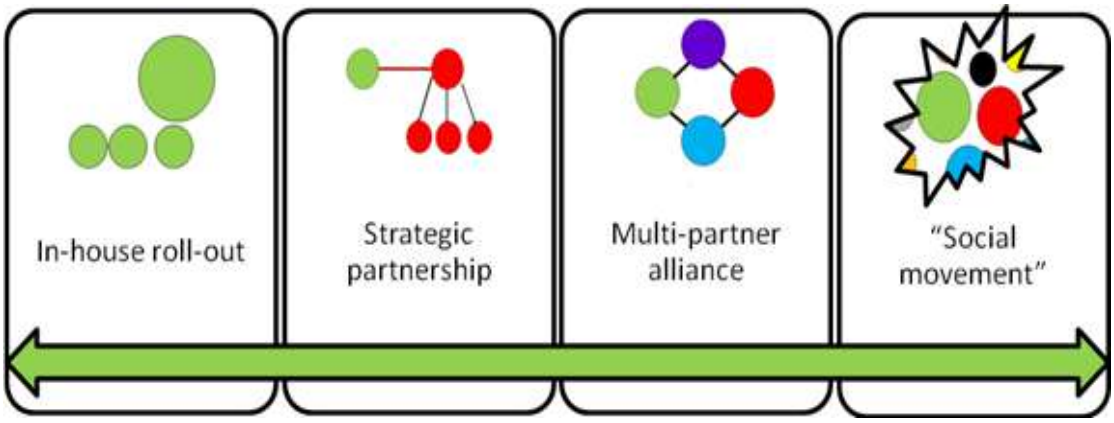


Figure 32: Institutional embedding of BCC. Figure developed from ExpandNet. SNV Netherlands 2017.

Many contributors felt that not enough attention and/or funding were given to hygiene promotion. This was an issue in Ethiopia in the past. However, the country managed to rectify this by:

- Developing a clear strategy;
- Developing a clear structure of engagement of the other ministries; and
- Upgrading of hygiene and environmental health from a team to a directorate

In countries, where the responsibility does not lie with MOH, there is often a concern that there isn't enough collaboration with MOH, and/or that the responsible ministry does not have the outreach structure or required expertise. In Zambia, for example, the leadership for hygiene promotion lies with the Ministry of Water. However, Zambia does not yet have clear national level guidance on BCC, defining who does what, in which ministry and at what level. This is still work in progress, and a communication strategy to guide advocacy and

behavioural change communication efforts in Zambia. The Ministry of Water also does not have the same established outreach structure as MOH. In Mozambique, the problem is that the MOH and Ministry of Public Works do not collaborate closely. In addition, BCC responsibility lies at the provincial level where there is limited outreach structure. As such, operationalizing hygiene promotion and institutionalising BCC capacities is still a considerable challenge.

Some feel that hygiene promotion should not be the responsibility of a single ministry, but rather a shared responsibility among ministries. Some felt it should be shared between MOH and Ministry of Education and/or the Ministry of Water Supply and Sanitation (or equivalents) in order to optimise different expertise, outreach and experience. Still others wanted to see a drive in all departments.

Nepal is a special case, due to the new constitution, which has created federal states, changing the government structure. There used to be a strong structure for sanitation and hygiene promotion in Nepal, with clear responsibilities, informed by the National Hygiene and Sanitation Master Plan (2011), as well as the Total Sanitation Action plan (2017). The responsibility lied with the Ministry of Water Supply and Sanitation (MoWS), but there are WASH committees at different levels to ensure coordination, broad buy-in and aligned action. With the Federalisation of the country, it becomes unsure where the responsibility should lie. Many contributors from Nepal feel that it should be at the municipality level, while others feel it should be with MOH, or the Ministry of Education, while still others felt it should remain with MoWS. While many expect that the responsibility will go to the local level, it is still too early to tell.

When the responsibility lies at the local level, for example provinces, regions, or states in a decentralised structure, the question is often whether they manage to prioritise hygiene promotion and allocate budget. A solution to this issue could be in the form of a budget specifically earmarked for hygiene promotion at central level, with the local level responsible for implementing the activities.

One participant explored an issue with MOH outreach structures a little deeper: he explained that in Zambia, the government is moving the "Health Volunteers" to a full-time position of "Community Health Assistants", in order to retain them. The issue remains though, that within their package of work, hygiene promotion for WASH gets limited attention, because the focus lies where they have most budget, which is not hygiene promotion. The question is then whether staying with using Community Health Assistants as key actors is the best way to go or would it be better to go with the sanitation action group (SAG), which is not so dependent on MoH.

In summary, clarity around the responsibility for hygiene promotion is essential for institutional embedding, but it also needs:

- A clear mandate and budget
- Clear national guidance
- Engagement of other sectors
- An effective outreach structure
- Making sure that at all levels (but especially the lowest) there is still time and money for hygiene promotion

Question 2: Should hygiene promotion campaigns be led and designed nationally or locally?

Figure 33: Outcomes of DGroup question: Who should lead BCC for WASH? SNV Netherlands, 2017.

When asked during the DGroup, nearly half (48%) of the contributors felt that hygiene promotion campaigns should be led and designed at national level (Figure 33). One participant from Kenya even felt that hygiene promotion campaigns could be Africa-wide, considering the common motivators of human nature. The reasons for proposing national leadership in design are quality control and resource allocation. Specifically, the overall concern is that design of hygiene promotion is complex, and that it's hard to find or build the expertise for that at local level. Some felt that the design should be essentially national but that there may be situations which require a localised design to deal with a specific issue.

About 36% of contributions, however, felt that design should be a shared responsibility between national and sub-national levels. They point to the need for a national policy and guidelines to ensure there is a level of alignment and clarity. There were suggestions for a national design, which can then be tailored to local needs, beliefs, language and images: making optimal use of national expertise and local knowledge.

A further 12% strongly felt that design should happen at the local level. There was discussion on the need for local leadership buy-in and commensurate budget allocations. The example of the success of the CLTS movement was raised, pointing to extensive social mobilisation, engaging some national expertise but essentially local.

Question 3: What can be done to monitor effectiveness, and ensure learning& innovation in hygiene promotion?

Monitoring is an extensive topic, and one that is not always fully considered during the design stage of hygiene promotion campaigns. Monitoring of hygiene behaviours among the target group (and perhaps health trends) is usually included, but when the campaign fails to generate the expected change, the causes of that failure are a black box. Is it the outreach or recall among the target group? Is it the choice of messages and motivators? Are there other barriers? For real progress on behaviours, it's becoming clear we need continuous learning and refining, no matter how brilliant the original design. Monitoring needs to be built in more strongly from the start, not as an afterthought, and with adequate resource allocation.

To operationalize better monitoring, without creating large additional costs is challenging. Some suggest integration into existing monitoring information systems. These systems, however, are not often designed to capture the qualitative information that BCC monitoring requires. Suggestions included regular participatory monitoring, development of community-based monitoring and evaluation tools, and development of joint monitoring protocols with district stakeholders to also build buy-in and capacity, as well as engaging research organisations who may bring much-needed expertise.

Ms Kome concluded this section with a short recap of the key points from previous discussions on including monitoring BCC campaigns:

- Programmes often don't measure if the *strategy* is successful: only measure the behavioural outcome (e.g. hand washing) and recall; monitoring of the communication objective should be included from the start of the campaign. If this is

not reached or if it is not the one that is most important for the behaviour then effectiveness of the whole campaign will be reduced;
- Campaign development often focuses predominantly on the design without thinking through how monitoring can be inserted into the campaign;
- Need to periodically assess the message using a clear M&E framework and well-defined indicators;
- Need benchmarks for what "reasonable" success is. What is the percentage increase that a "good" campaign can see in two years? For example, London School of Hygiene and Tropical Medicine achieved 32% coverage of hand washing in India, which was considered very good. After slippage, this dropped to 22%. Perhaps a good campaign has an increase of only 30% even if we are aiming for 80%?

She then reminded participants of the three pillars of effective BCC (the "Three Little Pigs"):

1. Did you reach the people?
2. Did your campaign manage to achieve the communication objective?
3. Was this communication objective the right barrier that led people to act?

She recommended using the seven steps of the cascade from "exposed to the message" to "acted on the message" to develop questions to investigate whether the communication objective is being achieved. In order to get a more accurate understanding of how effective the message is, Ms Kome recommended including questions that are relative to other people in same target group as people are more likely to give what they perceive as a "socially desirable" answer if asked directly and may be more truthful if asked indirectly (questions 3, 5 and 6, below):

1. Have you heard the [branded] message? (Recall)
2. What does it mean? (Understanding)
3. Do you think that your [relative linked to target group] understands what it means?
4. Do you like it? (Approval)
5. Do you think that your [relative linked to target group] likes it?
6. Do you think that your [relative linked to target group] would change his/her behaviour? (Intention to act)
7. Whether the behaviour was changed (Act).

Answering these questions will help identify how to improve the messaging if it appears that you are not seeing the outcomes you expect

Country Group Work on Information, Analysis and Action Regarding BCC

Role Play be Kenya team

This theory was then put into action through a role-play presented by the Kenya Country Team. Set in a country hospital, the play involved a health worker (HW) discussing the concept of sanitation and hygiene with several local villagers and then showing them some BCC materials. The HW showed an image on the flip chart of a woman in a field with a snake and a man nearby and asked the villagers what they saw. The villagers recognised it as a woman defecating in a field. They saw the danger of the snake nearby, noting that snake medicine is very expensive and not always available. One villager told a tale of an older woman in the village who had recently died from snakebite. Another villager felt that the man in the picture might be peeping at the woman as she defecates and that this would cause shame and embarrassment both to the woman and to the male members of her family if they found out. They also noted that for men to be observed defecating would make them lose dignity and respect – they would not then be taken seriously in leadership positions.

The villagers noted that they could see village houses in the picture but no latrine. They clearly saw the connection between the dangers presented by the snake and/or the man and the safety of having a latrine.

The HW also reiterated the issue of sanitation: OD allows flies to carry faeces to food and into water sources. He then asked the villages what key messages they had taken from the discussion (OD is dangerous, especially at night due to snakes and other animals and the risk of rape; OD makes people lose dignity and respect) and asked if the discussion would make them change their behaviour. At the time, all villagers said, yes, they would construct a latrine near their house.

The next scene took place a month later at the same country hospital with the same villagers but with an interviewer who had come to assess the achievement towards the *communication objective* of the previous discussion. He first asked some general questions about the clinic and their satisfaction with the care they were receiving. He then asked if they had heard any talks about sanitation recently (exposure, recall). All villagers answered that they had and that they recalled the key messages about the benefits of having a latrine as well as the slogan. He then asked them what they thought the message was saying to them (meaning). They responded that is was important for them as a community to have a latrine and to use a hand washing facility.

He asked if they saw the pictures and if they remembered the discussion. When the villagers answered affirmatively, he asked if they approved of or agreed with the message (approval). They all responded that of course they agreed with the message – it would prevent deaths in the community, which was definitely a good thing. The interviewer then asked if others in the community would approve of the message. The villagers responded that most of the younger people would understand it and agree but perhaps older men, who have been doing OD for many, many years with no obvious issues, might not see the benefits so clearly. However, if the older men saw the picture and related the woman in the picture to their wife, this might scare them into changing their behaviour.

Following the role-play, the other participants were asked to provide feedback and questions:

Feedback One person noted that the message had been received but that there was no time-bound decision to act (i.e. to build the latrine) so there was less motivation to act in a timely manner.

Feedback Another person questioned the reason to have a different person doing the follow up. In response Ms Kome noted the difference between follow-up messaging and monitoring if the message was received and works. For example, the villagers may now understand the need to build a latrine but have not yet because they don't know how.

Each member of the target audience is in a different stage, how can we know what proportion is getting stuck at each stage? This is qualitative research so it is not necessary to do a statistically significant survey for each step. It is likely that there will be a very obvious pain-point. We want to identify this and then work out how to address it.

Any behaviour has its own duration, frequency, and purpose. Following this exercise, will people make this a habit? Or will they revert to previous behaviour? Forming a habit is the next step!

In Uganda we ran a campaign on the radio; six stations. We started to ask people if they recalled the message. In a community of 100 people, less than 10% remembered – this was very deflating! But can people not remember the message but still somehow act? They do not remember the motivator but are still prompted to act? What do we remember?

- Something when it is new;

- When it is branded;
- Visuals, especially linked visuals and messages.
- We only remember a few things at a time: this is the real trick. If you mention all messages at the same time people will not remember all and may in fact not remember any. This is why *sequencing* of messaging is so important.

The Country Teams were then invited to work together to identify simple things that could be done in their respective countries to monitor and check the effectiveness of their BCC strategies.

> *"The most effective campaign is the one that keeps learning, that moves towards continual improvement."*
>
> Antoinette Kome, SNV Learning Event Uganda 2017

Tanzania

We are currently running two campaigns, both of which work on triggering emotions. We would like to embed this monitoring so that instead of waiting to watch and see if the outcomes change. We need to be more proactive: We are moving into some new and more challenging communities in terms of cultural differences. Need to do follow up to make sure that the triggers that we develop are in fact effective in these communities.

Kenya

We have CLTS happening in the community, and have also been discussing M&E and have been developing questions. These discussions today are very helpful for us to adapt what we already have to better monitor our messaging and how effective it is.

To date we have left men out, and we are learning that we really need to involve men – they still seem to see that hand washing and other sanitation activities are just for women.

Uganda

We have clearly defined communication objectives, but we still have some work to do. Our key issue was to target men but we have done nothing about it. In addition, we see that everyone recalls the message but they do not necessarily act. We need to investigate *why* they are not acting.

Ghana

Looking at CLTS, we have covered the entire district where we work. Acceptance level is very high: over 80% latrine coverage. Hand washing is still lacking. We have put in the groundwork and have provided the education. The communities began following the practices then have abandoned it. The tippy-taps often get destroyed by animals and so on. Some people fix them but if they are destroyed regularly, people get tired and don't want to keep replacing them. How do we build them to a standard that animals cannot destroy them? This is one of our current discussions.

Ms Kome If there is a real practical challenge, is that just "our" problem (extension workers). No, we see that for solving local problems, local people come up with good and creative solutions. It is very important to involve local people and not to assume the responsibility for solving these types of practical issues.

Rwanda

We have not yet started BCC so are working out how to apply this tool to our existing M&E framework. Already have M&E going from district level down to sub-village level including monthly M&E visits where we report back to health centre level.

Once we start BCC, we will see results in terms of increased number of latrines and tippy-taps. If numbers are not as expected, this tool could be used to provide more qualitative research on how to improve the messaging.

Ethiopia

Overall, there has been good progress and improvements. OD has reduced. More than 80 percent of households have HW stations in project area but knowledge about HW before preparing food and before eating has not changed much since baseline.

There is a good government structure from federal to HH level, with all HH interconnected. We are using the existing structure to strengthen the messaging coverage. This is a challenge but is important for sustainability. We are planning to train and equip all the schools using this structure.

However, we are still challenged by of water to sustain HW stations and other sanitation activities. Water very scarce: in some places we need to drill up to 300m to reach the water table.

Ms Kome Should we only start talking about HW when people have water?

Ethiopia Country Team No, we still need to take some water for HW but it is of course challenging. We have managed to raise the priority of HW

Ms Kome The problem sometime is that the officers that are linked to HW and sanitation are also linked to those that are responsible for water supply – so maybe communities use this as a reason to try to accelerate water supply. Even if we put all the money from hygiene into water supply, however, it would still go slowly. Nonetheless, hygiene is very important especially after defecation and before eating, and still needs to be prioritised.

Ethiopia Country Team If the mind-set of the community is changed, even in the scarcity of water, people will set some water aside to wash hands.

Mozambique

Using baseline and mid-term (MT) surveys we found that at two critical points for hand washing –before breast-feeding and before eating – uptake was very low, even through the same MT showed that *knowledge* of the importance of HW before eating was very high. As such, our campaign focused on these two areas. Our message was originally *Hand washing is the cheapest vaccine to prevent malaria*. This did not really resonate, however as people understand vaccine as only injection or pill.

Water for drinking is brought from far away, which is a challenge, but we still need to still identify what other barriers are preventing people from washing their hands. We thought it was knowledge but MT does not show this. Need to qualify our message. We have M&E templates where hygiene promoters collect information but only for the MT reviews. Tend to focus on increasing outreach, rather than reflecting back on what is working and what is not.

Ms Kome made big progress at the second mid-term but by the third mid-term people had lost the soap. Why did they do this? That is the question.

Nepal

We knew already that many people know to wash their hands after defecation and the need to focus on the critical moments of before preparing food and before eating. Try to reach school children and then to trigger the mother (showed germs on the hands). We discovered that children are very motivated by idea of germs climbing over your hand so we created BCC especially for children. Among mothers, we originally promoted the six stages of hand washing but it was confusing. So we changed the message to “miti miti”: don’t forget your nails, palms, etc. It was easier for people to understand and remember.

In the baseline survey, only 10 percent of households had HW stations. We had target of 250,000 people reached and 75,000 HW station; we reached nearly double.

Our BCC strategy is different for different regions. In poor HH fewer people were getting the message. Radio station outreach was only reaching richer people, so we moved to using the village PA systems to spread the message. In addition, we used champions to extend outreach to the poor, focusing in particular on mother and caretakers. We gradually introduced improvements into our campaign.

Ms Kome Continuously adjusting. It is the only way to really make progress. It doesn't matter how beautiful your campaign is, if it is not continually adjusted, it will lose efficacy over time.

Zambia

We followed all the stages of developing a BCC campaign. Our target groups were breastfeeding mothers and children. When we measured during the second MT our reach was very high. We predominantly used village PA systems to deliver our messages. At baseline, no HH had hand-washing stations. During the second midterm, some 12 percent had them but by the third mid-term, this dropped to 5 percent.

We identified that a key barrier was that animals destroyed the tippy-taps. When we make one for demonstration, it is not so strong. People then think, however, that this is how it should be made. So how do we make them stronger? During M&E visits, we need to check that tippy-taps are strong.

If a community prioritises HW, they will use water. Some communities think that the water from the well is ok for washing body but not for washing hands. We also need to link ODF triggering with HW triggering: This is a government directive. When this is being monitored we do not see why this is not happening – perhaps the message is not being well understood.

Ms Kome What can we do to help you take time for this type for reflection and then to make improvements? Sometimes not historic memory – old reports are not revisited with fresh eyes. How can PMU help you to build in this type of reflection and learning into your programmes? We also need to think very carefully about how demonstrations will be interpreted.

World Café

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. The briefs and advice offered are summarised in Table 6:

Ethiopia
Brief 1 SSH4A results programme has been implemented in Ethiopia. Formative research, BCC strategy, messages and channels were produced and implemented. There is good achievement so far. However, in the process of implementation, we have realized to make our BCC strategy designing more effective. What do you advise us to consider in revising our strategy, message and channels to make more effective?
Response 1 Use religious leaders who are best positioned to influence their followers and/or older and

influential people and more trusted people; Develop a creative brief clearly stating what the country would wants to achieve; Message theme “we have a toilet, we have pride in it.” Use novel channels e.g. wall painting; Use of upgraded technology e.g. LCD projectors; Embed monitoring and learning mechanism; Review and check whether the barriers identified by the formative research are removed or not; Redesign the BCC strategy informed from feedback from the field.
Brief 2 What do you advise us how to monitor and measure outreach figures reached through radio and posters?
Response 2 *For radio* Buy a very good radio brand and form listeners’ group. Audience mapping; Use prime times; Use selected radio station with “listeners’ tracker” with a reference; Move radio stations to more close to community; *For posters* Include questions like “have you ever seen this poster?” (showing it during interviewing) into monitoring surveys. Arrange FGDs and ask the participants to tell whether they have seen the poster or not. Keep a person to count near a poster to tally whenever somebody sees it or install CC camera in places where posters are placed
Ghana
Brief 1 How can we improve BCC on hand washing with soap?
Response 1 Assess the efficiency of the existing strategies Develop your new strategy in accordance with what was existing Make strategy more participatory: "if I see I forget but if I do I remember"
Brief 2 What can we do to improve and sustain latrine construction and usage?
Response 2 Educate communities on dangers of open defecation with relevant indigenous examples Constantly visit homes and individuals to keep reminding them.
Brief 3 What ways can hygiene education be delivered effectively to promote sustainability?
Response 3 Depending on the identified interest of the audience you may use songs, story telling, drama,

video shows, poetry and posters to propagate your message. As you sensitize, you entertain as well to keep them attentive.

Kenya
Brief 1 Do we need to reach everyone in the project area for BCC to upscale?
Response 1 You should reach everyone, or at least 80% of your target population Start small, learn and upscale progressively Align to government plans
Brief 2 Do you have any suggestions on basic technologies to replace and upgrade leaky tins and tippy-taps?
Response 2 Encourage the community to invent options or simple technologies that can overcome the limitations. You could organise a competition or pledge a reward for the best innovators. Conduct supply chain assessment and explore more
Brief 3 how often should you monitor and track if the communication objective is being realised?
Response 3 This should be determined at the planning stage Should be as frequent as possible Should be continuously integrated with BCC activities
Mozambique
Brief 1 Who should be responsible for funding BCC?
Response 1 Social-corporate responsibility Clients Iovitel Vodacom Mcel
Brief 2 How to mobilise multi-secotral coordination to promote hygiene?
Response 2 Strengthen or establish district-level sanitation committee or platform
Brief 3 How to maximise the capacity of the actors and make them more accountable for the new behaviour?
Response 3 Households: to practice new behaviour Local leaders: resource and community mobilization
Brief 4 Monitoring and reporting for decision-making?

Response 3 Analyse the monitoring outcomes and share at different levels.
Nepal
Brief 1 Sanitation coverage is 92%; target is 100% by end 2017. Have to reach the target + BCC needs to be scaled up – how can these two goals be achieved?
Response 1 Focus more on BCC than sanitation coverage because sanitation coverage is already very high Sustainability measures to be put in place for good sanitation coverage Focus on more activities in BCC: intensify Allocate more resources for BCC
Brief 2 Nepal government has 5 +1 indicators, but SNV focuses on two only. So should we align with government or just focus on the two indicators?
Response 2 Every activity needs to be aligned with the government. First conduct quantitative & qualitative formative research to know community priority behaviour and motivator. Once you have the findings, then you can prioritise the most critical indicators. SNV should give the TOR including objective to the consultant. Consultant will do formative research. Results will be reviewed and validated by the government. Key indicators will be identified. Develop appropriate message and the message should be tested and presented in front of all actors. Design effective communication channels. Implementation should be aligned in terms of both government and NGO
Brief 3 There are different ecological regions in Nepal that are very diverse in terms of culture, language, geography and so on. Should BCC be designed locally or centrally?
Response 3 Overall mandate should be done at national level but with information from unique regions. Diversity in country should be explored through formative research, Framework at national level, choice is local: Province will generalise what they need from the national framework with specific BCC materials designed at local level.
Tanzania
Brief 1 How shall we sustain hand washing with soap campaigns in the country given that the population has high uptake but is now dropping
Response 1 Align what people do but also understanding the factors, beliefs and attitudes of people. Have to understand how far the BCC will be – cheap and long lasting Conduct formative research, craft the messages identify monitoring mechanism in line with the ability and willingness to act on that. Promote other containers rather than just tippy-taps Identify motivators
Brief 2 We hope to have leadership buy-in for the plan to conduct the frequent monitoring

exercises and to engage schools at the local level government. How should we improve the leadership buy in for HWWS?

Response 2

Design a mechanism so that they are involved right form the beginning and engage them

Conduct stakeholder analysis to determine who will be most influential

Brief 3 How effective can the channel for HWWS be?

Response 3

Know the target audience, understand the motivators, identify the channels – radio, IPC, gatherings, coffee gatherings etc.

Use formative research to make informed main choices.

Uganda

Brief 1 Should BCC campaigns be central/private or at district level?

Response 1

You should come up with the segmentation of the languages spoken in the four cluster regions: central Uganda which will use Luganda, the north to use Luo, the south western to use Runyanakitara and the eastern region should use Lusoga and Ateso

To constitute a multi- discipline committee with representatives from the Ministries of Health and Water, Sanitation and Environment, local government, gender specialists and community development specialists to work with the consultant to develop the message.

To use the health data from the Ministries of Health and Water, Sanitation and Environment to guide the design of the BCC message

To identify major radio and TV stations in the four regions to disseminate the BCC messages

Work with the local government (districts) in the four regions to contextualise the BCC messages

Zambia

Brief 1 *Issue* : we feel that we have followed the BCC process (BL identified HW is lacking: 0%). This was prioritised and formative research conducted to understand why people weren't washing their hands. Key issues identified were: lack of knowledge, and scarcity of water. We identified m*otivators*: people want to wash to get respect, to feel comfortable, to fit in, to attract female partners. We were also able to define target audiences.

We then developed a BCC strategic plan at district level. From there each district developed clear messages/motivators/determinate/communication objective

Messages were tested Ulusonga – rejected by the community because they said it did not communicate anything. This was then adapted to the "Clean Hands" campaign, targeting HW at 5 critical times.

Training was rolled out to the ward-level champions, environmental health technicians, hygiene promoters and so on. Then the campaign itself was rolled out through many different channels: Radio, live phone in, recorded, jingles. IPC through champions, large gatherings, small gathering, posters, leaflets.

Question: at the time of campaign, all households put in facilities but three months later many no longer had them. How do we make facilities sustainable?

Response from 3 teams
Go back to household and find out why they are relapsing. Is it behavioural issue or technical issue?
BCC is a process: people don't want to change at the same time. Some seeds fall on the road and are lost, some fall in the bad soil and grow weakly but some will land in the good soil and flourish.
Explore some ways to recognise villages that are doing well.
Extend visits for key leaders.
Enforcement of by-laws.
Reorganising the communication objective.
Go back to the village and talk to those that are doing well and ask why, also for those that are not doing well.
Look for durable HW facility – through community competition.
Also need to be realistic re: expected gains; do comparison study in a chiefdom that is doing well (e.g. Chuungu) and other areas.
Do regular follow up.
Issues of familiarity – if champion is very well known people may actually not listen to them. Consider exchange visit between villages in target districts.

Table 6: Outcomes of the World Café. SNV Learning Event, Uganda 2017.

Shopping Bags

An important objective of the learning event is for participants to take home a 'shopping bag' full of new 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 World Café session.

The shopping bags from each country as well as for the SSH4A PMU are presented in Table 7, below:

Country Team	Content
Ethiopia	Check steps to monitor BCC implementation Recall, understand approve, intention to act, able to act, act, habit National hand washing initiative (Uganda) Creative brief using specialise agency to guide the development of SBCC materials Use of community radio for BCC messaging
Ghana	Formative research should be conducted before implementing any BCC activities

	Inclusion of political leadership at local level in BCC implementation Integration is key to sustainability Incorporating indigenous people to support the dissemination of BCC messaging
Kenya	We will use the framework provided to develop tools for monitoring the communicative objective Strengthen involvement of the Ministry of the Interior
Mozambique	Shared financial responsibility for BCC: social corporate responsibility Establish or strengthen sanitation committee or platform Improve accountability for householders and local leaders Share the monitoring and evaluation at different levels to provide data for informed decision making
Nepal	Review the BCC strategy and revise the message focusing on target audiences Strengthen collaboration with the health sector for SBCC implementation Improve the monitoring process Explore the opportunity and lobby for nationwide SBCC campaign to contribute to total sanitation
SNV PMU	Technical support for utilization of available data Sharing tools and systems for monitoring BCC
Rwanda	In the process of designing BCC strategies Audience segmentation Sequencing of messaging Routine monitoring of communication objective Taking into account coaching and mentorship Hand washing ambassadors approach Always test BCC materials before use Engage creative agencies in designing BCC materials and messaging Have a view towards sustainability at the end of the project
Tanzania	Embedding monitoring tool in our BCC film and emos demos campaign Undertaking assessment using the monitoring tools focused on three groups Group 1: Heard the message but don't practice any more Group 2: Heard the message but never practiced Group 3: Heard the message and practice HW but don't use soap Inform ministerial level of the efforts undertaken by SNV on BCC

	campaigns.
Uganda	Self monitoring/peer monitoring Periodic review of messages Address knowledge barriers first Install a feedback mechanism Contextualising BCC at district, sub-district and grassroots levels
Zambia	HWWS facility: Protection of soap from domestic animals and rain Use of the tool to test the "three little pigs" questions to see if the communication objective is being achieved Usage of one pit latrine with two stances Clustering of households and using them as agents of change Need to embed BCC activities into routine programme activities Need to improve monitoring of BCC at district and sub-district level

Table 7: Country Team "Shopping Bags". SNV Learning Event, Uganda 2017.

Ms Kome, the learning event facilitator also developed her own shopping bag of her observations of each of the Country Teams (Table 8):

Ethiopia	Believe they are the capital of Africa
Kenya	Have been told they are the London of Africa … and they believe it
Uganda	Calm, no hurry, enjoy their food immensely!
Ghana	Very expressive, very African, generous
Tanzania	Refused to speak Swahili
Nepal	Very polite
Rwanda	Too quiet!
Zambia	
Mozambique	

Table 8: Ms. Kome's "Shopping Bag". SNV Learning Event, Uganda 2017.

Closing of the Learning Event

Presented by The Honourable Margaret Kihika, Vice Chairperson of Kabarole District, Western Region, Uganda

The Learning Event was officially closed by the Honourable Margaret Kihika, Vice Chairperson of Kabarole District. She brought apologies from the Honourable Chairperson of Kabarole District who was unable to attend and provided the following summation of the event:

In the field , everyone has seen the reality of BCC in the region. In most cases, people have heard the message, but most are still reluctant to practice some of those behaviours. Over the past few days you have all learned some new strategies on how to catch their attention.

Continuously move forward and cooperate will different sectors. Is it still a big challenge: people are moving forward but reluctant, especially when it comes to using soap. They are, however, becoming aware that it is very important that they should wash hands with soap and this message must continue to be spread to the communities.

Ms Kihika gave sincere thanks to SNV and the Government of the Netherland for their continued support, especially in many countries of Africa. She noted that SNV's efforts had earned great respect expressed her hope that SNV would continue to support Uganda and other nations.

She then appealed to the officials who were present to try to put into practice the strategies they had discussed with their friends and colleagues. She noted that all had learned something from each country's presentation and that this knowledge can be used to help efforts to fight sanitation diseases, and emphasised the need to come up with BCC strategies that attract the attention of communities, so that they can move towards behaviour change.

Ms Kihika also expressed how impressed she had been by all the different strategies of facilitation evident throughout the event. She thanked Ms Kome greatly for all her hard work and organisation and noted that Ms Kome's facilitation had been both enjoyable and helped everyone to learn.

In conclusion, Ms Kihika asked all delegates to please convey the greeting of the Kabarole and Uganda people to their people and then pronounced the workshop officially closed.

Annex 1: Participants

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Annex 2: DGroup Summaries

Making the invisible, visible in BCC

Increasing effective implementation of behavioural change communication in rural sanitation and hygiene

Contents

Introduction

This is the summary of an email discussion held on the WASH Dgroups platform from the 24th of August till the 13th of September 2017. A total of 109 contributions from 12 countries: Nepal, Cambodia, Ghana, Kenya, Laos, Zambia, Mozambique, Uganda, Ethiopia, Bhutan, Tanzania and Rwanda, were written over the course of the discussion. The discussion aims to bring together examples and perspectives of practitioners from the field with perspectives from people working at international level. It also aims to reflect together on new ideas and best practices in sanitation and hygiene. It is not intended as a conclusive document on the subject.
The discussions are linked to the learning component of the Sustainable Sanitation and Hygiene for All programme, and form an input for the SSH4A learning event "Making the invisible, visible" in Fort Portal, Uganda, from 18th till 21st of September 2017.

Topic 1: Challenges in effective implementation of hygiene behavioural change communication (BCC) in rural sanitation and hygiene programmes

The importance (not) given to hygiene promotion

One of the most difficult issues is the lack of importance given to hygiene promotion across the board, meaning by officials, politicians, communities and even sometimes by the promoters themselves. Many of you point to this issue. As Ratan Budhathoki from Nepal says, in rural areas more importance is given to physical infrastructure, visible things like tap stands, pipelines, reservoir tanks, and less importance to knowledge or information about hygiene. The newly elected officials in Nepal have requested to "provide a truck for the disposal of solid waste instead of all this information" (Tika Ram Khadka). Also Alabira Osman from Ghana explains, tangible things score political points and help politicians to win the elections; intangible, invisible things like hygiene do not. As many of you point out, when there is no support given to the messages and work by politicians, it is much harder to mobilise and motivate communities, and much harder to keep hygiene promoters motivated as well. Furthermore, Befekadu Kassahun from Mozambique says, hygiene promotion being invisible, leads people to conclude that it should be cheap or zero cost. When infrastructure is half built, everybody can see it, when hygiene promotion isn't done properly or doesn't lead to results, it's much harder to observe. This also makes it easier to cut budget or plan for limited hygiene promotion budget; the consequences are not readily observed…

In addition to politicians and officials, communities also tend to consider that BCC activities not to tackle their direct and most important needs (Moses Fred Ogwal from Uganda), not in the least because their needs are pressing and diverse. Many of you point out that with a lack of water supply close to the home, hand washing with soap will not be successful (Raju Shrestha and Ram Prakash Singh from Nepal, Amos Kanuu from Kenya, Getachew Belaineh from Ethiopia, Warren Simangolwa from Zambia). Such practical barriers need to be addressed. Befekadu and Moses go a step further and make a case for catering for broader basic needs and economic development in a more integrated way, and then integrate hygiene promotion in aspects of life. The question is whether in such a broad integrated programme, hygiene promotion would get the required attention, or be lost among the multiple messages. This is not to question the existence of real needs of communities, but rather whether it can be addressed simultaneously. Thinley Dorji from Laos explains that the challenges of programmes with too broad objectives, and how the same beneficiaries (and project staff) are bombarded with multiple interventions, multiple messages, and so on. Amos, Raju and Warren also point to the downside of multiple messages. Thinley Dem from Bhutan explains that governments often prefer multiple messages, as they see it as cheaper. This is the thinking of "2 for the price of 1" (the latter are my words).

The overall consensus is that hardly anybody gives sufficient priority to hygiene promotion, and that this lack of importance and visibility of results, affects the quality of hygiene promotion directly. Not in the least because hygiene promotion is a gradual long term process as explained by Sushma Kafle from Nepal and many other contributions. There is a consensus that more attention should be given to build political buy-in and engagement of officials with hygiene campaigns, which will influence the importance given by communities and by hygiene promoters themselves.

The capacity of the front line hygiene promoters

In different countries, different words are used for the front line hygiene promoters. While Lilian Nabasirye from Uganda speaks about front line promoters, Alabira from Ghana speaks about field facilitators, Meseret Kebede from Ethiopia mentions change agents and in Zambia, Kedrick Makukula talks about hygiene promoters and community champions. There is a general consensus that we need hygiene promoters who are trained, experienced and motivated as stated by Brian Andaje from Kenya. Ratan further adds that they need to be trustworthy, and Mary Namusoke from Uganda emphasizes that they need to have the right attitude.

The problem is that with low budgets and low status, we attract people with low-level training, low pay and put very high expectation in terms of working hours and remoteness (Befekadu). Moreover in Zambia, front line hygiene promoters are volunteers who, aside from a desire to contribute to community, also have aspirations to earn money and grow professionally. In Kenya, says Hilda Muteshi, there is an overreliance on government staff to do this work, who also have many other responsibilities. This staff is then not always in the best position to ensure quality of hygiene promotion.

Sanna-Leena Rautanen from Nepal adds the very high turnover of government staff responsible for hygiene promotion. She feels as if they are continuously training people who tend go on to higher paid (?) jobs. The staff is young and motivated, but inexperienced, and looks at hygiene promotion activities like a check box: doing the activities but not reflecting enough about the results. Sanne's programme tries to motivate a greater result-orientation of hygiene promotion staff by engaging them directly in monitoring. Result-orientation in hygiene promotion is very important, but also important is a realistic understanding of the difficulties in hygiene promotion. Solomon Mbewe from Zambia shares how hygiene promoters get disillusioned because they do not see results fast. Similarly, Grace Uwizeye from Rwanda tells how hygiene promoters are eager to see quick results, while communities require time to change. Part of this challenge arises from the fact that many come from a CLTS background says Maurine Simiyu from Kenya. CLTS and hygiene promotion is not the same. Some hygiene promoters end up taking short cuts says Bunleng Tan from Cambodia. In Ethiopia, hygiene is integrated in CLTS in CLTS-H, but this is not always very clear in training for staff (Osman Yiha from Ethiopia).

When hygiene promoters are unconvinced themselves about the importance of hygiene promotion (Sushma Kafle) or disillusioned by the lack of (visible) results (Krishna GC from Nepal) or have difficulty to understand or practice the approach (Warren), there is no longer a consistent implementation of the intention and many slip back into enforcement of behaviour (Mary), or too much fear, shame, embarrassment without any aspirational message (Warren). There is a need for aspirational messages, and also, says Ambika Yadav from Nepal, for messages that link closer to the communication style of the receiving side.

While in theory it seems better for people from the same ethnic group to speak to their own group, Godfred Yelewere from Ghana shares that it is not always easy for hygiene promoters to work with people from their same tribe. They may not be taken as serious as outsiders. At the same time, language barriers are a huge issue, which everybody mentions. Rita Ambadire from Ghana explains that there are more than 10 languages in her programme area, Bessy Odame-Boafo from Ghana also mentions language as one of the key barriers in implementation, but clearly this is not limited to Ghana. Colleagues from Kenya, Uganda, Ethiopia all mention language. Aside from language, there is

the cultural diversity Gilda Uaciquete from Mozambique explains. This means that both languages and messages should be tailored to the needs of different groups, which is demanding on hygiene promoters, who are not always strong enough to develop this creatively and effectively (Charles Ooko Onyango from Kenya).

Last but not least, I asked you for the most challenging aspects, and you shared those challenges, which is good for all of us to learn. However, it should not go without mentioning that there are also many high quality, strongly motivated hygiene promoters, who are willing to commit for long term processes and delivering great results.

Design issues affecting the quality of hygiene promotion

With so many challenges to find the right hygiene promoters on the ground and keep them motivated, it would be tempting to work with mass media for hygiene promotion. Yet that is a mistake say Krishna GC and Wycliff Omondi from Kenya. With all this one-way communication (road shows, radio's, posters and so on), it's very hard to see whether it's effective. It's important to use smaller groups, or a combination of channels as Grace says. Lilian further points to the importance of using a combination of channels, in a coherent way, which also use good sequencing, frequency and an appropriate level of repetition. Unfortunately, Thinley Dorji says, it's too often a one-off activity. How can we expect to see results from that?

Another important message around the target groups, which has been raised by several contributions, is that most hygiene promotion has been prepared for the able mainstream audience. People living with disability are not visible as an audience, not other special needs groups. Getachew states that it's unlikely that one message will resonate equally with all groups, "one size of shoe will never fit all", and we need to conduct proper audience segmentation accepting that good hygiene promotion needs time and effort. However, Dennis Lakwo Odong from Uganda shares that audience segmentation in practice is often very hard. In his experience, hygiene promotion has to be persistent, consistent and normally delivered through all relevant channels like women groups, youth groups, religious institutions, and other social institutions / events.

In general, it is hard to motivate communities to attend hygiene promotion events, they don't feel it is important and there is a certain apathy towards it says Jackson Wandera from Tanzania. Chiranjibi Koirala from Nepal states it's important to target messages to women specifically, due to their role in hygiene in the household says. Warren mentions that it's very important to reach men as well, considering their position in households, and the need for them to support hygiene changes. While this may lead to the conclusion that meetings should include both men and women, that will not be effective in all cultural context, as Vinod Kumar Sharma from Nepal explained. Aside from participation of men and women, it's also a practical challenge, Jackson points to the women's busy schedule in his context, while men, are hardly at home when free.

There is no one size fits all for design of hygiene promotion, but as Thinley Dem shared, not all partners see the importance of formative research. Every context has their own specific needs, Kamal Prasad Tharu from Nepal gives a clear example of how "cleanliness" is understood differently by communities, and that this requires very specific, to the point, hygiene promotion to change that perception. Similarly, in Ethiopia, Meseret explains how some people misquote a religious text affecting their hand washing behaviour. Specific targeted promotion in collaboration with religious leaders would be required. Several of you mention formative research as a key step, as well as good monitoring and closing the learning loop. Rita, Bunleng, among many, suggests annual revisiting of the BCC strategy, and good follow-ups.

Summary Topic 2: Design assumptions in behavioural change communication (BCC) in rural sanitation and hygiene programmes

Understanding of the logic for design of behavioural change interventions

Behavioural change communication is about convincing people, and for that, we need the right messages. When we are in a one-on-one conversation with our friends of family, we may find those messages intuitively, but to reach a large population, it needs a design logic.
A common logic for the design of behavioural change interventions is:

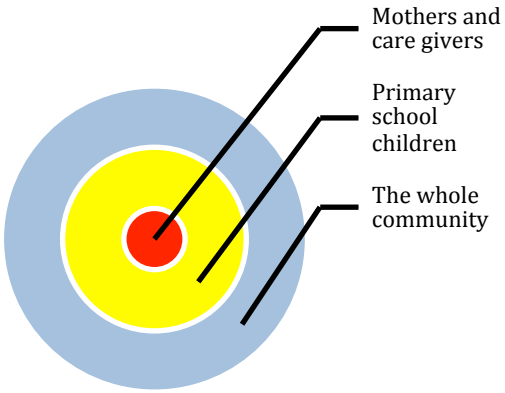
In the discussion questions for this block, we asked you to share about the 4 of those elements:

- Target group and focus behaviour
- Motivators
- Message
- Channels (materials, media etc.)

We also asked which evidence (information) you use to decide all of those things. I will try to summarise your contributions below.

Target group and focus behaviour

About 66 percent of contributions referred to a specified target groups, whereas the others talked about communities in general, “rural households”, “general population” or “everybody”. A number of contributors distinguished between a core target group, a secondary target group and then the wider community, for example Maurine Simuyu from Kenya explained it a bit like this:



Others, like Krishna Hari from Nepal, Befekadu Kassahun from Mozambique, Lillian Nabasirye from Uganda, Thinley Dem from Bhutan and Meseret Kebede from Ethiopia, seemed to have similar thinking around primary, secondary target groups and the wider community.

For the vast majority of contributors, women, women with children under five, and caregivers (mostly women) are the key target population, in fact only eight contributions mention fathers or men explicitly as one of their target groups. Henry Kakooza explains the importance of influencing fathers in the Ugandan context, because of their greater control over resources in the household. Also, Hilda Muthesi mentions that in the campaign in Kenya, specific messages have been developed for men. Sanna-Leena Rautanen from Nepal argues for thinking very carefully about the core target groups. In their analysis, they found out that there are groups which they seem to miss, such as elderly, specific ethnic or religious groups and migrants.

Of course, the choice of target groups depends on the focus behaviour, but sometimes we need to look closer at the social context in which people live. For example, mothers of children under five in Nepal often live in with their parents in law. Krishna Hari explains that mothers-in-law believe that using soap is frivolous and a waste of money. Hence, they will criticise soap use by their daughter-in-law. Therefore, programme has specific hand washing messages directed at the mothers-in-law to convince them it is not a luxury. In Ethiopia, the government officials and health development army have a strong influence; hence Getachew Belaineh, Dejene Kumela and Osman Yiha include these in their target group.

In terms of target behaviours, I have analysed the contributions by country:

- HWWS at all critical moments
- HWWS after defecation
- HWWS before eating
- HWWS before food prep
- HWWS after cleaning a child
- Drinking save water
- Toilet construction
- Toilet use
- Toilet use for people living with disabilities
- Toilet cleaning
- Menstrual hygiene management

All countries work on hand washing with soap at critical moments, but some have a special focus on a particular critical moment, which was considered weak. Most countries also work on toilet behaviours. The focus depends on the level of progress, for example Mary Namusoke from Uganda talks mainly about reducing open defecation and constructing a latrine, whereas in the context of Nepal, the focus lies on hygienic use and maintenance, shared among others by Chiranjibi Koirala, Kailash Sharma and Vinod Sharma, resulting in a "Clean Latrine Family Plan". In Cambodia and Ethiopia, safe drinking water handling at the household is a key behaviour to address. As mentioned, the choice of focus behaviours would depend on the importance and the risks involved.

Some countries, like Nepal, work on six different behaviours, though Ratan Budhathoki, Lek Shah and Mun Bahadur explain that this is done in different stages, depending on the progress of the community. Different messages are used for communities which are not yet ODF, and those post-ODF, as well as those moving towards "total sanitation".

Motivators

Motivators are the reasons behind behaviour, also called "behavioural determinants". These can be knowledge, values, priority, and so on. The idea is that if we can influence those motivators, as a result, people will change their behaviour. About 40% of contributions were very clear about the motivators they were trying to influence. People who were not very clear talked about motivators in general terms, e.g. "knowledge, beliefs and attitudes" or "traditions" without explaining which specific traditions, knowledge beliefs or attitudes were affecting the behaviours. Without clarity on the specific motivators that you are trying to influence, the communication objective and messages will remain very general. Specific motivators will result in more focussed efforts. For example, Vanny Suon from Cambodia shared the motivators around hand washing with soap by mothers. The mothers know about the importance of hand washing for disease prevention, but they associate it more with eating than with contact with faeces. Hence, the BCC focus become more on hand washing after defecation and cleaning a child's bottom. Yet in the mountainous region of Nepal, the issue is about management of the hand washing station and the soap, shares Tika Ram Khadha. Similarly, Thinley explains that in Bhutan it was found that the soap kept moving around the house, and was not readily available for hand washing. They made a "keep your soap here" reminder sticker. Raju Shrestha from

Nepal shared another common perception which affects the motivation of women to wash their hands:

> *"Most of women spend their days inside the home, this contributes to the perception that their hands are clean. "Dirty" hands result from visible dirty things, working in the pigs or cow shed, touching faeces and doing tasks outside the home."*

Similarly, Anna Emmanuel from Tanzania shared that perceptions about cleanliness affect the motivation to wash hands:

> *"Nursing mothers do not believe that after cleaning a baby's bottom, hands that do not show visible smear of faeces are dirty and will transmit diseases."*

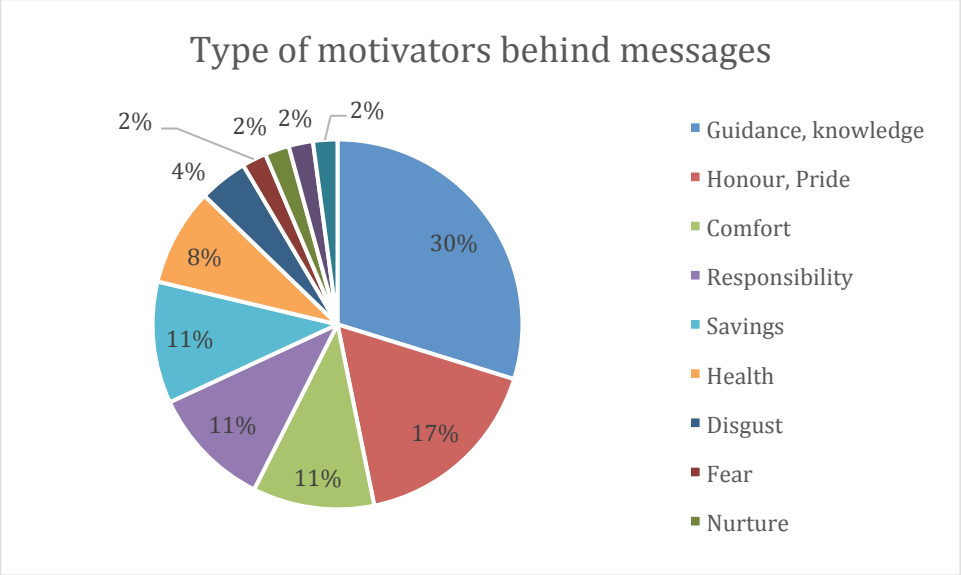
Mukama Mukungu from Uganda explain that their message is: "Zero tolerance to open defecation", thereby suggesting that the motivation for behaviour change would come from the community exerting peer pressure and possible enforcing toilet use.

Messages

Nearly everybody (80%) was clear about the messages used in the campaign, but there were some people who did not share their message or perhaps their campaign does not have a clear slogan yet. Having a clear slogan generally help to give focus to a campaign.

When analysing your messages, it appears that most messages (30%) are about providing knowledge and guidance; another significant part is about honour and pride (17%). Then there are messages arguing about the improved comfort, financial and time-savings, as well as that people have own responsibility for their health (11%). In the graph below the different type of motivators and frequency of use can be seen.

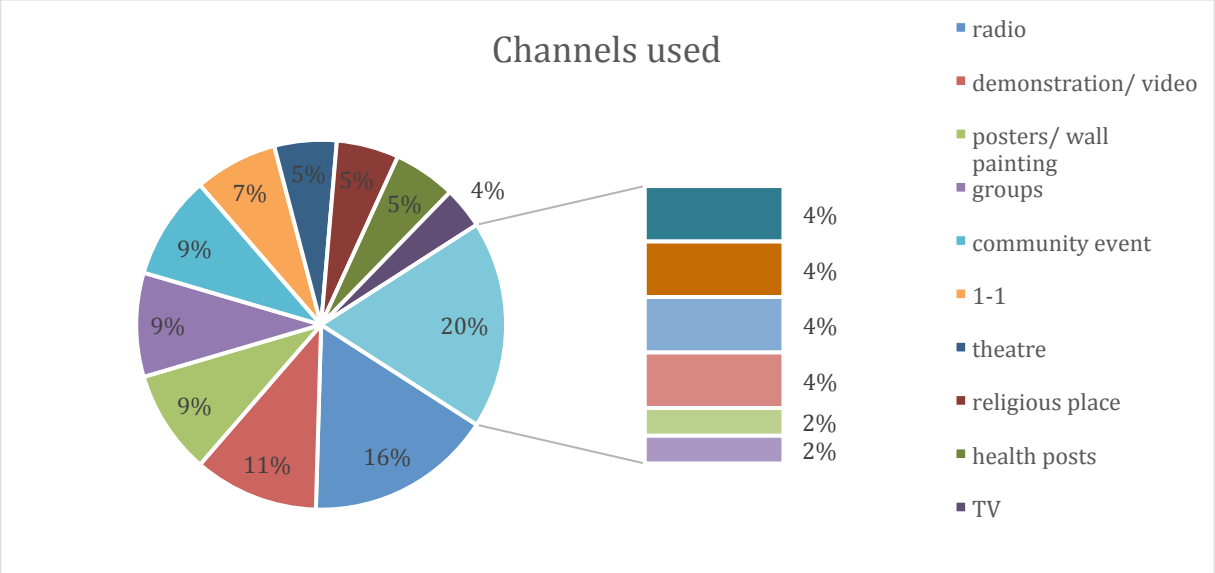
Examples of promoting own responsibility is from Bunleng Tan in Cambodia, where the message says, "hygiene comes from you!" and "Our health is our responsibility" as shared by Charles Onyango in Kenya. Another is the message from Ethiopia: "Your health is in your hands!"



It should be noted that it's not wrong to have messages that provide knowledge and guidance, if this is really the issue that is affecting people's ability to change. Safe emptying of toilet pits is an area of limited knowledge of rural households in many countries for example. Also, how to clean a toilet, is often unknown to rural households. One should always question though, whether the issue is in fact the lack of knowledge. Hari Shova from Nepal provided a detailed overview of which messages were chosen to address which audiences and motivators in her programme.

Channels (communication materials, media, visits or meetings) used to reach the target group

The examples on communication channels were many and everybody had clear ideas on communication channels. As can be seen from the graph below, a large variation of channels is used. All countries use radio and nearly all demonstrations/videos. Posters or wall paintings, small groups, community events are also common. Several people mention the importance of interpersonal communication for example through female health volunteers or through district health workers. It should be noted that in the list below, 12 out of 16 different channels here are not interactive, but predominantly one-way communication. According to Wycliff Omondi from Uganda, the interaction is essential, that is why "small groups" is their main approach.



There is no information to compare the effectiveness of the different channels or the effectiveness compared to costs. This is surprising because it is costly.

The design of a campaign of course goes beyond the choice of the channel. A lot also depends on how it is implemented and whether it's properly tested. As Jerry Sabogu Yakubu from Ghana said, BCC needs to be precise and concise to avoid of multiple interpretations. He gave the following example of a communication objective going wrong:

> *In a demonstration aimed at reducing the consumption of alcohol, a local beverage known as "akpeteshie" was poured into one glass and water in another glass. One live worm each was dropped into each of the glasses. Within minutes the worm in the alcohol died appearing burnt, while the one in the glass of water continued to swim around. The intended impression was for participants to realize the negative effect of alcohol on living things, but this was not so because the people concluded that alcohol will help to kill worms within the human system.*

In the above example, the communication objective was to convince people that alcohol has a negative effect on living things, and the expectation was that thereby they would reduce their alcohol consumption.

Language is another essential characteristic of the effectiveness of channels. Rita Ambadire from Ghana shares that all messages on posters are in English, but that the radio also uses local languages. Language is very delicate and can vary from place to place. Tika Ram shares that in the upper part (high mountains) of Dolpa, 75% of people are illiterate and cannot read national language. Mulugeta Tilahun from Ethiopia confirms that the radio broadcasts in their national language (Amharic) as well as local language of the area (Himetegna).

Who assumes that less confusing can happen using only pictures, no words, might be wrong. Sanna shared an example of a poster that had been used for many years. It was a poster with a toilet at the background with adults around it. In the front, a child is defecating in the open. Nobody wanted to test the poster, as all health promoters thought the message was clear. Yet, upon asking people what they say, they said: "Adults should go to the toilet, for children it's OK to defecate in the open". The lesson learned is that testing always remains important.

Topic 3: Implementation and institutional embedding of BCC

Question 1: In your context, who is responsible and/or should take the responsibility for long-term hygiene promotion?

All of contributors are of the opinion that the responsibility for long-term hygiene promotion lies with the government, but there are differences between:

- Whether it's national or sub-national responsibility, and how responsibilities cascade down.
- Whether there is a shared or multi-stakeholder responsibility between Health, Water and Education (and sometimes Local Development) and,
- In the cases where there is a multi-stakeholder responsibility, there are differences at which level of government this integration happens.

Of course, in many countries the responsibilities have already been defined legally, though in others, there is not clear responsibility for (WASH related) hygiene promotion. The clarity is the first and most important thing for institutional embedding of hygiene promotion. Other differences relate to the outreach structure of the responsible ministry, and of course the need (or not) to engage other ministries.

Many contributors feel it's the Ministry of Health (MoH) that should have (and take) the responsibility. The main reason given is the strong, extensive outreach structure of the Ministry of Health, which allows for in-house rollout of hygiene promotion (see figure). However, some contributors, such as Sushma Kafle from Nepal and Warren Simangolwa from Zambia, point out that preventive health is often not given due attention by the MoH, whose priorities lie with curative health. However, Jackson Wandera from Tanzania suggests that both the preventive and the curative part of MoH should be engaged in hygiene promotion for WASH, because in this way broader outreach is assured, especially to vulnerable groups such as mothers of children under five.

The problem of insufficient attention to hygiene promotions was also an issue in Ethiopia in the past, explain Dejene Kumula, Osman Yiha, Muguleta Tilahun and Getachew Belaineh. However, the country managed to rectify this by:

- A clear strategy
- A clear structure of engagement of the other ministries
- Upgrading of hygiene and environmental health from a team to a directorate

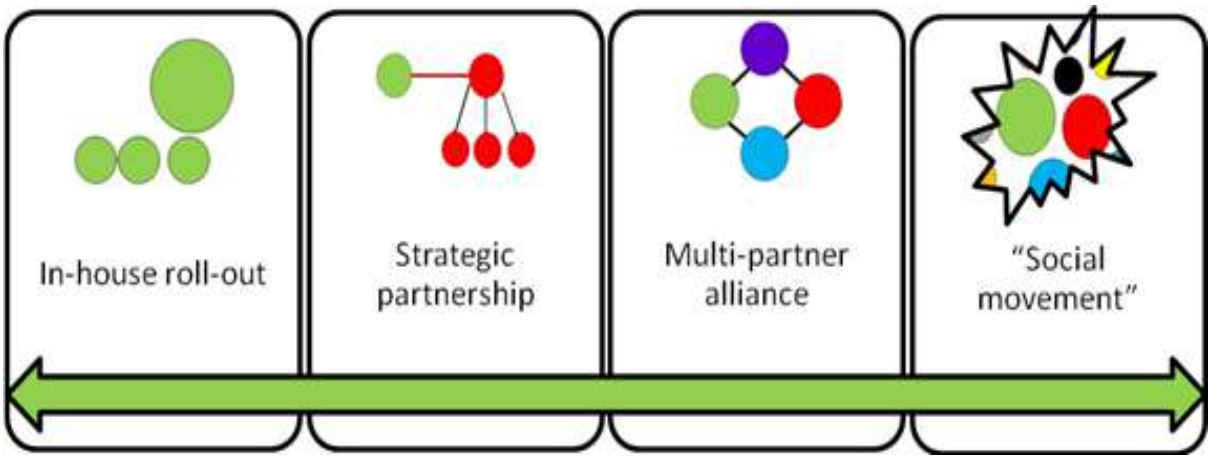


Figure developed from ExpandNet

In countries, where the responsibility does not lie with MoH, there is often a concern that there isn't enough collaboration with MoH, and/or that the responsible ministry does not have the outreach structure or required expertise. For example, in Zambia, Solomon Mbewe and Kumbulani Ndlovu explain, the leadership for hygiene promotion lies with the Ministry of Water. However, Zambia does not yet have clear national level guidance on BCC, defining who does what, in which ministry and at what level. This is still work in progress, and a communication strategy to guide advocacy and behavioural change communication efforts in Zambia. The Ministry of Water also does not have the outreach structure like MoH. Nelson Chauca shares that in Mozambique, the problem is that the MoH and Ministry of Public Works do not work closely together. As the responsibility lies at the provincial level in Mozambique, and there is a limited outreach structure, operationalizing hygiene promotion and institutionalising BCC capacities is still a big challenge in Mozambique says Befekadu Kassahun.

Some feel that hygiene promotion should not be the responsibility of a single ministry, but rather a shared responsibility among ministries. Ratan Budhathoki would like to see the three ministries involved in Nepal: Ministry of Water Supply and Sanitation, Ministry of Health and Ministry of Education. Charles Ooko Onyango from Kenya, would like to see roles distributed between the Health promotion department, the Public Health department and the Ministry of Water, making the best use of their different expertise and outreach. Mary Namusoke from Uganda would like to see a drive in all departments.

Nepal is a special case, due to the new constitution which has created federal states, changing the government structure. There used to be a strong structure for sanitation and hygiene promotion in Nepal, with clear responsibilities, informed by the National Hygiene and Sanitation Master Plan (2011), as well as the Total Sanitation Action plan (2017). The responsibility lied with the Ministry of Water Supply and Sanitation (MoWS), but there are WASH committees at different levels to ensure coordination, broad buy-in and aligned action. With the Federalisation of the country, it becomes unsure where the responsibility should lie says Krishna GC. Many contributors from Nepal feel that it should be the municipality level (Kailash Sharma, Tika Ram Shrestha), while others feel it should be MoH (Chiranjibi Koirala, Lek Shah), others Ministry of Education (Raju Shrestha) and again others feel it should stay with MoWS (Sushma Kafle, Vinod Sharma). Many expect that the responsibility will go to the local level. Time will tell…

When the responsibility lies at the local level, for example provinces, regions, or states in a decentralised structure, the question is often whether they manage to prioritise hygiene promotion and allocate budget. Moses Ogwal from Uganda, who also asked whether it could perhaps be the central government who provides earmarked funds specifically for hygiene promotion, suggested this point.

Everybody mentions the outreach structure, but Warren Simangolwa digs deeper into the issue. He explains that in Zambia, the government is moving the "Health Volunteers" to a full-time position of "Community Health Assistants", in order to retain them. The issue remains though, that within their package of work, hygiene promotion for WASH gets limited attention, because the focus lies where they have most budget, which is not hygiene promotion. The question is thus whether it's the right way to go, with Community Health Assistants, or that it's better to go with the sanitation action group (SAG), which is not so dependent on MoH.

In summary, clarity around the responsibility for hygiene promotion is essential for institutional embedding, but it also needs:

- A clear mandate and budget
- Clear national guidance
- Engagement of other sectors
- An effective outreach structure
- Making sure that at all levels (but especially the lowest) there is still time and money for hygiene promotion

Question 2: Should hygiene promotion campaigns be led and designed nationally or locally?

Nearly half (48%) of the contributors felt that hygiene promotion campaigns should be led and designed national. Hilda Muteshi from Kenya even felt that hygiene promotion campaigns could be Africa-wide, considering the common motivators of human nature. The reasons for proposing national leadership in design are quality control and resource allocation. Specifically, the overall concern is that design of hygiene promotion is complex, and that it's hard to find or build the expertise for that at local level. This was echoed by Krishna, Raju and Lek. Dejene explains that the design should essentially be national, but that in some cases, there may be need for a localised design addressing specific problems.

However, about 36% of contributions felt that design should be a shared responsibility between national and sub-national levels. They point to the need for a national policy and guideline (Moses, Amos Kanuu from Kenya and Tika Ram), to ensure there is a level of alignment and clarity. Others, like Jackson and Solomon, would also like to see a national design, which can then be tailored to local needs, beliefs, language and images. Osman and Moses emphasize the regional diversity in their countries, and the risk of large mistakes. Nelson also emphasizes the importance of local verification. Henry Kakooza from Uganda asks for the soft copies Meseret Kebede and Muguleta Tilahun from Ethiopia suggest that there should be a collective design which makes optimum use of national expertise and local knowledge. Vinod says: national design and local innovation.

Yet, there are others (12%) strongly felt that design should happen at the local level. Brian Akello from Kenya talked about the need for local leadership buy-in and budget allocations. Ratan would like to see a similar level of social mobilisation as the CLTS movement, engaging some national expertise but essentially local.

Question 3: What can be done to monitor effectiveness, and ensure learning& innovation in hygiene promotion?

Monitoring is a large topic, and not necessarily clearly present at the moment of the design of the hygiene promotion campaigns. Surely there will be monitoring of hygiene behaviours among the target group (and perhaps health trends as suggested by Henry), but when the campaign fails to generate the expected change, the causes of that failure are a black box. Is it the outreach or recall among the target group? Is it the choice of messages and motivators? Are there other barriers? As Krishna, Amos and Rita Ambadire from Ghana explain, for real progress on behaviours, it's becoming clear we need continuous learning and refining, no matter how brilliant the design. Osman, Jackson,

Sushma and Getachew all point out that monitoring needs to be built in more strongly from the start, and not as an afterthought. This would also come with the required resources say Osman and Befekadu. Mun Bahadur from Nepal also suggests that this has to be mandatory in a BCC strategy or hygiene promotion strategy, otherwise it will not happen.

Rita also asked whether we sufficiently learned from the past. Did we analyse previous campaigns or have information on why results were not fore coming or behaviours were relapsing? Did we act on those findings?

To operationalize better monitoring, without creating large additional costs is not easy. Some suggest integration into existing monitoring information systems, but it may not be easy to capture the qualitative information that explains the lack of uptake in such systems. Tika Ram suggests regular participatory monitoring, and Muguleta also suggests involving villagers themselves. Chiranjibi suggests community based monitoring and evaluation tools. Ram Prakash advises that the best way forward would be a joint monitoring protocol with district stakeholders, as this will at the same time build buy-in and capacity. In addition to that, the involvement of research organisations could be useful say Jackson and Dejene. Also, Meseret emphasizes the need to engage expertise.

Annex 3: Field Trip Reports, Case Studies, Photo Journals & Testimonials

The outputs of the field work for each of the five groups is available at https://www.dropbox.com/sh/mbvakr686j3bdiu/AADYaW0jp_wKR6Z-hdqDeklea?dl=0

Annex 4: Other Presentations

Copies of the presentations delivered at the learning event are available at https://www.dropbox.com/sh/ppww975zgoi9aoa/AAAHAPzFGrHivcfCje1hnotqa?dl=0