Thematic Discussion:
Sanitation and hygiene behaviour change programming
for scale and sustainability

Discussion Synthesis
By Tracey Keatman, Partnerships in Practice Ltd.

Table of contents

Introduction

The **Water Supply and Sanitation Collaborative Council Community of Practice on Sanitation and Hygiene in Developing Countries** (WSSCC CoP) and the global **Sustainable Sanitation Alliance** (SuSanA) came together in late September 2015 to hold a joint three-week thematic discussion on sanitation and hygiene behaviour change programming and sustainability. It was the first time the two networks had come together to host an online collaborative learning event. Both platforms have over 5,000 members each working in WASH and other related sectors. Hence, this thematic discussion was an opportunity to bring together these two global communities to share learning and to explore links between research and practice on behaviour change.

The discussion was divided into three inter-linked sub-themes to further explore how behaviour change can be better understood and improved to ensure health and WASH outcomes are sustained. Each week was led by specialists in each theme who framed the content for debate and posed structured questions for discussion amongst online participants. The three sub-themes included:

1. **Programming for scale** – week one focused on defining scale for sanitation and hygiene behaviour change (BC) programming, sharing examples of successful scale-up (or the ingredients thereof) and understanding stakeholders' responsibilities and relationships;
2. **Sustainability for behaviour change** – the second week sought to explore the social and behavioural norms and dynamics that influence hygiene practices – specifically, handwashing and the use of sanitation facilities;
3. **Open defecation free (ODF) status and slippage** – the third and final week of the discussion focused on understanding terminology, exploring patterns of slippage and local strategies for preventing or mitigating slippage.

This summary paper brings together key discussion points from across the three sub-themes and captures key reflections on each. The author of this synthesis acted as the thematic discussion coordinator across the two online platforms; she would like to express her gratitude to everyone that shared their time and insights for this exercise.

Programming for scale

Suvojit Chattopadhyay, a consultant focused on monitoring and evaluation, led the first sub-theme by highlighting that the sanitation challenge is a complex and "wicked problem". The key challenge for the WASH sector is to induce lasting behaviour change:

> *"The very nature of careful social engineering required to bring about this behaviour change seems to run contrary to some of the factors that make an intervention scalable – an ability to standardise inputs and break programme components down to easily replicable bits."*

Suvojit called for WASH sector practitioners to: avoid target-driven hardware interventions which will neither change behaviour, nor create social cohesion but to do construction well, with usable and lasting designs that promote local ownership; learn from effective marketing (social or otherwise) to reach each and every person; recognise that conventional approaches are not working and that there should be a focus on personal and environmental sanitation and hygiene as a whole (not just ensuring that communities are ODF) and also on starting 'at scale' rather than settling for incremental coverage.

Defining 'for scale' in sanitation and hygiene BH programming

As anticipated, there was a good level of debate trying to understand what 'scaling up' means in different contexts for sanitation and hygiene behaviour change; and therefore programming for scale depends on having a clear, coherent and accepted definition – which is not necessarily understood or agreed upon by all. As Elisabeth von Muench said:

> "So what is it that we are scaling up? Purely those things that don't require hardware intervention? Actually, everything, even handwashing and stopping [open defecation] OD needs some form of hardware intervention. So that can't be it. I thought it's all about hygiene behaviour change (mainly handwashing and not doing OD when you have a toilet) - and not really about getting toilets to the people, right?"

Parallels were drawn to the challenge of defining scale-up in the context of nutrition programmes, Alexis D'Agostino said:

> "… there didn't seem to be a lot of agreement within our field of what that term really meant. Expanding programming to new geographic areas? Integrating it into a local system? Both? Neither? Something else?"

Participants noted that the challenges in such complementary sectors may provide important lessons that are transferable to scaling up behaviour change programmes.

What does BH programme scale-up mean for WASH practitioners? Expanding? Integrating?

To scale up or replicate interventions on a large scale, sanitation hardware supply and hygiene education (which can lead to behaviour change) require tailored efforts as they probably will not happen at the same pace nor be comprehended together as a health improvement 'package'. This is the primary challenge when considering programming for scale – the different elements of WASH programmes do not scale up in the same way or through the same mechanisms. Plus, scale-up in one dimension may not have a causal relationship with another. For example, Roland Werchota noted that behaviour change at scale alone would not necessarily mean that scale is also reached on access to sanitation.

As Peter Bury highlighted there is a need to distinguish between but also promote integration of sanitation and hygiene (whereby hygiene education can influence behaviours and hygienic practices) and not treat them as separate activities. Similarly, participants noted that hygiene can never be sustained without adequate water – so the focus remains on water quantity too.

> "Improvement in health depends therefore more on sanitation once a minimum of clean (utility) water is available." (Quote from Roland Werchota)

Dependent on the context, there has to be some water access integrated with a sanitation service (on-site, shared, household) and behaviour change to have the impact required. Views on how interventions are sequenced, which stakeholders are involved and who leads the process (community, government, private sector, NGOs) differed among participants who highlighted the different needs in different contexts (e.g. rural, urban, peri-urban, in schools or health centres, post-conflict, internally displaced person camps, etc.).

Access to adequate and equitable sanitation and hygiene for all

This sub-theme was discussed during the same week that the UN General Assembly came together in New York to agree and finally adopt the new Sustainable Development Goals. Of relevance to this discussion is the commitment to target 6.2 which demands an acceleration of pace and practice for sanitation and hygiene:

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

The mandate to achieve access for all has clear implications for programming – it reinforces the need for ensuring **equitable and inclusive** services as well as products, hygiene education and ongoing support or follow-up over the long term. Similarly, in terms of intended **public health impact**, Suvojit highlighted:

"…without the inclusion of all households in a community, gains from improved sanitation cannot be realised. Unless all families adopt hygienic sanitation practices, we will not make a dent on the incidence of disease prevalence."

Does this mean scaling up hygienic sanitation practices always means reaching 100 percent of the population? It was agreed that BH cannot happen overnight but is a gradual process that requires ongoing focus and support due to population growth, people forgetting, and the need for repeated education in schools and through media. Access for all surely implies ongoing action to ensure changed hygiene behaviours and practices are sustained.

Ingredients for successful scale-up

In the cases of successful scale-up, were programmes initiated and sustained by governmental or non-governmental actors? What are the key elements of a successful partnership? How can we strengthen national ownership?

There was an example provided of how partnerships and convergent action are central to scaling up – Anand Shekhar shared how the Ministry of Drinking Water and Sanitation, the Government of India and the Global Sanitation Fund have announced the [Shillong Declaration](#) on 'Promoting Sustainable Partnerships'. In addition, the process of achieving ODF status in Nadia District in West Bengal (see [sabarshouchagar.in](#) for more) required that stakeholders share 'key values' to ensure success at scale. These values include decentralisation, joint planning, co-financing and collective action.

Several people commented on how there is not a one-size-fits-all approach and that there is a need to look beyond the WASH sector more, to integrate efforts with those of others working on livelihoods and other sectors.

Stakeholders' responsibilities and relationships

Participants highlighted that sanitation BH campaigns need to be locally led and sustained by local governmental or collective community resources plus inter-ministry, as well as community, buy-in and coordination. Achieving this is easier said than done. For example, Anand noted that:

"Generally, programmes of development organisations are guided by values which may or may not match and converge with others. Scaling up demands scaling up of core set of values that promote sustainability of benefits."

Given the enormity of the challenge to reach scale there is a recognition that one organisation or stakeholder group cannot do everything needed to reach wider scale alone. Unless all parties have an agreed, defined understanding of what it is they are trying to achieve together, it is unlikely they will achieve their goals. The hype and rhetoric of partnership so often conceals the difficult realities of working with other organisations, especially governments.

Suvojit prompted a debate on the role of public health engineers – their role in the design and execution of services and also for budget holding rather than that related to behaviour change software. Lalita Pulavarti provided an example from India:

> *"… In Orissa the Executive Engineers (of a joint WATSAN department) are still in charge of the sanitation program. However, this does not mean that they are paying attention to structural or design issues! It only means they are in charge of the money that flows in through the scheme. Sub-contracting (and the resultant kickbacks), and not giving ownership to the citizens to get the toilet built themselves (due to scale issues/labor issues [skilled masons, etc.] or any other reason) is killing the scheme. Unless this changes under SBM, we will see more of the same in India."*

There is also a need to work more with non-traditional partners – such as "*anthropologists, sociologists and psychologists*" in sanitation programming to better understand the determinants of mass behaviour patterns. Plus, perhaps they can assist more in raising awareness of the need for sanitation and hygiene amongst people, notably the poorest, who have so many competing priorities for their time and money. Suvojit also noted the prominent role that the private sector can play in the promotion of hygiene and sanitation campaigns and expansion of programmes: "*Whether in the form of innovative communication campaigns, or financing through CSR, private sector resources need to be harnessed through mutually fruitful collaborations*."

At the end of the week, Suvojit provided readers with his 'six step formula' to a successful sanitation and hygiene campaign:

1. Do not approach communities with a single message (build and use toilets), but with a comprehensive health and hygiene intervention.
2. Instead of being subsidy-averse, be ready to experiment until you get the design right.
3. Play on local power relations.
4. Allow communities to evolve their own norms around individual and collective rights and responsibilities.
5. Do not hurry into scaling up.
6. Perhaps most importantly, be conscientious about quality.

Sustainability for behaviour change

The second week explored the social and behavioural norms and dynamics that influence hygiene practices – specifically, handwashing and the use of sanitation facilities. By way of definition:

> *"Social norms are socially accepted or agreed values, beliefs, attitudes and behaviours – reflecting what a person considers right and expected behaviour. This is related to how people think others expect them to behave, and what most other people do." (IDS, 2015)*

As the previous week focused on understanding what might be required to programme for scale in BH activities, the second week of conversations focused on how BH can be sustained once programmes are in place.

Active consideration of social and behavioural norms

Henrieta Mutsambi, the WASH Manager at the Institute of Water & Sanitation Development (IWSD) prompted the discussion by sharing her knowledge and experiences of behaviour change efforts in Zimbabwe. She highlighted that:

> *"Health behaviours should be engrained in one's already existing everyday culture. Scaring tactics do not work and people including children do not believe that they will 'die just like that' if they do not use a toilet or wash their hands. BUT why are we pushing for handwashing to happen – to avoid diarrheal and other related communicable diseases."*

Henrieta went on to highlight some of the key ways for mainstreaming handwashing and latrine use in existing socio-cultural beliefs and norms. For example: using **religious scripture** to reemphasise handwashing with different faith communities; **building on traditional beliefs** about hygiene (e.g. the Ndebele people in Zimbabwe do not believe in eating in public places where there are no facilities such as handwashing); **experiential learning** (show visually how handwashing with or without soap cleans hands differently by using a white towel for hand-drying); and the value of linking hygiene to social **status** and concepts of **dignity** and **pride** which can work in some contexts (although not all). Several contributors noted the value of **influencing the young** so that hygienic practices become routine behaviour.

Context is key

Understanding the **incentives and internal motivations** for behaviour change is key to designing behaviour change techniques – such techniques must be tailored to the context. For example, Sam French described WaterAid's experience in West Africa when the organisation was taking what it had learned about CLTS from Bangladesh and tailoring it for different contexts:

> *"We had to learn a lot about the socio-cultural context and tailor appropriately – we soon learnt that 'shame' did not motivate communities in Nigeria to change their behaviour, but rather positive motivators such as the feeling of dignity and pride."*

Nabil Chemaly shared his experience from the GIZ Water Programme in Burundi, where behaviour change interventions were designed to target mainly psychological factors and were tested and assessed in the short term (one month after implementing the intervention) and medium term (6 months after implementing the intervention) to determine scale-up potential. The sanitation behaviour change interventions consisted of a combination of the following initiatives:

- Awareness sessions to households + training for local construction workers + in-kind subsidies up to 50% of the cost of a latrine;
- Awareness sessions to households + training for local construction workers + assistance in household family planning to save enough money for the construction of a latrine;
- Awareness to households through theatre as a means of mass communication + trainings for local construction workers.

Nabil noted that many other activities were undertaken to **create an enabling environment** for the success of these interventions such as training health promoters to conduct awareness sessions, training pharmacists to produce chlorine, training latrine construction workers and plumbers, building demonstration latrines in pilot areas, etc. The short-term evaluation of sanitation interventions showed many valuable learning points, including that: theatre as a means of mass communication did not have a major impact on access to sanitation and therefore has a limited potential without consistent follow-up; awareness using local agents is an effective technique, but proper follow-up and monitoring from local, provincial and central sanitary authorities is necessary; and, the first awareness sessions to households were more effective than follow-up sessions planned according to the approach proposed.

As noted in week 1, BH is a long-term, slow process that does not happen uniformly – additionally, several contributors noted that the time limits of many local NGO interventions are too short. Similarly, Franck Flachenberg noted that some programmes "*just jump from behaviour change objectives straight to the activities, without giving much thought to why people do what they currently do and what may be preventing them from adopting the hygiene behaviours promoted.*" Analysis by 3ie showed that:

> *"Barriers to behaviour change depend on the stage of the project. Many studies assess the health benefits of initial uptake of safe water, hygiene and sanitation technologies and*

practices. But few studies consider sustained use. The early project period may be characterised by enthusiasm over the new technology or promotional activities. Although external support ends during the early post-project period, the promotional messages may still be fresh in people's minds. However, influential household members who were sceptical may reassert their domination during this phase. And finally, in the late post-project period stockouts, technology failure or poor maintenance systems can pose a serious threat to sustained adoption."

The 3ie-supported systematic review also found that:

"... frequent, personal contact with a health promoter over a period of time is associated with long-term behaviour change. The review suggests that personal follow-up in conjunction with other measures like mass media advertisements or group meetings may further increase sustained adoption."

IWSD, GIZ, Concern Worldwide, WaterAid and 3ie contributions all highlighted the value of taking a holistic, multi-pronged approach to increase the potential for BH to be sustained. Where there is information, education and communication (IEC) provided to communities in various media plus practical support to ensure there is an enabling environment, the techniques used appear to have more chance of success and may be better sustained. Hence, using tools that more systematically analyse barriers and drivers towards BH should be planned into programmes from the start, and subsequent BH campaigns should be based on the context.

Behaviour change techniques: examples and challenges

Hygiene promoters – who does what?

Franck Flachenberg shared Concern Worldwide's approach to hygiene promotion, highlighting that many WASH programmes rely on training hygiene promoters who are usually members of WASH committees that have been set up to manage infrastructure. Franck argued that for sustainability purposes it would be better to rely on existing local networks, such as community health workers, and that hygiene promotion should be integrated as much as possible within the existing health system rather than setting up parallel systems such as WASH hygiene promoters.

Jihane Rangama agreed, providing an example from Burkina Faso, where hygiene promotion activities are performed by local volunteers (members of local women's associations for example). However, feedback showed that the volunteers' motivation decreased quite quickly, and the results in terms of behaviour change interventions were not as good as expected. Sam French added that cross sector integration is also key to a multi-pronged approach whereby schools, health centres, midwives, etc. all use and reinforce the same messages.

Tom Davis suggested however that the focus on using paid professionals for health promotion is unfounded and referred to research[1] that found that projects using Care Groups had double the adoption of handwashing with soap as projects that did not use Care Groups. Care Groups rely on volunteers. Susan Davis also contributed to this point by highlighting a study that compared CLTS to the Community Health Clubs approach (Whaley and Webster, 2011).

"Whilst both approaches effectively encouraged measures that combat open defecation, only health clubs witnessed a significant increase in the adoption of hand washing. However, CLTS proved more effective in promoting latrine construction, suggesting that the

---

[1] George et al, 2015 *Evaluation of the effectiveness of care groups in expanding population coverage of Key child survival interventions and reducing under-5 mortality: a comparative analysis using the lives saved tool (LiST),* John Hopkins Bloomberg School of Public Health, USA. Available at: **http://www.biomedcentral.com/1471-2458/15/835**

emphasis the CHCs place on hygiene practices such as hand washing needs to be coupled with an even stronger focus on the issue of sanitation brought by CLTS."

Systemising behaviour change

Ways to systematise behaviour change techniques and to understand social norms have been developed. One such system was shared by Professor Hans-Joachim Mosler from Eawag – the "RANAS" framework that seeks to provide a process for systematically mapping potential behavioural determinants (based on human psychology) and then linking them practically to specific behaviour change technologies. With such frameworks, practitioners are able to develop a tailored, context-specific approach. Tom Davis also referred readers to the different determinants found for the 18 Barrier Analysis studies on handwashing with soap shown on the Food Security and Nutrition Network's Behavior Bank.

Designing approaches

Professor Mosler also pointed out that designing context-specific approaches could be better done by engaging with creative agencies – who would also have to understand the context and audience – which is an approach that many private sector organisations use for behaviour change. It was noted that the WASH sector could do more to better understand and learn from the private sector about their experiences and expertise on the basic mechanisms or structures behind the design of large-scale behaviour change media campaigns. This is to ensure these design principles are coherently addressed in the design of WASH programmes and complement whatever is happening on the ground on personal health education and follow-up.

Having a complementary approach (mass media plus local, sufficiently long-term support and follow-up) can clearly reap rewards (as noted above). Yet, how is this systematically planned for and delivered in a project or programme cycle? Hygiene behaviour change rarely seems to be elevated to this systematic planning status in WASH programmes – despite the recognition of its importance. It also requires us to work in partnership with others that we may not usually engage with (as highlighted earlier).

Monitoring behaviour change

In terms of monitoring and evaluating BH, Franck also highlighted that "*a robust M&E system is associated to each new campaign so as to be in position to assess its results in terms of effective behaviour change (and not just improvement in knowledge)."*

Takudzwa Noel Mushamba highlighted that the "*absence of cases or low prevalence of water and sanitation diseases is not necessarily and indicator of 'improved behaviour'*". He drew attention to the epidemiologic triangle, which shows the linkages between the agent of disease, the host and the environment noting that:

> *"We are more a product of the environment than what people tell us. The same message means different things to two people. To one it means open the tap and a hand sanitizer and to another it means buy extra soap, travel to a borehole 8 km away and get an extra bucket of water and wash before you eat. Infrastructure plays a huge role not only in reducing exposure but also in fostering new behaviour."*

Finally, Hanna Woodburn[2] from The Public-Private Partnership for Handwashing (PPPH) noted that during UN discussions on the adoption of the SDGs "*when behaviour change was mentioned as being key to achieving these goals responses were often abstract*".

---

[2] Hanna also drew participants attention to the PPPH Handwashing Behaviour Change Think Tank event held at AfricaSan4 in Dakar, Senegal, which looked at three big ideas in hygiene behaviour change: emotional motivators, behavioural settings, and the science of habit.

So monitoring efforts also need to be multi-faceted, holistic and able to change along with contextual changes and the stages of particular programmes.

ODF and slippage

In the third and final week of discussions, the conversation moved on to address what happens when changed behaviours 'slip back' or where BH programmes may require extra support. Colleagues from the Global Sanitation Fund (GSF) that led the week highlighted the following:

> *"Large-scale behaviour change oriented sanitation programmes often focus on supporting communities to achieve open defecation free (ODF) status, criteria for which are locally defined but often include a complete stop of people defecating in the open, access to basic but fly-proof latrines for all community members, and presence of handwashing stations with water and soap or ash close to the latrines. As these programmes mature and when the challenge shifts from bringing communities to ODF to sustaining their ODF status, many are confronted with the issue of slippage – a return to previous unhygienic behaviours or an inability of some or all community members to continue to meet all ODF criteria. However, there is a lack of clarity (or at least acceptable/universal definitions) of what slippage actually is and there is no panacea for how to come to terms with slippage, which is dynamic and context specific. What we do know is that slippage is an expected aspect of sanitation interventions, especially those at scale, and NOT a sign of a failure thereof."*

ODF and slippage definitions

Two relevant comments were made in connection to GSF's definition of ODF and slippage. Kimberly McLeod agreed with the three main principles for recognizing an ODF village and reinforced that the "*presence of handwashing stations with water and soap or ash close to the latrines*" should go further and state that villagers must also be "*washing hands properly at critical times.*" Akhilesh Gautam also reflected on what time period could be considered for having achieved ODF status as a "stable – sustained use" of a toilet before being construed as 'slippage'. Akhilesh noted that in his field experience in India:

> *"In many villages the "stable" period of sustained behaviour of toilet use was never achieved in the first place and therefore calling it slippage is erroneous and has different implications for strategy course correction in the sanitation programming."*

Patterns of slippage

> *"Sanitation and hygiene behaviour change is a non-linear process that might look like this: a community is triggered, endeavors to reach ODF, is declared ODF, slips back repeatedly (due to various individual/collective and internal/external factors) to non-ODF status followed by interventions to regain ODF status. A common trend seems to be that the more often interventions are repeated and follow-up support is provided, the less dramatic the slippage will be until eventually a level of maturity is met and behaviours 'stick'."* (GSF colleagues)

In terms of ODF slippage experienced in different programmes around the world, there was an interesting selection of reasons for and patterns of slippage – some of which were external influencing factors (e.g. socio-cultural, environmental, financial and political aspects) and some which sanitation and hygiene professionals may have more control over (e.g. poorly designed programmes or programmatic limitations). The following bullet points summarize the **key ODF slippage factors** shared by colleagues on both discussion platforms:

- ➢ **Socio-cultural aspects** – communal conflict; IDPs' needs and impact on available local facilities; vulnerable people unable to meet ODF which impacts on all community; lack of peer pressure from certified ODF communities to their colleagues;
- ➢ **Environmental aspects** – seasonal or other flooding (leading to loss of latrines, fewer possibilities for follow up by facilitators); too much rain so less ash for hand cleaning and cleaning latrines;
- ➢ **Financial / economic aspects** – affordability of suitable hardware by the urban poor; poor management of funds for BH and related follow up;
- ➢ **Political aspects** – "*Unhealthy competition between local governments to meet central government targets, at all (non-financial) cost*";
- ➢ **Programmatic limitations** –
  - o Poor or weak community-led total sanitation (CLTS) triggering facilitation;
  - o Unclear messaging on hygiene and poor delivery of messages, e.g. people openly defecate outside their community for convenience indicating that the message is not fully understood, that there's a lack of awareness and motivation, or that the message has not been passed on to the entire family / household and low levels of actual and engrained behaviour change due to low quality implementation;
  - o Hasty and low quality building of facilities that do not meet national standards and where there is no post-construction maintenance / repairs provision; unequal or inconsistent supply of hardware facilities to meet demand or unsuitable, inappropriate sanitation facility for the context;
  - o Lack of sufficient and / or well-funded follow-up, e.g. support structures, maintenance / repair options, by government, environmental health staff or natural leaders, etc.;
  - o Lack of sufficient engagement of the municipality.

Carolien van der Voorden shared learning from Madagascar that indicated that sanitation and hygiene practitioners must accept slippage as inevitable and respond with tools and approaches to keep encouraging behaviour change. Indeed, much like water supply and access to latrines, ODF and related hygiene behaviour change must be regarded as an 'ongoing service' and not just a one-off, supply-led event or intervention.

Again, roles and responsibilities of key stakeholders need clarification to support and manage ODF status. For example, Joséa Ratsirarson highlighted the role that WASH practitioners can realistically play in supporting ODF:

> *"Once identified, facilitators should help the community to find its own solution rather than bringing external solutions to them. We, as external to the community, cannot just solve nor have all the solutions. The problem comes from within the community and therefore the solution should be community-led, our role is to facilitate the process of finding these internal solutions."*

Kamal Kar and team at the CLTS Foundation provided a case study (abridged) on Kalyani Municipality in West Bengal, which was declared the first ODF urban town in India in 2009.

As part of a DFID funded project, a pilot was undertaken in 5 slums in Kalyani in 2006 at the time when OD was rampant in these slum communities and free distributed toilets remained abandoned everywhere. Unlike rural CLTS, the intervention began at the municipal council level involving the Chairman and Ward Councillors belonging to different political parties. Once the need for the involvement of the local community was understood and local power relations/equations were sorted out, community triggering was facilitated. This involved all formal/informal leaders of a particular slum. The municipality was completely involved in the triggering process and post triggering follow up.

Within 6 months, these 5 slums were declared ODF. Soon, a spill over effect was seen in other neighbouring slums as well and by 2009 all of the 51 slums in the Municipality were declared ODF. This rapid scaling up was only possible because of the collective action that was generated within the communities and the natural leaders who emerged during this process who ensured that all the slums were made ODF. However, the rate of progress of all the slums was not the same because of the varied nature of involvement and commitment of different ward councillors.

After 6 years we saw that the communities have maintained their ODF status and many of them have upgraded their toilets using their own money. It is important to note the key facilitating role that the Municipality played in this entire change process. During the triggering they allowed the community to take the lead and made sure that the messages for collective hygiene behaviour was sustained through the Honorary Health Workers (HHW) who belonged to the community in the follow up stages. Kalyani is a clear example that for comprehensive sanitation planning and implementation in urban/peri-urban areas, the full participation and engagement of all stakeholders, particularly the local community members at all stages of planning and services delivery, is essential.

Local strategies for preventing or mitigating slippage

Several interesting local solutions were suggested by Nanpet Chuktu from his experiences in Nigeria – all of which relate to consistent and clear follow-up activities to maintain changes. His suggestions included:

- ➢ **WASH Clinics** – which bring together a group of villages (20-30) that have a common heritage of administrative affinity. An appraisal of the performances of the communities is made and those performing well are praised;
- ➢ **Local Task Group on Sanitation** – for example, a locally based group of senior staff of the Local Government Authority, religious leaders and traditional leaders. They have been trained on the National ODF verification protocol and the criteria expected. Their role is to conduct monthly verification of ODF communities and have been used to advocate to 'stubborn' or lagging communities;
- ➢ **WASHCOMS** – when a community becomes ODF, they are supported to form a WASH committee (at least 6 men and 6 women). These become the vanguards in their respective communities to sustain the ODF status. These WASHCOMS now seek to ensure that households are supported to have latrines that meet the ODF criteria, help the aged and widows who otherwise cannot build one for themselves.

Dennis Alioni discussed a local strategy used by the Water and Sanitation Program in Uganda, which included CLTS triggering as part of a wider, holistic initiative that seeks to improve the enabling environment too (e.g. by introducing entrepreneurs and financial institutions into the mix "*to provide services and access to finance for improved facilities*"). This was accompanied by demand creation activities.

Joséa provided an example from Madagascar about 'living by an ODF spirit' – which occurred when good facilitation and effective support to generate a deep understanding of the benefits of ODF status led to a community in Boeny Region being able to rebuild their latrines (on their own) after a powerful cyclone.

Slippage critical threshold – impacts and monitoring

Matilda Jerneck and colleagues at the GSF asked whether there is a critical threshold for when slippage has an impact on the social or health status of the community and how slippage, as a dynamic process, can be monitored. Several contributors noted that some types of slippage are "*more critical than others depending on the context*".

As regards how slippage can be monitored, there was agreement that ways of monitoring do need to change due to the dynamic process of slippage and changed behaviours. There is a need to be more interrogative and analytical to understand *why* slippage has happened in order to inform the next steps. Plus, not all indicators of measuring ODF status are 'equal' – they also must be understood within the local context and responses must be tailored accordingly. Kimberly suggested that:

> "There is a strong need to develop a robust evaluation system in order to maintain the status of an ODF village. In addition to sustaining the everyday routine of an ODF village, one must evaluate the village to determine where the issues are occurring or even where they are excelling. […] We propose to ask more direct questions such as 'Why is this village failing?', 'Where is the village failing', and 'What is the frequency of failure'. This way, we can better pinpoint the next steps of how to get the village back to ODF.

Concluding comments

Overall, the comments made indicated that there is still a lot to learn about how to plan for at-scale BH programmes that effectively link to local social and behavioural norms and inform BH techniques in different contexts. The discussion provided an opportunity to share some recent and relevant lessons learned from participants' different experiences and programmes. In terms of integrating learning to improve interventions, both Kimberly and Kamal implied that there is a need to continue 'learning by doing'.

Discussion contributors

Suvojit Chattopadhyay, consultant focused on monitoring and evaluation
Anand Shekhar, Team Leader at NRMC, Executing Agency, Global Sanitation Fund in India
Kitchinme Bawa, WSSCC Steering Committee member: Middle/Northern & Western Africa
Peter J. Bury, Consultant, Development Processes
Alexis D'Agostino, M&E Specialist at John Snow Research and Training Institute
Roland Werchota, GIZ
Aisha Hamza, Sanihyg education initiative (SAHEI)
Anwer Sahooly, Senior Institutional Development Consultant (freelance consultant at GIZ)
Lalita Pulavarti, Senior Manager, Protects at Public Affairs Foundation
Godwin, a WASH Specialist and Consultant
Hitesh Chakravorty, India
Henrieta Mutsambi, WASH Manager, Institute of Water & Sanitation Development (IWSD), Zimbabwe
Nabil Chemaly, GIZ Water Programme, Burundi
Franck Flachenberg, Environmental Health Technical Advisor, Concern Worldwide
Chhabi Goudel
Samantha French
Jihane Rangama, Technical Assistant, GIZ Water & Sanitation Program
Hanna Woodburn, The Global Public-Private Partnership for Handwashing (PPPH)
Edith Kamundi
Prof Hans-Joachim Mosler, Eawag
Takudzwa Noel Mushamba
Tom Davis, Chief Program Officer, Feed the Children
Susan Davis, Improve International
Nivedita Mahotra, Urban Management Centre (UMC)
Tracey Keatman, Partnerships in Practice
Matilda Jerneck, Global Sanitation Fund
Carolien van der Voorden, Global Sanitation Fund
Clara Rudholm, Global Sanitation Fund
Kimberly McLeod, Medical Care Development International
Akhilesh Gautam, Sanitation for All in India, GIZ
Nanpet Chuktu, Concern Universal, Nigeria – GSF Executing Agency
Jonathan Ekhator, Concern Universal, Nigeria – GSF Executing Agency
Vincent Ouma, AMREF Health Africa, Kenya – GSF Executing Agency
Marijn Zandee, Nepal Biogas Promotion Association, GIZ
Aditya Soni, Urban Management Centre, India
Orlando Hernandez, USAID-funded WASHplus Project
Tobias Omufwoko, WSSCC National Coordinator, Kenya
Dennis Alioni, Uganda
Joséa Ratsirarson, Medical Care Development International, Madagascar
Pandit Thakur, Nepal
Kamal Kar and team, CLTS Foundation
Ministry of Health, UNICEF and WSSCC/GSF, Benin
Renuka Bery, WASHplus Project

Reference materials

Cavill, S. with Chambers, R. and Vernon, N. (2015) 'Sustainability and CLTS: Taking Stock', *Frontiers of CLTS: Innovations and Insights* Issue 4, Brighton: IDS www.communityledtotalsanitation.org/reso...nd-clts-taking-stock

Coffey, D., Gupta, A., Hathi, P., Khurana, N., Spears, D., Srivastav, N. and Vyas, S. (2014) *Revealed Preference for Open Defecation: Evidence From a New Survey in Rural North India*, SQUAT Working Paper 1, Rice Institute, riceinstitute.org/research/revealed-pref...onger-working-paper/

GSF Progress Report 2014: wsscc.org/resources-feed/global-sanitati...gress-report-2014-3/

GSF Progress Report Mid-year Update 2015: *http://wsscc.org/resources-feed/global-sanitation-fund-progress-update/*

GSF (2015) *'Sanitation and Hygiene Promotion in Madagascar'*: wsscc.org/2015/10/02/learning-progress-a...otion-in-madagascar/

Hanchett, S., Krieger, L., Kahn, M.H., Kullmann, C. and Ahmed, R. (2011) *Long-Term Sustainability of Improved Sanitation in Rural Bangladesh*, Washington, DC: World Bank www.communityledtotalsanitation.org/reso...ion-rural-bangladesh

Mosler, H-J., Huber, A., Inauen, J. and Tobias, R. (2012) 'How to achieve evidence-based behavioural change', *Sandec News* Issue 13, Switzerland: Eawag / Sandec
Please see the attached document.

O'Connell, K. (2014) *What Influences Open Defecation and Latrine Ownership in Rural Households?: Findings from a Global Review*, Water and Sanitation Program Working Paper, Washington DC: World Bank, www.wsp.org/sites/wsp.org/files/publicat...anitation-Review.pdf

Oddsdottir, F. (2014) *Evaluations of scaling up*, GSDRC Helpdesk Research Report 1097, GSDRC: University of Birmingham http://www.gsdrc.org/docs/open/HDQ1097.pdf

Presentation on *Systematic Behavior Change*, Prof. Hans-Joachim Mosler, Eawag - please see attached presentation. (www.eawag.ch/)

Taylor, B., (2013) Effectiveness, Scale and Sustainability in WASH Programmes – A Review, *Springfield Working Paper Series* (2), The Springfield Centre, Durham. http://www.springfieldcentre.com/wp-content/uploads/2013/10/2013-10-Effectiveness-Scale-and-Sustainability-in-WASH.pdf

Tyndale-Biscoe, P., Bond, M. and Kidd, R. (2013) *ODF Sustainability Study*, FH Designs and Plan International, www.communityledtotalsanitation.org/reso...inability-study-plan

UNICEF (2014) *Evaluation of the WASH Sector Strategy "Community Approaches to Total Sanitation"* (CATS), UNICEF, www.unicef.org/evaluation/files/Evaluati...RSION_March_2014.pdf

USAID (2011) *At-Scale Hygiene and Sanitation Experiences and Lessons Learned*, USAID Hygiene Improvement Project, The Academy for Educational Development, Washington D.C. http://www.hip.fhi360.org/file/29832/HIP%20At-Scale%20Hygiene%20and%20Sanitation%20-%20Experiences%20and%20Lessons%20Learned.pdf

Water and Sanitation Program (2012) *What Does It Take to Scale Up Rural Sanitation?* Water and Sanitation Program Working Paper series https://www.wsp.org/sites/wsp.org/files/publications/WSP-What-does-it-take-to-scale-up-rural-sanitation.pdf

Wilbur, J. and Jones, H. (2014) 'Disability: Making CLTS Fully Inclusive', *Frontiers of CLTS: Innovations and Insights* Issue 3, Brighton:
IDS, www.communityledtotalsanitation.org/site...ue3_Disabilities.pdf

Websites:

UNICEF: www.unicef.org/wash/index_43107.html

The Global Public-Private Partnership for Handwashing available here: globalhandwashing.org/resources-main/

3ie: http://blogs.3ieimpact.org/making-wash-behaviour-stick/

UNILEVER design advice for mass media campaigns: https://www.unilever.com/Images/slp_5-Levers-for-Change_tcm13-387353_tcm244-409796.pdf

http://www.biomedcentral.com/1471-2458/15/835

http://www.fsnnetwork.org/behavior-bank

Interesting related study by Whaley and Webster (2011) comparing CLTS to Community Health Clubs approach: www.iwaponline.com/washdev/001/0020/0010020.pdf

Shillong Declaration: Promoting sustainable partnerships (2015)
http://www.mdws.gov.in/sites/upload_files/ddws/files/Shillong_Declaration.pdf

On the sanitation efforts in Nadia District in India: http://sabarshouchagar.in

On defining scale in nutrition projects:
https://www.spring-nutrition.org/publications/briefs/defining-scale-nutrition-projects

Ongoing to scale on nutrition behaviour:
http://finalmile.in/behaviourarchitecture/category/social-behaviour

On the link between malnourishment levels and sanitation coverage:
The Research Institute for Compassionate Economics: http://riceinstitute.org/

On effectiveness of a rural sanitation programme in Odisha, India:
http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(14)70307-9.pdf

On improving consumer voices and accountability in Odisha and Tamil Nadu, India:
http://pacindia.org/uploads/default/files/publications/pdf/aaf68c1db435342f0cd6bd77fb9d31c7.PDF

On a private sector initiative funded by Infosys in Karnataka, India: http://parishudh.sedam.org/