

SUSTAINABLE SANITATION AND HYGIENE FOR ALL

ASIA REGIONAL LEARNING EVENT

**“BEHAVIOUR CHANGE COMMUNICATION
FOR SANITATION AND HYGIENE”**

9-12TH MARCH 2015

KICHU RESORT, PARO, BHUTAN



SNV



IRC



SNV is a not-for-profit international development organisation. Founded in the Netherlands nearly 50 years ago, we have built a long-term, local presence in 39 of the poorest countries in Asia, Africa and Latin America. Our global team of local and international advisors work with local partners to equip communities, businesses and organisations with the tools, knowledge and connections they need to increase their incomes and gain access to basic services – empowering them to break the cycle of poverty and guide their own development.

For more information visit www.snvworld.org



IRC is an international think-and-do tank that works with governments, NGOs, businesses and people around the world to find long-term solutions to the global crisis in water, sanitation and hygiene services. At the heart of its mission is the aim to move from short-term interventions to sustainable water, sanitation and hygiene services. With over 40 years of experience, IRC runs programmes in more than 25 countries and large-scale projects in seven focus countries in Africa, Asia and Latin America. It is supported by a team of over 100 staff across the world.

For more information visit www.ircwash.org

This workshop report was written by Erick Baetings and Ingeborg Krukkert, IRC International Water and Sanitation Centre, The Hague, the Netherlands. The findings, interpretations, comments and conclusions contained in this report are those of the authors and may not necessarily reflect the views of either SNV or the Ministry of Health of Bhutan.

This workshop report can be found on the on the Sustainable Sanitation and Hygiene for All (SSH4A) project pages at: <http://www.ircwash.org/projects/sustainable-sanitation-and-hygiene-all>

Acknowledgements

Kudos go to Gabrielle Halcrow, SNV Asia SSH4A Programme Leader, and Antoinette Kome, SNV Global Sector Coordinator for WASH, for brilliantly organising and facilitating the learning event in Bhutan. Heartfelt thanks go to the Public Health Engineering Division of the Department of Public Health, Ministry of Health for co-hosting the event and to SNV Bhutan for all the expert arrangements. Thanks also go to the local authorities, partners and communities visited during the field assignment for their warm welcome and for providing the teams with valuable information and insights. Final thanks go to all the participants for their active involvement and superb interactions and for all their inspirational stories they shared.



This learning event was undertaken with support from the Australian government as part of SNV Asia's Sustainable Sanitation and Hygiene for All Programme.

CONTENTS

SYNTHESIS OF KEY LEARNINGS	1
Introduction	1
Key learning points	1
INTRODUCTION	3
Sustainable Sanitation and Hygiene for All Programme.....	3
SNV Asia regional learning event on Behaviour Change Communication for Sanitation and Hygiene.....	4
DAY 1: MONDAY 8 MARCH 2015	6
Welcome and official opening	6
Workshop objectives and programme	7
Introduction to Block I	8
Summary of Dgroup discussions	9
Group work BCC drivers and success factors	11
Formative research Presentation on SNV's experiences in Asia.....	12
Group work Communication materials used	16
Presentation of group work	17
Explanation of field assignment and formation of groups.....	17
The context of sanitation and hygiene in Bhutan	18
DAY 2: TUESDAY 9 MARCH 2015.....	22
Field assignments	22
DAY 3: WEDNESDAY 10 MARCH 2015	24
Group work Consolidations of field visit findings and recommendations.....	24
Presentation of group work	24
Reflection in country groups	29
Introduction to Block III	30
Presentation Work on BCC by 17 Triggers in Cambodia.....	31
Presentation SuperAmma campaign in India	35

Group activity Debating Game	39
DAY 4: THURSDAY 11 MARCH 2015	42
Programme of day four	42
Recap BCC success factors	42
Introduction to block IV	43
Presentation Costs and effectiveness of hygiene promotion in Bhutan	45
Group work Exploring the use of hygiene effectiveness studies	47
Group activity Debating Game	49
World Café	50
Group work Country shopping bags	52
Success factors for effective BCC	54
ANNEXES	56
Annex 1: Participants list of Regional Learning Event on BCC for sanitation and hygiene	57
Annex 2: Programme of the BCC face-to-face learning event	59
Annex 3: Summary of Dgroup discussions	61
Annex 4.1: SaniFOAM cheat sheet.....	70
Annex 4.2: FOAM cheat sheet	72
Annex 5: Team compositions for field assignments on Tuesday 9 March 2015	73
Annex 6: Hygiene effectiveness ladders developed for and by SNV Bhutan	74
Annex 7: Example of a flowchart for the hygiene practice “toilet and use of toilet” ...	75

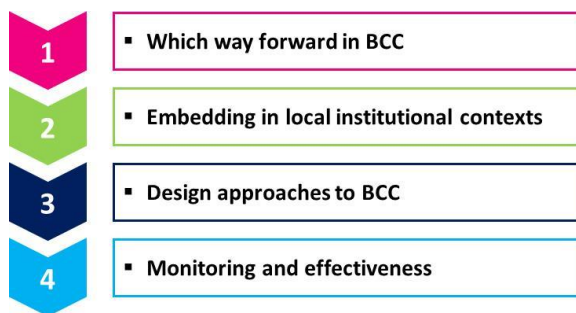
SYNTHESIS OF KEY LEARNINGS

INTRODUCTION

From 9 to 12 March 2015, a regional face-to-face learning event on behaviour change communication was held in Bhutan as part of SNV's Sustainable Sanitation and Hygiene for All (SH4A) Programme. The specific objectives of the learning event were:

- 1) Reflect where we are with BCC and how to make it more successful;
- 2) Look at different design strategies for BCC; and
- 3) Identify priorities for innovations in our own context.

The programme of the four-day learning event consisted of the following four main learning blocks.



A total of 45 individuals, consisting of SNV staff as well as representatives of local partners of five Asian countries (Bhutan, Cambodia, Indonesia, Laos and Nepal) participated in the learning event. The detailed proceedings are documented in this report.

KEY LEARNING POINTS

The following sections will summarise the key learning points.

BLOCK I: WHICH WAY FORWARD IN BCC

1. The “**success factors**” for effective BCC were captured throughout the four-day event and these were summarised at the end of the fourth day as follows: 1) clear messages; 2) target audiences; 3) contextualised and evidence-based; 4) monitoring and follow-up; 5) political will and linking with others; 6) long-term campaign / perspective; 7) no BCC without services; 8) good design and communication objectives; 9) capacity and good facilitation; and 10) community participation.
2. As many hygiene behaviours are interlinked, it is likely that we will work on more than one behaviour at once. It must be remembered however that working on **multiple behaviours** at once is likely to create noise and thus messages may not be heard.
3. Do your homework well before designing behaviour change campaigns. **Fine-tune and adapt** universal drivers and messages to the local context as it is not always possible to start from scratch each time a BCC campaign is designed. Remember **BCC is not a one-off thing**, sustained behaviour change requires time, dedication and sufficient follow-up.
4. **Innovations** are still somewhat limited but it is expected that there will be more support for innovations if these are 1) user-friendly in terms of methodology; 2) cost effective; and 3) have a solid evidence base.

5. **Formative research** reports including analysis of research findings are getting better. However in the past it was a bit too much with insufficient focus resulting in too much data and subsequently shallow data analysis. Materials and communication activities are not always linked to research findings.

BLOCK II: EMBEDDING IN LOCAL INSTITUTIONAL CONTEXTS

6. Field assignments (field visits) provide a good opportunity to learn from local practices and experiences but also provide time to reflect on whether this would work in the participants own context.
7. Different actors (e.g. Ministry of Health and Ministry of Education) collaborate more effectively when they share a **common goal**. Well-functioning learning loops at and between the different government levels are crucial to improve implementation and to enhance capacities at the different levels.

BLOCK III: DESIGN APPROACHES TO BCC

8. Effective BCC strategies or campaigns start with a clever design. It is all about the **design logic**: have a clear intention and be clear about it. There is a need to be more conscious and explicit in our designs, and more evidence-based
9. We can learn from other organisations and programmes. **17 Triggers** in Cambodia uses different more rapid and more participative approaches to study behaviours and to test communication materials. The critical path methodology used by 17 Triggers helps to map the fastest way to get from A (current behaviour) to B (desired behaviour) and identify the critical steps along the way that you need to be aware of.
10. Only carry out behaviour change campaigns when services are in place. For example if there are no local entrepreneurs that are willing to provide pit emptying service, there is no benefit of promoting regular pit emptying to individual households.
11. The results of the **SuperAmma** campaign revealed that fast and furious does not seem to work. However focusing on emotions such as nurture, disgust and affiliation seems to work better than improving access to knowledge.

BLOCK IV: MONITORING AND EFFECTIVENESS

12. Studying the **costs and effectiveness of hygiene promotion** interventions can contribute to a credible evidence base on the cost-effectiveness of hygiene promotion. This can then be used to inform programmes and decision-makers whether and where to make improvements, but the results can also be used to decide whether specific approaches and or programmes can be replicated and or scaled up.

INTRODUCTION

SUSTAINABLE SANITATION AND HYGIENE FOR ALL PROGRAMME

The Sustainable Sanitation and Hygiene for All (SSH4A) Programme aims to improve the health and quality of life of rural people through enhanced access to improved sanitation and hygiene practices. Developed since 2008 with IRC International Water and Sanitation Centre in Bhutan, Cambodia, Laos, Nepal and Vietnam, the SSH4A approach is now implemented in rural districts in 15 countries across Asia and Africa. In 2010, the approach was subsequently adapted and applied to urban and peri-urban contexts in Asia.

The SSH4A approach uses an integrated model that combines work on demand creation, sanitation supply chain strengthening, hygiene behaviour change communication and WASH governance as illustrated in the figure below. An additional cross cutting regional component of the programme focuses on performance monitoring and learning.



SNV's experience working on WASH programmes in more than 22 countries has shown that strategies need to be embedded in longer-term processes that develop sustainable service delivery models at scale. SSH4A is essentially a capacity building approach, supporting local government to lead and accelerate progress towards district-wide sanitation coverage with a focus on institutional sustainability and learning.

The SSH4A approach recognises a number of principles. It focuses on the understanding that sustainable sanitation and hygiene is first and foremost about behavioural change. However, whilst demand creation should come first, affordable hardware solutions also need to be in place so that people are able to act upon their newly defined priorities. SSH4A also recognises the need to reach all by making explicit inclusive strategies with local stakeholders. It focuses on the need to develop capacities and approaches that can be scalable through a government-led district-wide approach, as opposed to focusing exclusively on individual communities.

The SSH4A approach addresses the need to innovate in hygiene promotion practice, linking this to the sanitation drive, but also embedding this practice in long-term health promotion. It also recognises and addresses the need to have a long-term strategy to sustain sanitation and hygiene behaviour change, beyond one-off triggering and ODF-focused programmes. Last, but by no means least, SSH4A focuses on the need to measure progress in small steps (moving up the sanitation ladder), and to measure access as well as the use and maintenance of toilets.

SNV ASIA REGIONAL LEARNING EVENT ON BEHAVIOUR CHANGE COMMUNICATION FOR SANITATION AND HYGIENE

Since 2008, the SSH4A programme has been working to introduce and build capacity in behavioural change communication methodologies at local level, with the active involvement of local and national agencies. A SSH4A learning event in 2010 in Laos mainly focused on this topic and introduced the participants to the work of WSP in terms of FOAM and SaniFOAM¹, as well as barrier analysis (Devine, 2009)². Following the first learning event, a comparative study was conducted in 2010; draft guidelines³ for the component developed and a draft external learning brief prepared which focused predominantly on the formative research work as that had been the key focus.

As a result of the implementation and learning, the country teams have gained increasing experience in formative research using WSP's FOAM and SANIFOAM frameworks and developing district level BCC strategies for both rural, informal settlements and urban populations. We have learned that local formative research contributes to a better understanding of behaviours and change in hygiene promotion practice but that change is slow. While the frameworks, such as FOAM, are helpful, their application requires strong support in the analysis phase and the risk is that without this support the research findings are not translated into changed practice, but, rather, the same lists of activities are proposed. A start has been made to simplify the frameworks for local use, going through a first phase of limiting behavioural determinants. Further work is needed in terms of innovating approaches and moving beyond the business-as-usual way of working.

From 9 to 12 March 2015, SNV (in collaboration with the Public Health Engineering Division, Department of Public Health, Ministry of Health, Bhutan and IRC) organised a regional face-to-face learning event on innovation in behaviour change communication in Bhutan as part of SSH4A Programme. The face-to-face learning event was preceded by a facilitated Dgroup discussion and it will be followed up by in-country activities. The entire BCC learning activity consisted thereof of:

- 1) A preparatory email discussion running on the Dgroup platform from Wednesday 29 January till the Tuesday 24 February 2015;
- 2) A face-to-face regional workshop from Monday 9th till Thursday 12th of March 2015; and
- 3) Follow-up activities in countries, depending on country preferences and local context.

The Dgroup discussions were facilitated to dig further and deeper into the topic of hygiene promotion and the application of BCC insights in practice. As there is a lot of innovation ongoing in hygiene promotion it was thought to be wise to discuss these innovations, and to ask ourselves how much of these innovations are actually visible on the ground. The Dgroup was also expected to answer the question whether it is at all possible to mainstream these innovations in local service delivery, and if yes, how. The Dgroup discussion covered the following three topics.

	Dates	Topic
Week 1	29 Jan – 4 Feb	Where are we now with hygiene promotion?
Week 2	5 Feb - 16 Feb	How do we feel about promising BCC innovations in the sector?
Week 3	17 Feb - 27 Feb	What does it take to mainstream BCC innovations?

¹ Introducing SaniFOAM: A Framework to Analyze Sanitation Behaviors to Design Effective Sanitation Programs, Jacqueline Devine, October 2009, WSP; available on http://www.wsp.org/sites/wsp.org/files/publications/GSP_sanifoam.pdf

² The report of the 2010 SNV Asia learning event on “Performance Monitoring and Hygiene Behaviour Change” is available on http://www.ircwash.org/sites/default/files/asia_workshop_pm_and_bcc_laos_22_24_aug.2010_.pdf

³ The 2010 draft guidelines for the BCC component are available on <http://www.ircwash.org/resources/behavioural-change-communication-guideline-component-3-draft>

The main findings from the Dgroup discussions are presented in this report and more detailed summaries on the three topics are presented in Annex 3 of this report.

This report will focus primarily on reporting the proceedings and immediate outcomes or results of the regional workshop conducted in Bhutan. The generic objectives of the SSH4A learning activities are to:

- ✓ Exchange ideas and deepen our understanding of Behaviour Change Communication strategies and practices;
- ✓ Promote discussion about good practices among partners and staff; and
- ✓ Explore possible innovations for the different country contexts.

DAY 1: MONDAY 8 MARCH 2015

The first day of the four-day face-to-face learning event focused on the following two learning blocks:

- ➔ **Block I: Way Forward in Behaviour Change Communication**
- ➔ **Block II: Institutional Arrangements for Behaviour Change Communication**

The first day started with the usual preludes which are part of any official start of a workshop, such as registration of participants, official opening, presentation of the workshop programme, and a quick round of introductions by all the participants and their expectations.

WELCOME AND OFFICIAL OPENING

The four day workshop kicked off on the 9th of March, 10 am at Paro with a warm welcome speech by Ugyen Rinzin from SNV Bhutan welcoming all the 45 participants from the following six Asian countries: Bangladesh, Cambodia, Indonesia, Laos, Vietnam and the host country of Bhutan.

Antoinette Kome, SNV's Global Sector Coordinator for WASH, thanked all the participants for being able to make it to Bhutan to participate in the workshop. Antoinette explained that the first BCC related regional learning event had been organised in Laos in August 2010 and that she was very happy indeed to be able to come together again after five years to discuss further on the same topic. She said it was a very unique thing, to be working in different organisations but coming together for one purpose.

Rinchen Wangdi, Chief Engineer and the Head of the Public Health Engineering Division, Department of Public Health, Ministry of Health, welcomed all the participants, and global and regional sector leaders to the four-day "Asia Regional Learning Event on Behaviour Change Communication for Sanitation and Hygiene" in the beautiful valley of Paro. Mr Wangdi said that what we know for sure is that behaviour change in sanitation is important but that it is not as easy as it sounds. Change is difficult because people overestimate the value of what they have and underestimate the value of what they may gain by giving that up. Quoting from a book by Gena Showalter, Mr. Wangdi said that people are the most difficult thing in the world to change. So change is hard but it is not impossible. With the right tools, the right motivation, and often with someone helping you out directly, one-on-one, change is possible.

Mr Wangdi said that over the next four days, BCC experts are expected to share best practices, workable strategies and time tested tools and ideas with each other. Furthermore, it will also provide a platform to discuss bottlenecks and challenges. Mr Wangdi concluded his speech by saying that Bhutan is a nation of Happiness and he hoped that everyone present will enjoy a moment of happiness and spread the message of happiness when you all go back to your country. Thank you and Trashi Delek.

The event was honoured by the presence of the Chief of Health Promotion Division of the Ministry of Health, Mr. Dorji Phub. He stressed how important the programme was and that he was proud to be a part of it. He further mentioned how important behavioural change is and that he was happy to see that it was the key component of the workshop. Dorji Phub also mentioned that he expected the workshop to provide further learning and guidance to realise the Royal Government of Bhutan's goal of universal access to improved sanitation even though at present basic coverage has already reached some 95%.

WORKSHOP OBJECTIVES AND PROGRAMME

Antoinette provided a quick introduction of a number of SNV global WASH programmes including the rural and urban Sustainable Sanitation and Hygiene for All (SSH4A) programmes as depicted in the figure below.



Sustainable Rural Sanitation and Hygiene for All

- In 13 countries across Asia and Africa reaching out to over 10 million people
- Collaboration between SNV, national governments and line agencies, and knowledge partners (IRC)
- One framework, tailored to each country

Sustainable Urban Sanitation and Hygiene for All

- In 6 countries across Asia and Africa
- ISF as knowledge partner



WASH in Schools

- In 5 countries in Africa
- Menstrual hygiene management mainstreamed in WASH in Schools

Figure: SNV Global WASH programmes with BCC components

The SSH4A approach has four integrated components supported by performance monitoring and learning. The 'fifth' learning component is meant to promote exchange among countries and focuses on analysis, dissemination and learning. The regional BCC workshop is part of the learning component. SNV organizes and facilitates regular learning activities and these usually take shape as follows:

- ⇒ Starting with a preparatory Dgroup discussion on the chosen topic;
- ⇒ A face-to-face workshop organized in one of the countries; and
- ⇒ Followed by in-country follow-up depending on country priorities.

Learning activities are not limited to the SNV programmes and SNV staff, but intended to exchange ideas, deepen our understanding and promote discussion about good practices among programme staff, partners and a wide range of sector actors. The specific objectives of the workshop organized in Bhutan were:

- 4) Reflect where we are with BCC and how to make it more successful;
- 5) Look at different design strategies for BCC; and
- 6) Identify priorities for innovations in our own context.

Antoinette then explained the logic of the four-day programme which was organised around five learning blocks. How the five learning blocks fit within the workshop programme is depicted in the figure below.

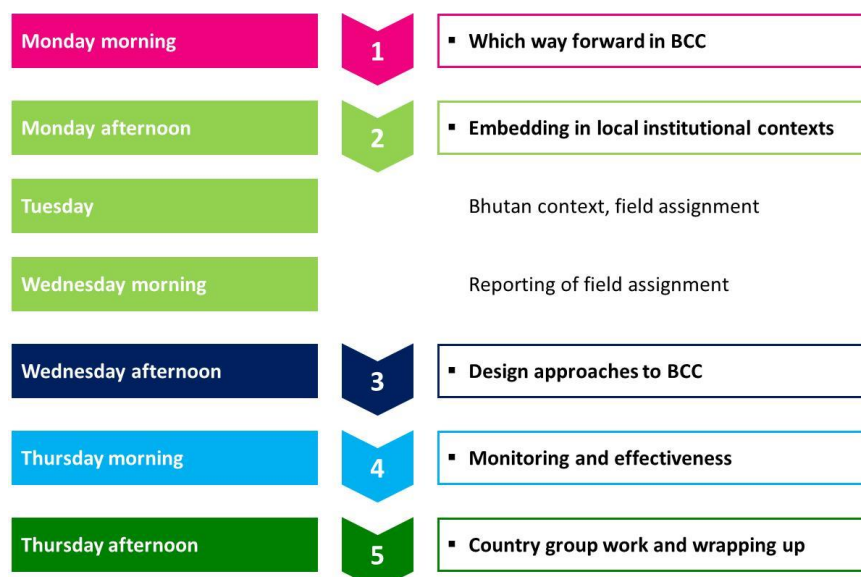


Figure: Breakdown of BCC workshop programme

The detailed workshop programme is attached to this report as Annex 2.

1 Way Forward in BCC

INTRODUCTION TO BLOCK I

Antoinette started the introduction by suggesting to agree on a number of essential concepts. This was done by explaining behaviour change communication on the basis of three simple questions:

1. How does BCC happen?
2. How does communication happen?
3. How to make it (behaviour change) happen?

How does it happen?

How do behaviour and practices change? Changes from one type of behaviour to another type of behaviour happen due to changes in someone's life and these are influenced by externalities. Reasons for change are referred to as behaviour determinants as shown in the figure below. Behavioural determinant refers to any factor which strongly influences and affects behaviour. Whatever, this factor may be, it produces a behavioural effect which may be desirable or undesirable. Cultural norms for example exert a major influence on how people behave.

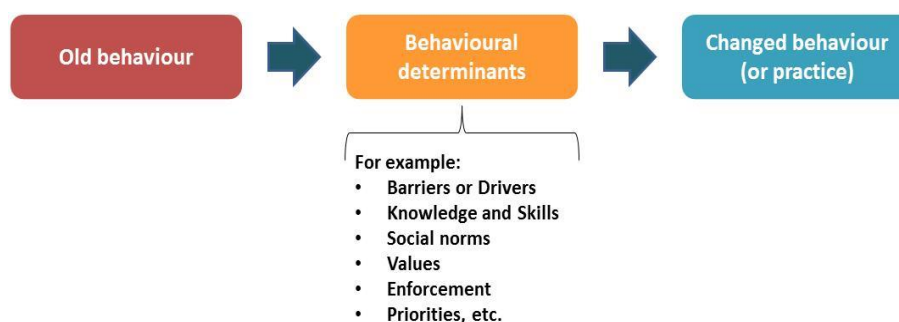


Figure: Role of behavioural determinants in relation to changing behaviour and or practices

How does communication happen?

To make sure we use the same language and to be able to refer to it, Antoinette explained how communication objectives help prioritise which medium to use best considering the behaviour you want to change and the persons you want to reach.



Figure: How does communication happen?

Communication always takes place between the sender and the receiver. The sender has the intention to say something and this can be done (communicated) in different ways. The process to communicate an intended message is as follows: 1) the sender has an intention (communication message); 2) this is encoded into 3) a message, 4) different communication medium can be used to communicate or pass on the message to the receiver; 5) the receiver receives the message and 6) has to encode it so that it is understood and gives meaning to the receiver. Medium can be interpersonal communication, poster, radio, television, theatre, banner, sticker, etc. Message and medium are not the same; in this workshop we will talk about medium, not about materials.

SUMMARY OF DGROUP DISCUSSIONS

Antoinette started by saying that some 100 inputs and or reactions had been received on the three discussion topics over a three-week period. She then reminded the audience about the three discussion topics, namely:

- 1) Where are we with behavioural change communication?
- 2) How do we feel about innovations in BCC?
- 3) What does it take to mainstream BCC?

The summaries of the Dgroup discussions are provided in Annex 3.

Where are we with behavioural change communication?

The main findings are summarised here. 50% of the contributions focused on toilet use combined with hand washing with soap, two contributions focused specifically about hand washing with soap, and the other contributions focused on menstrual hygiene management and pit emptying. Where it concerns drivers for change the following were mentioned: disgust, shame and embarrassment all related to CLTS triggering, guilt, social pressure and social norms, and social support.

A lot of different communication channels (medium) were brought up, for example road shows, racing, sanitation fairs, mini-buzz (mobile TV programme), stickers, songs, demonstrations, radio programmes, champignons, quizzes, peer-to-peer learning, use of mobile phone Apps, but also working with musicians, comedians, those providing local transport, teachers, local authorities, religious leaders, and of course interpersonal communication.



After the findings Antoinette presented the **first dilemma**: focus on a single behaviour or multiple behaviours at once?

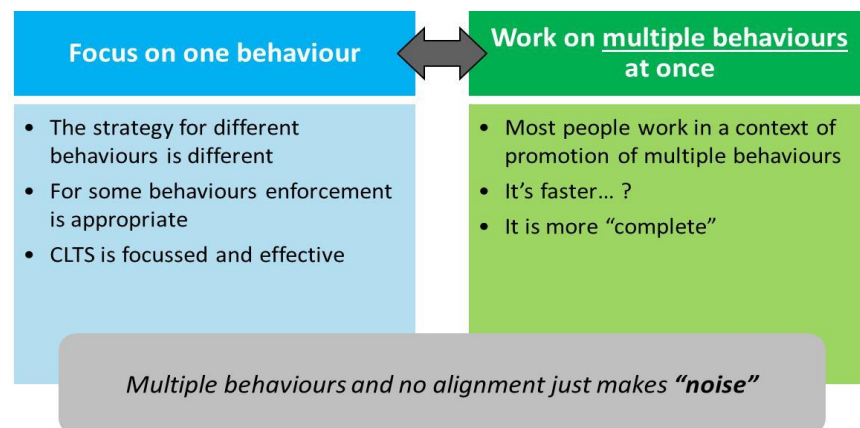


Figure: Dgroup discussion's first dilemma: one behaviour versus multiple behaviours

Some suggested that working on one behaviour at a time is ideal, however in practice it is likely that we will work on a multitude of behaviours at once as many behaviours are interlinked. Nga gave an example where she explained that evidence from four global programmes had shown that hand washing should be integrated in other programmes by linking it with behaviours that are closely linked to hand washing. It must be remembered that working on multiple behaviours at once creates noise and as a result the message will not be heard or got across.

The **second dilemma** that Antoinette presented was about the use of triggering using universal drivers (e.g. disgust and shame) or the need for tailoring using locally specific drivers.

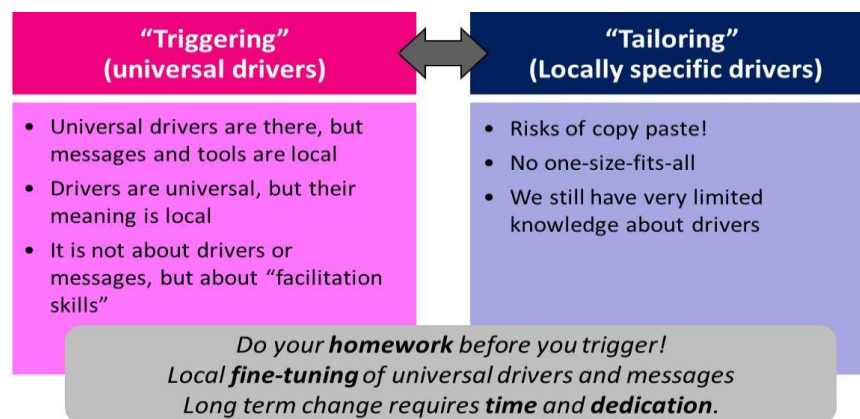


Figure: Dgroup discussion's second dilemma: triggering versus tailoring

The participants were advised to make sure that the drivers they use are valid in their specific context. As it is impossible to start from scratch each time a BCC campaign is designed, it is important to fine-tune what is already there. And remember BCC is not a one-off thing, BCC needs follow-up.

How do we feel about innovations in BCC?

The best known innovation is the CLTS approach developed by Kamal Kar and now used in an increasing number of countries all over the world. Dgroup participants also expressed a lot of interest in innovations in different "mediums", but there was less attention for "design innovations". Gadgets ("hoarding instinct") as a driver for behavioural change were mentioned a lot as they can help to motivate because of a new and positive (modern) association and they could possibly remove a practical barrier. There were however some questions whether gadgets were enough to sustain behaviour and whether they are affordable.

What does it take to mainstream BCC?

Many Dgroup participants stressed the importance of broad alignment and leadership: it starts in the hearts and minds of leaders. Some mentioned the correlation between leadership and enforcement. It was also mentioned that leadership will follow whenever results become visible: joining the bandwagon. Some suggested to employ professional ad-agencies to design campaigns as these agencies are expected to deliver value for money. If you really want to make drastic changes, it may be necessary to take risks.

Conclusions

Antoinette concluded the presentation of the Dgroup discussion by saying that there would be more support for innovations if these are 1) user-friendly in terms of methodology; 2) cost effective; and 3) have a solid evidence base.

GROUP WORK | BCC DRIVERS AND SUCCESS FACTORS

This session was all about the participants' personal experience and reflecting on those moments where they were the audience or the receiver of BCC messages. The country teams were instructed to discuss among themselves which hygiene or health campaign did change the behaviour of individual team members.

Plenary presentations of group work

Before lunch the groups presented the results of their discussions as can be summarised in the following table.

	Type of health campaign	Drivers and success factors
Laos	Mosquito nets campaign	Successful campaign because 1) it was comprehensive including training of staff and village health volunteers; 2) village by village campaigning; and 3) monitoring system put in place
Nepal	Household drinking water treatment campaign	Driver used was the fear of poor health
Bangladesh	Polio campaign	Drivers used were 1) fear of parents; 2) fear of health impact; 3) active participation Successful campaign due to 1) policy alignment; 2) commitment at all levels; and 3) health worker regularly visiting all households
Indonesia	Say not to corruption campaign	Drivers used were 1) transparency; 2) poor infrastructure; 3) corruption makes us poor Successful campaign because of 1) enforcement; 2) government commitment; 3) fear; 4) shame and guilt as it is a "big sin"; and 5) people are expected or encouraged to act as "whistle blower"
Bhutan #1 and Bhutan #2	Solid waste disposal campaign	Health and economic benefits were the drivers The campaign was organised to introduce the three R's (reduce, reuse, recycle) and in particular the segregation of solid waste at the source
Cambodia	Bird flu campaign	Driver used was fear Successful because easy to remember as there was only one message making it very clear

FORMATIVE RESEARCH | PRESENTATION ON SNV'S EXPERIENCES IN ASIA

After lunch Ms Nga Kim Nguyen, BCC Resource Person, presented the findings from a review she had carried out of SNV Asia's formative research. Formative research is the basis for developing effective strategies, including communication channels, for influencing behaviour change. It helps researchers identify and understand the characteristics – interests, behaviours and needs – of target populations that influence their decisions and actions.

Nga started by explaining that she had in fact been stock taking of SNV Asia's BCC activities to generate a quick snapshot of what the different countries are doing.

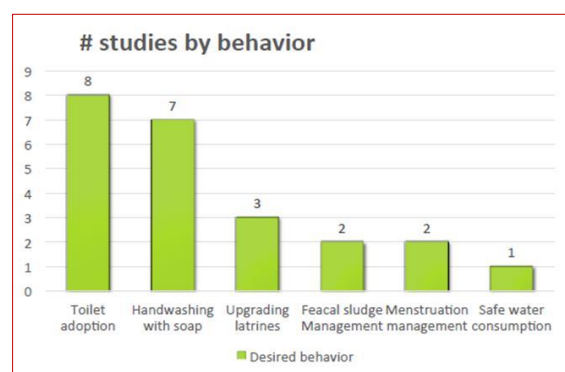


This was followed by introducing a good practice for developing strategic communication campaigns consisting of the following seven steps:

1. Background review of existing research studies, communication materials by behaviour;
2. Identify behaviour of interest and develop key research questions based on above review
3. Conduct formative research
4. Validate findings and develop localised BCC strategy including channels and messages
5. Use existing materials/develop new materials and activities
6. Implement campaign/activities
7. Monitor and measure

We need to start with the question: what are the behaviours we need to know more about? Then we need to answer the question: what do we need to know, followed by what do we have and what do we already know. In short it is all about picking a particular behaviour and questioning what we don't know about this behaviour. Part of this question can be answered through a communication materials audit. In Cambodia they know a lot about latrine construction. Are those factors also applicable to the poorest families? Based on what we know it will inform us to better understand this. You are better able to design your study if you already know what's up there.

Nga then presented an overview what the different countries had done with regards to developing BCC strategies and campaigns. As the following table shows, formative research studies had been carried out in all the six Asian countries. In actual fact a total of 13 studies (9 rural studies and 4 urban studies) were carried out most of them focusing on multiple behaviours. Most of the studies focused on toilet adoption and hand washing with soap. Four of the six countries had also subsequently developed a BCC strategy.



Country	Formative research studies	Target behaviours	Urban / Rural	BCC strategies	BCC materials
Bhutan	✓	Latrine adoption upgrading to hygienic latrines, HWWS, MHM, faecal sludge management	Both	✓	New materials developed for latrine adoption, sludge management and HWWS
Cambodia	✓	Latrine adoption, HWWS	Rural		Used existing BCC materials for latrine adoption and HWWS

Country	Formative research studies	Target behaviours	Urban / Rural	BCC strategies	BCC materials
Laos	✓	Latrine adoption, HWWS, safe consumption of water, MHM	Rural	✓	Games/materials for use in schools and community for latrine adoption, posters for pit emptying/MHM
Indonesia	✓	Latrine adoption	Rural		
Nepal	✓	Latrine adoption, hygienic use of latrines, HWWS	Both	✓	No new materials yet
Vietnam	✓	Latrine adoption	Rural	✓	New materials developed for campaign for latrine adoption

Table: BCC related achievements to date as presented by Nga Kim Nguyen

Formative research on hand washing with soap in Bhutan

Nga then presented a case study on the basis of formative research carried out by the team in Bhutan. She explained that the following two FOAM⁴ frameworks had been used for designing and guiding the formative research:

- 1) SANIFOAM⁵ for sanitation
- 2) FOAM⁶ for handwashing

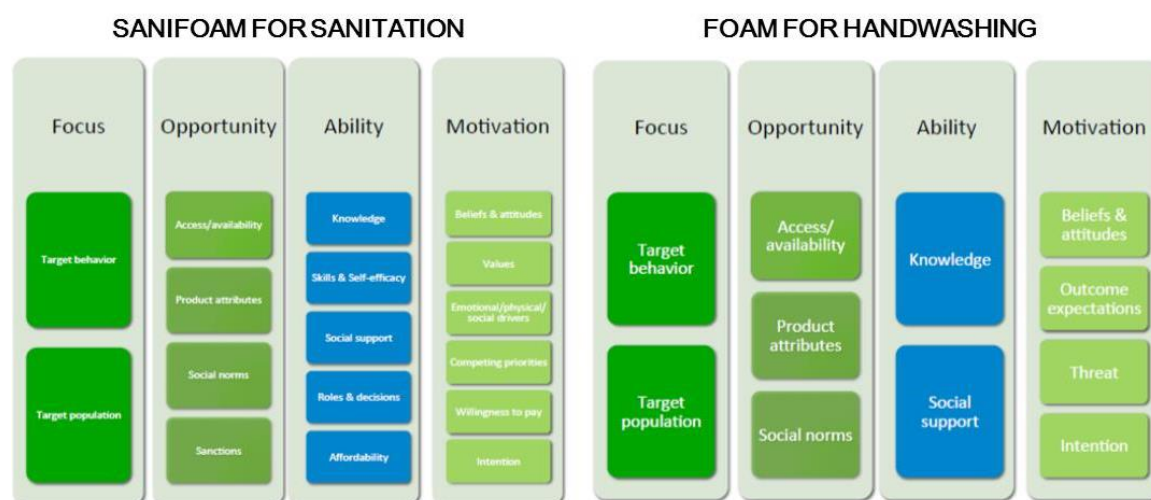


Figure: SANIFOAM and FOAM frameworks

⁴ **FOAM** is a conceptual framework designed to help program managers and implementers analyse sanitation behaviours to design effective sanitation programs. FOAM stands for Focus, Opportunity, Ability and Motivation. More information is presented in Annex 4.1 (SaniFOAM) and Annex 4.2 (FOAM).

⁵ Devine, Jacqueline (October 2009) *Introducing SaniFOAM: A Framework to Analyze Sanitation Behaviors to Design Effective Sanitation Programs*; Water and Sanitation Program Working Paper. Available on http://www.wsp.org/sites/wsp.org/files/publications/GSP_sanifoam.pdf

⁶ Coombes, Yolande and Devine, Jacqueline (August 2010) *Introducing FOAM: A Framework to Analyze Handwashing Behaviors to Design Effective Handwashing Programs*; Water and Sanitation Program Working Paper. Available on http://www.wsp.org/sites/wsp.org/files/publications/WSP_IntroducingFOAM_HWWS.pdf

The findings from the formative research carried out in Bhutan on hand washing with soap practices are presented in the following tables.

BARRIERS	FACILITATORS (drivers)
Access / availability: Although soap and hand washing facilities were available in many households, soap was moved between multiple locations within the house, and not readily available for hand washing during critical times. Hand washing facilities and soap are typically located closer to food preparation areas than toilet facilities. Knowledge: While caretakers know about the importance of hand washing with soap, they associated it more strongly with eating (before and after) than after contact with faeces. Threat: Though diarrhoea is common among children, the threat of dying is low because of relative good access to health care.	Social norms: Hand washing with soap is practised widely in the homes and is commonly related to before eating due to common practice of eating with hands. Outcome expectation: The benefit of hand washing with soap is mainly for prevention of diseases by washing away germs, dirt and bad smell.

Table: Research findings among caretakers of children under five in rural Bhutan

BARRIERS	FACILITATORS (drivers)
Access / availability: Availability of consistent water supply and soap is a challenge for many schools Social norms: Hand washing with soap is not considered as an enduring school norm/rule.	Beliefs and Attitudes: Children believe that hand washing is one of the most important things to do. They feel that hand washing with soap is not boring and not a waste of time. It fills into other fun activities in the school.

Table: Research findings among children aged 6 to 10 years old in rural Bhutan

Communication objectives for the handwashing with soap campaign were formulated as follows:

After the campaign, mothers and carers of children under 5 will:

- ⇒ Know they need to hand wash with soap before preparing food, before feeding their children, before eating, after cleaning their child's bottom and after using the toilet in order to have truly clean hands.
- ⇒ Ensure that soap and water are always available in locations convenient for hand washing, particularly after the toilet.

After the campaign:

- ⇒ School management will believe in the need for ensuring water and soap for hand washing is available at all times and are motivated to find ways to provide this opportunity.
- ⇒ Teachers will feel that promoting hand washing with soap at critical junctures is a way to promote GNH⁷ values or "is a way to become a GNH school".

The following **key BCC messages** were developed:

Caretakers of children under 5

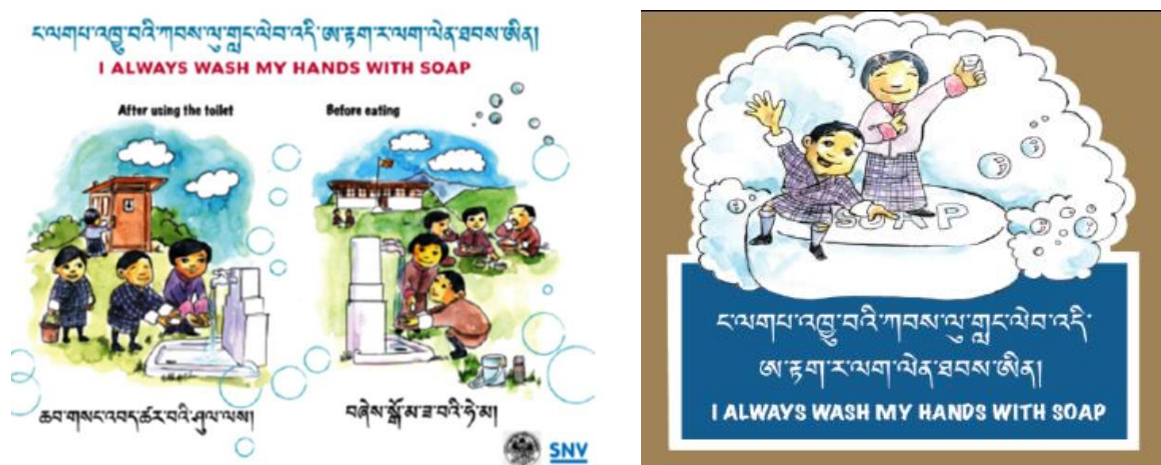
"Always have soap available in a convenient place when you need to wash your hands, particularly at the toilet for truly clean hands."

⁷ GNH = **Gross National Happiness**. Gross National Happiness is a term coined by His Majesty the Fourth King of Bhutan, Jigme Singye Wangchuck, in the 1970s. The concept implies that sustainable development should take a holistic approach towards notions of progress and give equal importance to non-economic aspects of wellbeing. More information can be found on <http://www.grossnationalhappiness.com/articles/>

“Remember the five times to wash your hands with soap: before preparing food, before feeding your children, before eating, after cleaning a child’s bottom and after using the toilet in order to have truly clean hands.”

School management

“A GNH school is one that provides soap and encourages students to always wash their hands after using the toilet and before eating so they are healthy at school.”



Pictures: BCC materials for hand washing soap campaign developed in Bhutan

After the case study on the BCC work carried out in Bhutan, Nga concluded her presentation by summarising the main observations she made on the basis of the stock taking exercise.

Lessons learned from formative research in all six Asian countries

- A bit too much! Multiple behaviours, several audiences per behaviour, too many determinants, too many interviews, too much data = shallow data analysis
- Not always clear which behaviour was studied
- Research tools for children should be developed with them in mind
- Each study should ideally begin with a Research Protocol
- Research reports should clearly state behaviours, audiences, determinants what will be explored
- Research reports need to have quotes to provide evidence for conclusions
- Approach to HWWS may need to go beyond FOAM to look at habit formation
- **Research reports and analysis of research findings are getting better over time ☺**

BCC strategy development and guidelines

- Some countries have BCC strategies, some have BCC guidelines, and some have bits of both
- BCC strategy is your vision or roadmap, BCC guidelines are your tools to help you get there
- Not all countries have BCC strategies but the existing strategies are of good quality overall

Activities/channels/tools/materials

- Compared to above, this component has been less strategically developed.
- There is a gap between the research and materials developed based on the research. Materials and communication activities not always linked to research findings
- In the case of HWWS, there is much more information (research findings) available than what is used for developing the materials. Campaigns should not focus on only one of the findings.
- Strong focus on informational messages rather than emotional, aspirational messages
- Need to work on building intention (more on **HOW** than **WHAT**) plan for latrine acquisition, plan to ensure soap and water are at the right place. Help families to think through all the steps so that they actually can get a toilet or actually can do hand washing with soap.

The presentation by Nga was followed by a question and answer session.

- ? Is there a difference between BCC and general (IEC) communication materials? It is about the whole approach not necessarily that there is a difference between BCC and IEC materials. IEC is often more about providing information to enhance knowledge. It does not address emotional and inspirational issues.
- ? Which poster is more effective: those with positive messages or those with negative messages? In the context of HIV/AIDS campaigns, talking about threats and diseases have not been effective. Talking about loss and gain appears to work. For example if you do not invest in a latrine you will lose out.
- ? Is there a rule of thumb for budget allocations to the different approach steps? No!
- ? Can you explain the interesting findings as presented by Nga that showed a gap between the formative research and the messages and or follow up? There was not a complete delink between the research and the follow up, but not all the information obtained in the research was used.
- ? When we develop the communication medium do we carry out any evaluation? No! However would it be useful to use light methods to evaluate BCC campaigns and in particular to test the approach and materials before the campaign is launched? This topic will come back later in the workshop.

GROUP WORK | COMMUNICATION MATERIALS USED

The country teams were asked to look at their own communication materials, to pick one example and then to prepare explanations by answering the following questions:

- What was the behaviour you were targeting?
- What was the group or audience you were targeting the campaign at?
- What was your communication objective (what was your intention)?
- What were the behavioural determinants you were addressing?



Pictures: Group work in country teams

PRESENTATION OF GROUP WORK

Following the afternoon tea break, the teams were asked to present their selected communication materials and to provide relevant background by answering the above questions.



Pictures: Presentation of group work



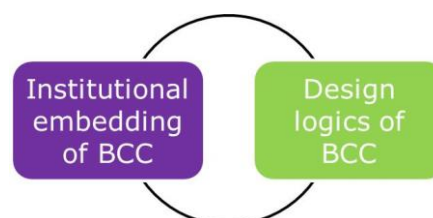
Institutional Arrangements for BCC

EXPLANATION OF FIELD ASSIGNMENT AND FORMATION OF GROUPS

Antoinette explained the field assignment with the use of a PowerPoint presentation. The following is a summary of the main issues presented.

Objectives of the field work

- Learn about the context and experience in Bhutan
- Reflect and discuss about the design logics behind the BCC activities
- Reflect and discuss about the institutional embedding of the BCC activities



Activities and expected outputs

What	When	Expected outputs
Preparation	Monday afternoon	
Visit to households	Tuesday	
Visit to stakeholders		
Consolidation of ideas in the group	Wednesday morning	
Presentation to partners	Wednesday morning	1) Photo diary; 2) Testimony; 3) Case study (2 pages); and 4) Recommendations
Dialogue		

The following **key guiding questions** were provided to the teams:

- Describe the **approach** to changing sanitation and hygiene behaviour
- What are the **institutional arrangements** for the approach to behaviour change?
- What is the **capacity** of responsible agencies to implement the approach?
- What do you see as **strengths** and **weaknesses** of the
 - Behaviour change approach?
 - Institutional arrangements?
- Thoughts about **recommendations**

Areas to visit and topics to observe and study

Team	Where	What (topic)
A	Chukkha town	Septic tank campaign
B	Schools	Hygiene in schools
C	Monasteries	Hygiene in monasteries
D	Thimphu	FSM
E	BHU	Mainstream hygiene promotion

THE CONTEXT OF SANITATION AND HYGIENE IN BHUTAN

Sonam Gyaltsen, Executive Engineer of the Public Health Engineering Division, Department of Public Health of the Ministry of Health Bhutan, gave a presentation in which he gave an overview of the context of sanitation and hygiene in Bhutan. The intention of the presentation was to provide the participants with a better idea of the context of sanitation and hygiene development in Bhutan prior to their field assignment.

Mr Gyaltsen started by explaining the history of the Rural Sanitation and Hygiene Programme (RSAHP) in Bhutan and how it evolved over the years as shown in the following figure. After a couple of years of testing and piloting (2008-2011), the SSH4A programme approach was officially adopted as the basis for the RSAHP since 2011.

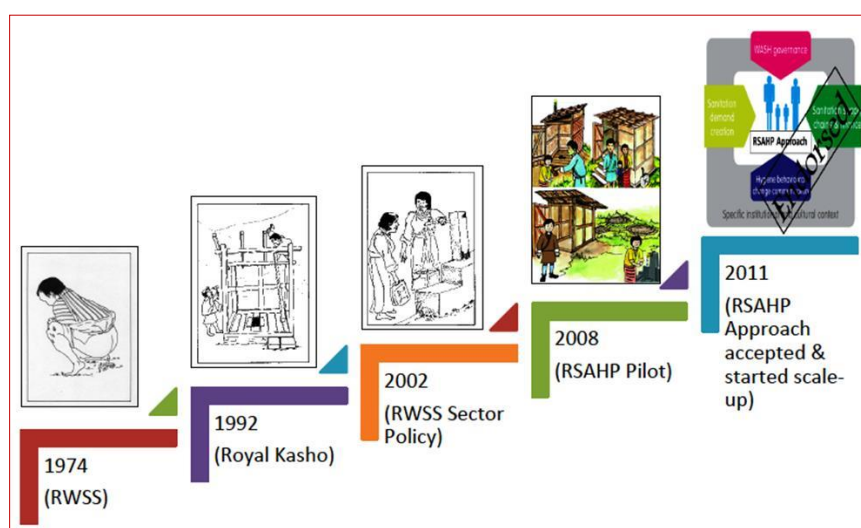


Figure: Evolution of the Rural Sanitation and Hygiene Programme in Bhutan

The **goal of the RSAHP** is to ensure that all Bhutanese citizens (present and future) living in rural areas have access to safe, sufficient and sustainable sanitation facilities, and adopt safe hygiene practices. The objectives of the programme are as follows:

- 1) To meet MDG target of 62% of rural population with access to an improved toilet by 2015;
- 2) To meet the national target of rural population with access to an improved toilet to >80% by the end of the 11th FYP; and
- 3) Sustained hygienic usage of toilets with hand washing practice.

The impact of poor sanitation (diarrhoea, stunting and reduced work productivity) and the benefits of improved sanitation (health, social and economic benefits) were explained. Thereafter Mr Gyaltsen showed a graph depicting the percentages of households without access to improved sanitation as per the National Health Statistics report of 2013. Thimphu had the highest coverage with only 9% of the households lacking improved sanitation whereas Trashigang district had the lowest coverage with 69% of the households lacking access to improved sanitation facilities. He then explained the demand driven non-subsidy approach of the RSAHP which had been officially adopted in 2011. The RSAHP is being gradually scaled up throughout the country and by 2018 all twenty rural districts should have been covered as can be seen in the following figure.

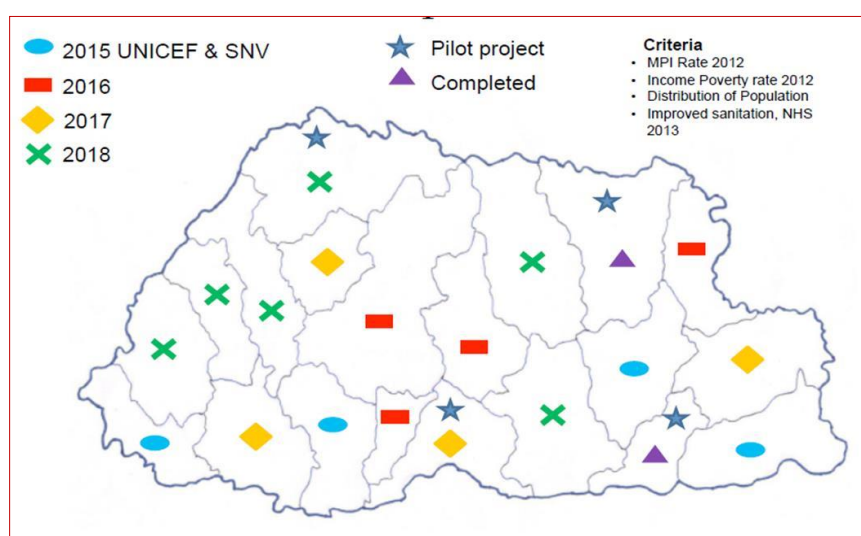


Figure: RSAHP district-wise implementation plan

A two-year implementation cycle forms the basis for replicating the approach in each of the twenty districts. An example of the implementation schedule for is shown in the figure below.

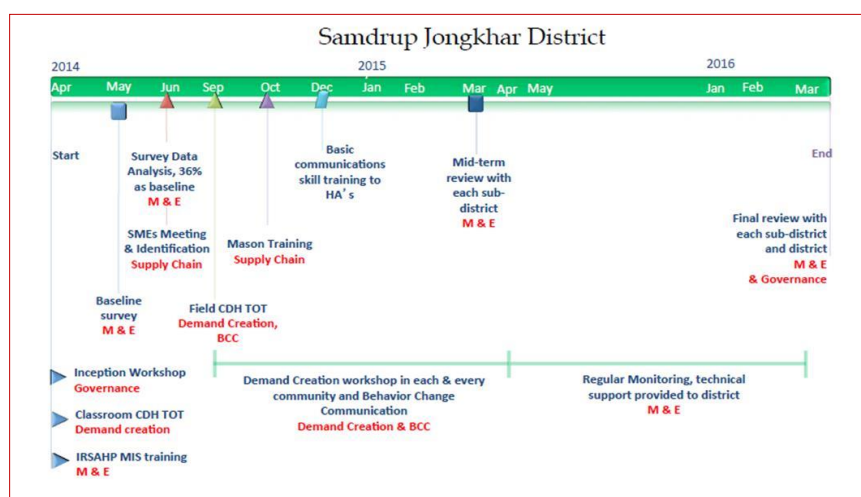


Figure: RSAHP district-level two-year programme implementation schedule

The following figure compares rural sanitation progress to date of 62% in 2015 versus the National Target of 80% by 2018. If correctly interpreted, the figures indicate that progress will have to quadruple in the remaining four years of the RSAHP to be able to meet the National Target in 2018.

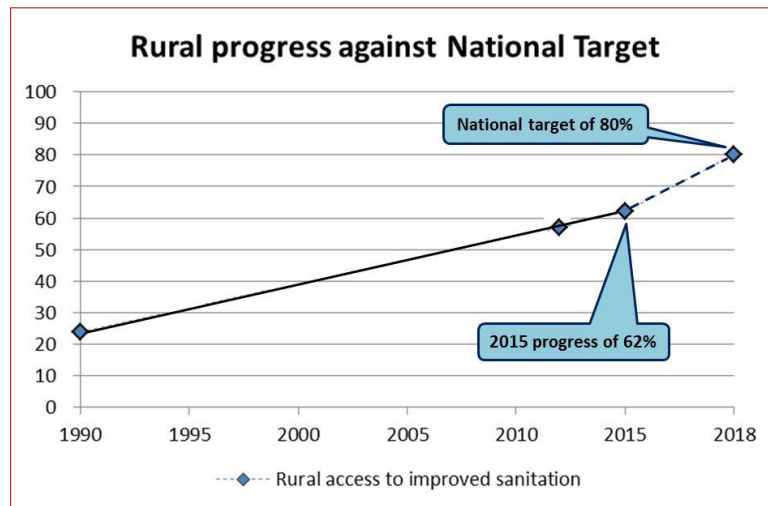


Figure: RSAHP progress versus Bhutan's National Target

Mr Gyaltshen concluded his presentation by listing the **main challenges** that the programme is facing at present, namely:

- Changing behaviour is complex and takes time;
- Reaching 100% coverage is expected to be difficult especially for the poorer households in the communities;
- Limited fund allocation by the districts for the demand creation and governance components;
- Labour shortages due to migration;
- Lack of specialised sanitation engineers;
- Non-availability of sanitation materials in rural areas.





Day 2: Tuesday 9 March 2015

The second day of the face-to-face learning event focused on the following learning block:

➔ **Block II: Institutional Arrangements for Behaviour Change Communication**

FIELD ASSIGNMENTS

The entire day was spent on field assignments. Five teams visited five different locations as indicated in the following table.

Team	Where	What (topic)
A	Chukkha town	Septic tank campaign
B	Schools	Hygiene in schools
C	Monasteries	Hygiene in monasteries
D	Thimphu	FSM
E	BHU	Mainstream hygiene promotion

The composition of the five teams is provided in Annex 5.



Day 3: Wednesday 10 March 2015

The third day of the face-to-face learning event focused on the following two learning blocks:

- ➔ **Block II: Institutional Arrangements for Behaviour Change Communication**
- ➔ **Block III: Designing Behaviour Change Communication**

GROUP WORK | CONSOLIDATIONS OF FIELD VISIT FINDINGS AND RECOMMENDATIONS

The first one and a half hour of the day was spent by the five teams to consolidate their findings and recommendations and to prepare their outputs, namely: 1) photo diary; 2) testimony; 3) written case study; and 4) presentation of field assignment with recommendations.

PRESENTATION OF GROUP WORK

Most of the morning was used by the five teams to present their findings and recommendations related to the field assignments carried out on Tuesday 9 March 2015. Each team was given a maximum of 15 minutes to present their photo diaries and their findings and recommendations.

Urban sanitation in Chukha District - visit to Tsimasham town | Group A

The purpose of the visit was to study the results of a septic tank campaign in an urban setting. During the field assignment the district authorities, community representatives and individual households were visited and interviewed.



Pictures: Visits to key stakeholders in Tsimasham town (District Administration; community representative and household visits)

Main **findings** as presented by the team:

- ➔ Hand washing with soap: ? questionable as no soap was found
- ➔ Latrine adoption or upgrading: ☒
- ➔ Hygienic use of latrine: ☒
- ➔ Environmental cleanliness: ☒ streets were clean; ☒ waste and open discharge was found behind the shops; apparently there is a loss of momentum, for example regular (weekly) cleaning not carried out during the past year

The team came up with the following **recommendations**:

Institutional:

- District government is dedicated and well in-charge, but there is a need to close the learning cycle: national to district to community to district to national

CDH as BCC approach:

- The approach is effective in initial transformation of community and adoption or upgrading of latrines, but CDH alone is not enough:
 - Follow up should be motivation focussed rather than inspection focussed;
 - Appropriate technologies should be introduced that are affordable (soakage wells vs septic tanks);
 - Resource use: think of composting; kitchen gardens; food for cows; community recreation areas
 - It requires a long-term time-frame

BCC activities:

- Materials developed were good, but it would be beneficial to also look at drivers rather than knowledge
- BCC strategy implementation should be continuously monitored and updated. Also target other behaviours (e.g. environmental cleanliness)

Behaviour Change Communication at Jigme Losel primary school | Group B

The purpose of the visit was to visit a “school of quality” and to consider how this successful approach can be replicated and scaled up in other schools. The team visited the school and talked to the head teacher and health coordinators. At the school a total of seven key hygiene practices were taught and maintained, namely: 1) safe use of toilets; 2) safe drinking water; 3) hand washing with soap; 4) personal hygiene; 5) menstrual hygiene management; 6) food hygiene; and 7) (solid) waste management.



Pictures: Visit to Jigme Losel primary school

Team **recommendations** for scaling up the successful approach:

- Motivated and capacitated head teacher is key
- Include life-skills in teacher curriculum
- Continue good working relations: Ministry of Health and Ministry of Education work hand in hand towards common goal
- Involve boys AND girls in life-skills based lessons, also in menstrual hygiene management
- Strengthen other school programmes using success schools as ‘live’ example
- Train health coordinators in social mobilisation skills to motivate parent involvement



Pangri Zampa Monastic School of Astrological Studies | Group C

The purpose of the visit was to observe the sanitation and hygiene conditions at one of Bhutan's monasteries. During the visit the principal of the monastery, the assistant principal and four students were interviewed. The testimony of the principal provided the following quote: ““We have been trying hard, yet sometimes some students listen and behave, while some are simply difficult to influence.”

A summary of the **findings** is presented below.

- ➔ Previously a sanitation committee was formed but it is not functioning at the moment
- ➔ Hostel wardens take care, monitor all general hygiene and sanitation aspect within the school and hostel premises
- ➔ There are a total of four toilet blocks. The toilets used by senior staff were very clean and had soap for hand washing. Some of the toilets and sinks for junior students were broken and soap for handwashing was not available. Cleaning tools and disinfectants were not available.
- ➔ A quick survey revealed that out of ten students, four students washed their hands with water and soap, four wash their hands only with water, and two students did not wash their hands at all.

The following **key challenges** were presented by the team:

- Graduation of oriented/older students and admission of new students every year combined with a general lack of annual trainings and or BCC campaigns
- Frequent changes of teachers

The team came up with following **recommendations**:

- Re-form the sanitation committee to enforce and monitor regularly, reporting broken equipment, or when running out of soap or disinfectant.
- Fix broken equipment.
- Add messages to remind students to use soap when washing hands. Furthermore add soap pouch tied to a thread in all bathrooms (so that soap won't get lost).
- Make cleaning material available in each toilet block.
- Add a checklist for weekly cleaning that includes soap being available, report broken equipment, etc.
- Use purity related to religion as a driver. Emphasize values of not destroying the monastery.
- Design tools so that they are permanently placed somewhere as reminders to sustain good behaviour.
- Enforce monastery wide sanctions if someone breaks equipment.
- Teach children how to clean bathrooms (toilets) properly.



Faecal sludge management in Thimphu | Group D

The purpose of the visit was to observe and assess the faecal sludge management practices in the capital city of Bhutan. The focus of the BCC interventions assessed by team was the timely desludging of human waste holding (septic) tanks. During the field assignment the faecal sludge treatment plant was visited, an urban dwelling was visited to observe the municipality sludge emptying practices, and finally a meeting was held at the Thimphu City Cooperation.



Pictures: Visit to Babesa waste stabilisation ponds and pit emptying operations in Thimphu

A summary of the **main findings** is presented below.

- ➔ The Babesa waste stabilisation ponds are well designed, well managed, and well operated.
- ➔ Strong commitment by RGoB and local authorities to manage and keep the plant functioning well and foresightedness to upgrade the plant to cope with future demand and to accommodate complaints by residents (odour).
- ➔ Less than 50% of the human waste is actually reaching the treatment plant as shown in the following figure.

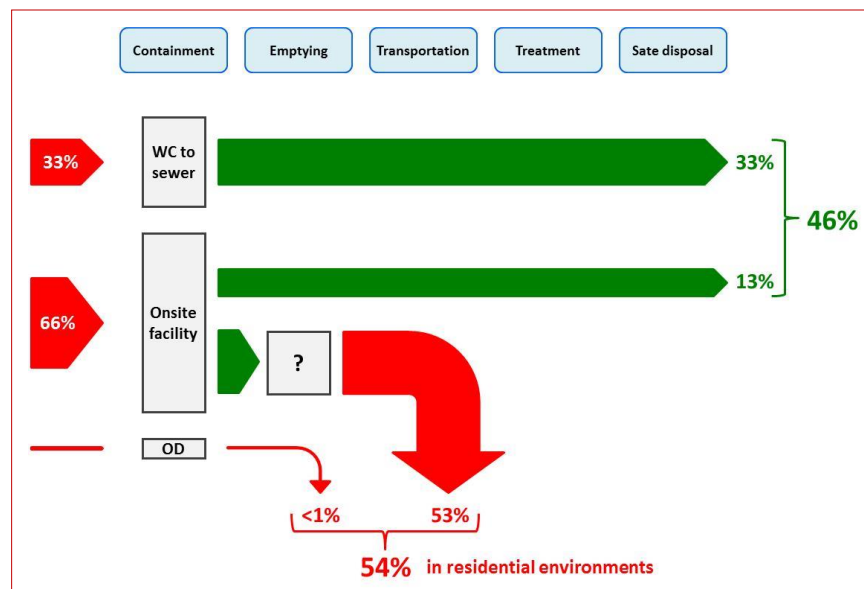


Figure: Crude diagram of faecal waste flows in Thimphu

The team presented the following **conclusions**:

- BCC interventions led to a review of the tariff system that is now consistently applied, transparent and easy to understand.
- BCC interventions might have increased emptying of onsite facilities but the number of facilities disposing human waste in the environment is still high (<50%).
- Current BCC interventions have not been effective in improving septic tank emptying practices (liquid part only) as it has mainly focused on increasing knowledge but has not considered home owner's willingness to properly manage the septic tanks (measuring depth and stirring).
- BCC interventions are hindered due to lack of sufficient staff to educate the public.
- Sustainable change requires a combination of different interventions including BCC.

Finally the team came up with the following **recommendations**:

- Maximise collection, treatment and safe disposal (or reuse) by increasing understanding on the current situation by developing a shit flow diagram on the basis of available data and by assessing quality of onsite (septic) tanks.
- Evaluate effectiveness of current BCC interventions on the willingness of households to manage their human waste holding (septic) tanks.
- Depending on the findings consider (mechanised) alternatives for proper emptying of onsite (septic) tanks.
- Consider undertaking additional research to support enforcement, willingness to pay and reuse.
- Don't sell what works well as long as it is profitable.



Mainstreaming of hygiene promotion in Basic Health Unit in Paro | Group E

The purpose of the visit was to assess to what extent hygiene promotion has been mainstreamed in regular health activities. The team visited therefore Paro Hospital, Dawakha Basic Health Unit in Paro, and a community in the vicinity.



Pictures: Visit to Dawakha Basic Health Unit and a community in the vicinity of Paro

Key findings as presented by the team:

- ➔ Access to basic sanitation in Paro district up to 97%; sanitation is not seen as a major challenge by the health staff
- ➔ Traditional sanitation and hygiene education
- ➔ CDH workshops include a lot of different health information (incl. sanitation and hygiene)
- ➔ Highly committed technical staff at BHU, but need for capacity building on BCC
- ➔ No soap in the toilet in BHU and no sanitation and hygiene related materials visible
- ➔ Beautiful large houses with simple pit latrines. Households are advised to construct a latrine, but no information is provided on technology options nor instruction on how to construct the latrine. Need to understand motivations and barriers.
- ➔ Importance of multi-sectoral cooperation highlighted both at district and sub-district level
- ➔ Improved annual household survey conducted nation-wide (based on the learnings from SSH4A target districts). Not only monitoring latrine coverage, but also progress monitoring in sanitation and hygiene behaviour change.

The team came up with the following **recommendations**:

- Capacity building on evidence-based innovative BCC approaches
- Evidence-based national BCC strategy → communication objectives and key messages
- Learning and exchange visits to SSH4A target districts
- Result-based planning and management with clear targets and action plans
- Introduction of informed choice options for improved sanitation
- Local leadership to promote “Model Dzongkhag” → certificates and official recognition



Following the five presentations, Antoinette invited the panel of Bhutanese representatives to comment on the team presentations.

Ms Deki Tshomo, Deputy Chief Programme Officer, Comprehensive School Health Programme, DYS, Ministry of Education, started by saying that the focus has been on sustainability and institutionalisation. This is being done by including hygiene promotion in the school curriculum and training programmes. However she explained that actual performance may differ per school. The Jigme Losel primary school visited by group B is being used as a model school and the head master is used to inspire other head masters and teachers.

Mr Rinchen Wangdi, Chief Engineer, Public Health Engineering Department, DoPH, Ministry of Health, said that on the basis of what he had heard he thought that the different groups had a good grip on the current situation. He said that the groups had seen different models that work well during the field assignments but that similar models still need to be implemented in other parts of the country. He also mentioned that collaboration among different institutions is getting stronger by focusing and cooperating on a shared vision. He explained that government departments don't only show their successes but also their challenges to the higher authorities. He concluded by asking the groups to continue to share their findings as it will help to improve the RGoB services.

Ms Dechen Yangden, Chief Engineer, Water and Sanitation Division, DES, Ministry of Works and Human Settlement, said that she felt very encouraged because of the good feedback given. We talked a lot about stirring the contents of septic tanks as that will improve pit emptying services, and that will be taken up with the right authorities as not everyone seems to be aware of the problem. She concluded by saying that the field visit and subsequent presentations brought up some interesting ideas.

REFLECTION IN COUNTRY GROUPS

Antoinette asked the participants to consider what they would take home from what we have learned from the five different field assignments. She therefore asked the country teams to go back to their country tables and to discuss what they would like to take home. The 'take home messages' were thereafter recorded on the flipcharts.

INTRODUCTION TO BLOCK III

Following the lunch break Antoinette introduced block III 'Designing BCC' with the help of a PowerPoint presentation. Antoinette started by reminding the participants about the success factors they need to be aware of before designing a BCC strategy, namely:

- ⇒ Clear message
- ⇒ Targeted message (for different audiences)
- ⇒ Campaign associated with action:
 - Presence of services
 - Enforcement
- ⇒ Message that speaks to "me" such as:
 - Fear of death, benefits, values
- ⇒ Participation, working together, political will, broad support

Effective BCC strategies or campaigns start with a clever design. It is all about the design logic: having a clear intention and being clear about it. Our design logic and our approach to design of BCC are often implicit. We need to be more conscious and explicit in our designs. We can be much more evidence-based. You need to be conscious about what your intention is. What is your communication objective? To design a good communication objective you need to understand how for a particular target group a particular behaviour is practised.

Our design logic and our Approach to Design of BCC are often implicit

In the Dgroup there was not much attention to "design innovations". The best known innovation that was brought up was CLTS. Furthermore many participants in the Dgroup discussions showed a lot of interest in "medium" innovations. Antoinette explained that there would be more support for innovations if these are user-friendly in terms of methodology (= design logic), cost effective and are based on solid evidence.

The past days showed that design is often intuitive. The approach to hygiene promotion changed over time: from social re-education, to IEC, to empowerment, to BCC, and finally to marketing. However, these changes were not always evidence-based.

What is design logic? On a question from one of the participants, Antoinette tried to answer the question. Stock taking is the first step: what is happening already. Based on baseline information we decide on a target group and target behaviour. Design is based on research findings: what are the behaviour determinants, what do people do and why are they doing it? This is why FOAM is used as guiding principle in SSH4A. Then we get an idea which determinants are the most important. This will help to frame our message and chose the types of channels we need to use. Findings will be evaluated and used to adapt the campaign if needed.

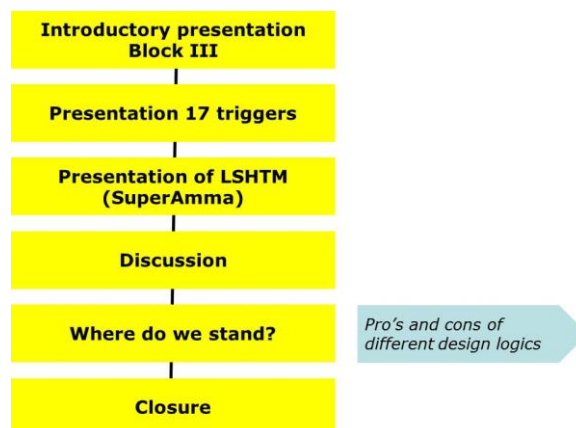
As there was still some confusion about the term 'design logic', Antoinette summarised what she understands about the term 'design logic' which is shown in the following box.

What is meant with design logic

What is our thinking behind the activities that we do?

- About why people change
- About how to reach them
- About how to inspire people
- About which things to do first and which things to do later (process)

Antoinette then explained what was going to happen in block III by showing the different elements as shown in the following figure.



Antoinette concluded the introductory presentation by asking the participants to keep the following questions in mind while looking at the next presentations:

- What is the design logic that was used?
- What info did they use to make the BCC design
- What was communication objective?
- Does it have evidence of effectiveness?

PRESENTATION | WORK ON BCC BY 17 TRIGGERS IN CAMBODIA

Mike Rios, Chief Innovation Officer of 17 Triggers⁸ and based in Cambodia, delivered an extremely interesting and lively presentation on some of the work being carried out by his organisation.

Mike started by saying that 17 Triggers looks at the whole system and that they approach behaviour change differently. It is much more than just communication. The best way is to explain this is to use an elephant and an elephant rider. The elephant represents our emotions (what we feel) and the rider represents the rationale side (what we think and know). He then showed a couple of simple behaviour change checklists for changing different behaviours.



⁸ **17 Triggers** calls itself a “social innovation lab” that does research, design thinking, and marketing for good causes. The mission of the organisation is to achieve 17x more impact and although they know that this might sound ridiculously high, the organisation believes programmes can achieve dramatically more impact by being bold, creative, and sometimes even a pinch ridiculous. More information can be found on <http://www.17triggers.com/>

The following is what you want to achieve with your campaign.

- ☒ The elephant rider knows clearly what to do
- ☒ The elephant is motivated

Mike then gave an example. Everybody knows that you should not smoke; so no need to say “stop smoking”. The elephant rider part is okay he has the knowledge but since the elephant is not motivated messages should focus on motivation. In other words: how can we motivate the elephant to quit smoking? The next part focused on using the same simple principles to change behaviours in WASH.

17 Triggers want all Cambodians to buy a toilet, and the behaviour change checklist for use of a toilet looks as follows:

- ☒ Rider knows clearly what to do
- ☒ But how to motivate the elephant?

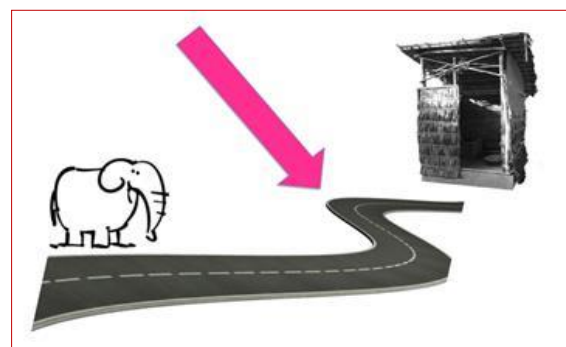
17 Triggers starts by learning about how the target audience truly sees the world revolving around the desired/undesired behaviour. They use a radical new concept and they have excelled in using processes to create truly innovative and impactful social behaviour change campaigns. One of the things 17 Triggers learned early on was the need to switch from cartoons to real pictures of shit. They discovered this when they exposed people to existing posters and asking them what they think without saying what it is about. A few issues came out clearly:

- The shit in a glass of water
- The hand with shit and flies touching a baby



Pictures: BCC material developed by 17 Triggers

CLTS seems to work in some countries by creating disgust and shame. Shit is used in posters. The research revealed that people spent 88% more time with the CLTS tools and materials. Mike then explained that BCC on its own is not enough. The path is the most important thing to change people's behaviour. The path makes it easy to change. How do make change easy. 17 Triggers spent most of their time looking at the path to make it easy for people to change behaviour. Map the path (drawings or pictures) and ask people to look at it and indicate where they have the biggest headache. Also ask others such as service providers. It looked very much as the “critical path methodology” used in other professions. What is the easiest and fastest way to get from A (current behaviour) to B (desired behaviour) and what are the critical steps along the way you need to be aware of?



If the path is considered crucial then a checklist for hand washing with soap should look as follows:

- ☒ The rider knows clearly what to do;
- ☒ The elephant is motivated; and
- ☒ The path makes it easy to change.

How do we make change easy? What is the step by step journey to make people change?

Let's say we want Tola a farmer to buy a toilet. A salesman pitches his story to a group of farmers. Tola goes home and talks to wife. Tola then saves money for toilet. Tola calls the salesman and asks questions. Tola goes to the toilet retailer. Tola buys toilet... and so on. Where's the difficulty in Tola's path to a new toilet? Where are potential or real headaches? How can we make it easier for him? The path needs to be analysed thoroughly so that you can address the bottlenecks. One way of doing this is by asking people to vote for the steps that give them the most headaches.

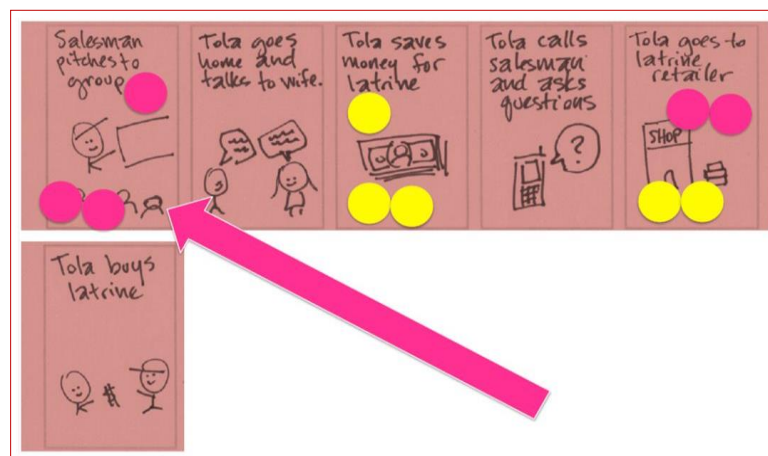


Figure: Identifying critical steps through customer voting

How do we cure the head aches?

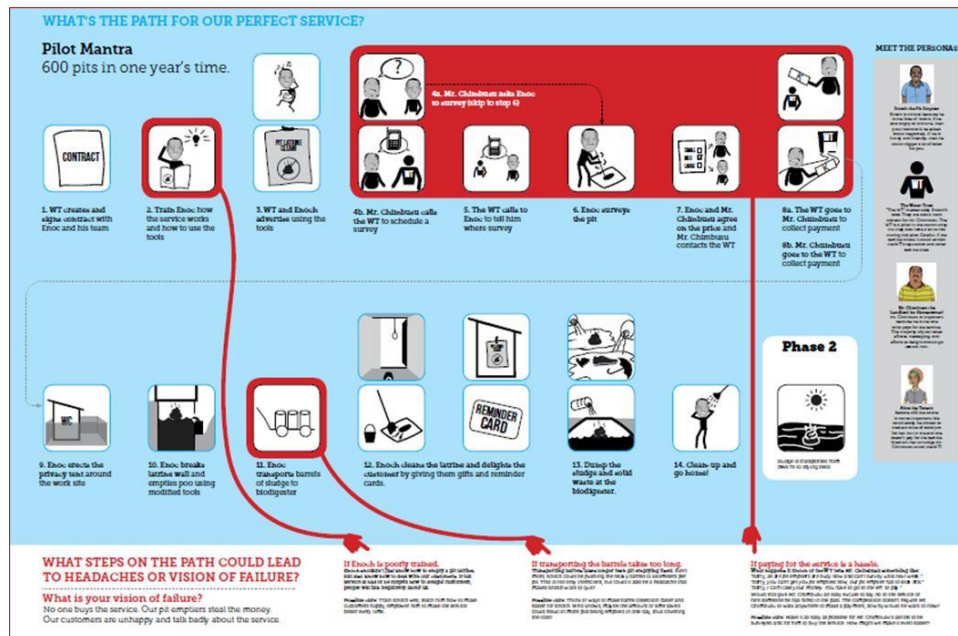
Mike explained that one of the key issues that came out of the research was the fact that entrepreneurs believed that "selling can be difficult" and that "some village chiefs were found to be not supportive". So that is what the campaign focused on primarily and 17 Triggers developed a range of tools to help sell toilets, such as:

- ⇒ Seven-page checklist to replace an earlier 50 page manual
- ⇒ 15 minutes sales pitch flipbook
- ⇒ Training video to motivate and provide tips to salesman
- ⇒ Inspirational video to convince community chiefs about the necessity of latrines

"...we developed a sales agent toolkit of sixteen sales tools, making training of sales agents significantly faster and easier for concrete producers. These tools included a training video, a 'site seller' to help consistently communicate the latrine benefits, training cards to help sales teams deal with common objections, as well as a visual receipt form to minimize order error."

Source: <http://www.17triggers.com/projects/ide/>

A total of 18 issues were addressed to make behaviour change easier. One of the things done was to change to 'free delivery' of the toilet components. All these changes resulted in an increased uptake of toilets. Actual sales increased from 10,000 toilets in the 16 months prior to the campaign to some 120,000 additional toilets in the 24 months following the campaign. Likewise revenue increased from US\$ 350,000 prior to the campaign to US\$ 4,200,000 following the campaign.



Finally Mike showed a couple of examples of how new ideas can be researched if you have only a week or less. It all starts with a simple hypothesis, for example: “people will spend 50% more time with CLTS tools than with other tools”. The innovation is in the way a hypothesis is tested. In the example given above the hypothesis was tested with the help of hidden cameras, timers and exit interviews. Other means for testing different hypothesis are being used but the common denominator is that they should be reliable, fast and easy to use.

Feedback from the participants

Following the presentation Antoinette asked the participants what the design logic is that Mike is using. She then asked the participants to discuss that in their country teams and present their findings in a plenary session to the other participants.

- Bhutan: In our opinion we understood the rider is our conscience, the elephant is our desire. The path is the roadmap to get to the desired end stage. Even if you want to eat the cookie, the rider knows there will be dental problems. However, if there is a great desire we will still eat the cookie. Logic behind this approach is short, simple and effective. It does not address everything. They do a proper problem analysis. That will save costs and resources.
- Nepal: They look at the entire sanitation chain leading to a holistic effort that is successful.
- Bangladesh: Clear intention; help individual and finally tried to remove the obstacles on the path to reach the desired end stage.
- Laos: We go for the short cut as it takes too much time. Design logic: use of real picture, they make some short cuts as well.
- Indonesia: It is not that different from the way SNV does it. It also includes stock taking of existing materials. Focus on target groups and intended behaviour. You do not use FOAM but all three elements are included OAM. Research part is much less rigorous and much more action focused. It is quicker as a way to identify in the field what are the blockages. Much more operational and practical than the classical approach.
- Cambodia: Key issue is to identify on the path what are the key barriers and do this in a visual way that people can relate to. Maybe when you start in a community with 100% OD tools may be effective, for last 20% you may need a different approach.

Mike explained that it is a different reality when it concerns the last 20%. At 17 Triggers we start by defining the ultimate action, for example “construct a toilet”. But it could also be a desire to motivate school principals to fix their latrines or the last mile to build a toilet. “We want target to action” so it will not do to say “have a toilet” as that is too broad. We experiment and test a lot instead of carrying out lengthy studies. 17 Triggers uses different methodologies to see how people react to certain situations.

He also explained the concept of early failure (fail test) by using the following example:

- Hypothesis/signal: if a poster is on a school latrine, 20% of the children will wash their hands with soap
- How will we test it?: through direct observations
- Result: 0% (because there was no soap available in the school).

Another example mentioned by Mike concerned pit emptying or desludging services. People may want their pit emptied but you should not even bother to do BCC if there are no desludging services available.

PRESENTATION | SUPERAMMA CAMPAIGN IN INDIA

This presentation was done by Adam Biran of the London School of Hygiene and Tropical Medicine⁹ (LSHTM) from his desk in London as he was not able to participate physically in the workshop in Bhutan. Adam’s presentation was about the SuperAmma¹⁰ campaign for changing hand washing behaviour conducted in Chittoor district in southern Andhra Pradesh, India. The campaign was a collaborative initiative between LSHTM, St. John’s Research Institute and the Centre of Gravity.

“The SuperAmma campaign is the culmination of years of behavioural science research to inculcate the habit of handwashing with soap. We designed a communication campaign based on the Evo-Eco theory of behaviour change. Here we make available the approach and the materials that worked successfully in Southern India to inspire and assist you in your behaviour change campaign.” Source: <http://www.superamma.org/>

Adam started on the key principles and explained the **mechanics of behaviour change**: environment => brain => behaviour. In simple words: the environment works on the brain and this leads to certain behaviour. To be able to change behaviour we need to address the environment as we cannot intervene directly in the brain. See also the figure on the following page.

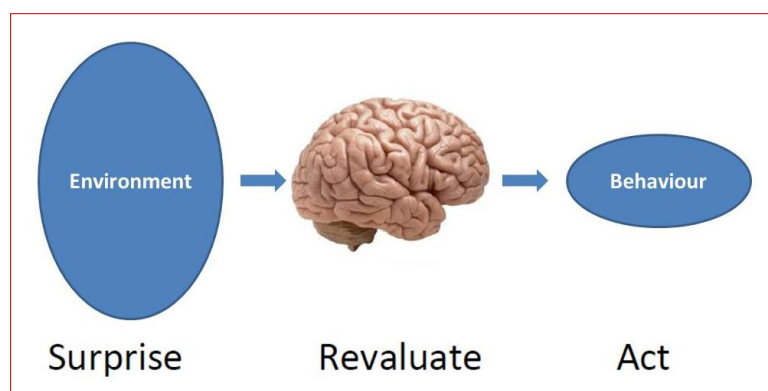


Figure: Mechanics of behaviour change

⁹ The London School of Hygiene & Tropical Medicine is a world-leading centre for research and postgraduate education in public and global health. Its mission is to improve health and health equity in the UK and worldwide; working in partnership to achieve excellence in public and global health research, education and translation of knowledge into policy and practice. <http://www.lshtm.ac.uk/aboutus/introducing/index.html>

¹⁰ **SuperAmma** means Super Mum; the central character in the hand washing with soap campaign. See more at <http://www.superamma.org/>

Adam then gave his own definition of the **marketing approach** which consists of the following three elements: 1) carefully crafted communication; 2) add non-health, often non-functional benefits; and 3) +/- lowering costs in the form of money, social and transactional costs to convince people by showing them what's in it for them either financially or socially.

Another key principle concerns the **human motives of behaviour** based on work by Aunger and Curtis. As part of the Evo-Eco approach to behaviour change¹¹, an understanding of human motivation has been developed based on the idea that each human motive evolved to solve a particular kind of problem of survival or reproduction presented by the human way of life. The set of 14 motives identified through this deductive process should encompass all of the kinds of motivations humans' experience. Investigating these different motives can be a powerful lever of change with respect to behaviour.

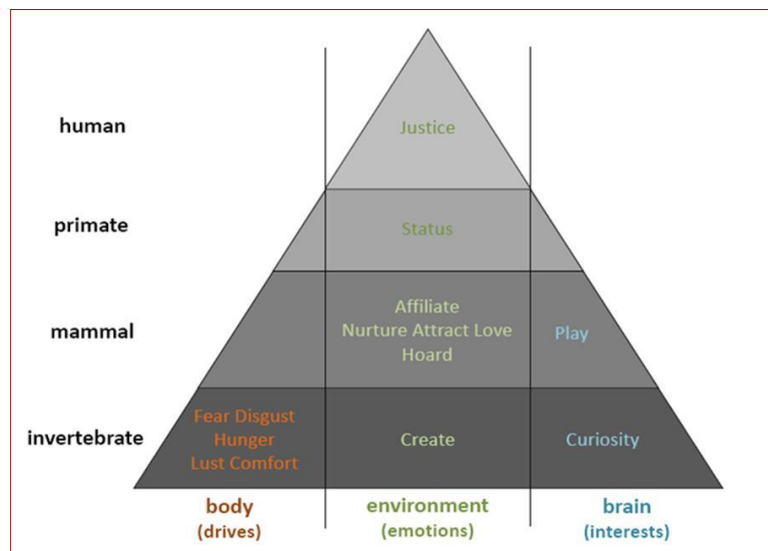


Figure: Human motives of behaviour (Aunger and Curtis).
Source: <http://ehg.lshtm.ac.uk/human-motives-of-behavior/>

Adam thereafter explained the process they have been following to design, test and roll out behaviour change campaigns and this consist of the following six steps:

- 1) Conduct formative research (both field and desk research).
- 2) Find a creative agency
- 3) Create concepts
- 4) Test concepts and executions – and re-test
- 5) Pilot
- 6) Roll out

The presentation then focused on the SuperAmma campaign. The challenge of the campaign was to promote handwashing with soap at key times in an environment where there are no health messages, where there is no mass media but with the potential for scaling up through small intervention teams having limited contact time with the target group. The programme started by conducting formative research with the purpose to find answers to the following questions: 1) when do people wash their hands; 2) why do they wash their hands; and 3) what could motivate handwashing.

¹¹ **Evo-Eco** is a new approach to understanding behaviour change. It is called 'Evo-Eco' because of its intellectual roots in evolutionary biology and ecological psychology. It is based on the insight that brains evolved to provide adaptive behavioural responses to rapidly changing or complex environmental conditions. From this foundation, we have developed a model with three basic components: 1) the environment, which presents a challenge or opportunity to the individual; 2) the brain, which produces potential responses to that challenge; and 3) the body, which engages in interactions with the environment (i.e., produces behaviour) that changes that environment. For more information go to <http://www.hygienecentral.org.uk/research-behaviour.htm>

The research revealed **three motives for hand washing with soap**, namely:

- Disgust: what you don't wash off your hands you end up eating
- Nurture: SuperAmma film: a hearth-warming tale about maternal love... and handwashing
- Social norms: everyone is (supposed to be) doing it; pledging ceremony; stickers on pledged houses; "wall of all" where it is important that you actively have all people in the community sign up to it

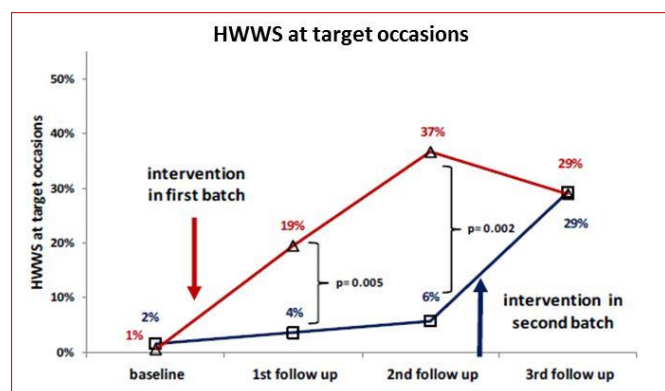
The campaign makes use of local role models, cues and reminders, and the central character of SuperAmma. It is crucial to embed the campaign into local relevance for example by using posters of local people (important people are doing it) and video testimonies of local people (people like me are doing it). People like to see themselves, so use pictures of neighbours, etc. Furthermore reminders in the form of stickers in bathrooms and children's report cards – children monitoring the behaviour of the family at home – were used. Good behaviour was rewarded by giving gifts and certificates, but also through ceremonies. Delivery was kept as mean as possible to be able to scale up the campaign at a later stage. There were two mobilisers: one technician and one driver, who had only four contact days with the community: two consecutive days, two weeks apart.



Pictures: SuperAmma hand washing with soap behaviour change campaign materials¹²

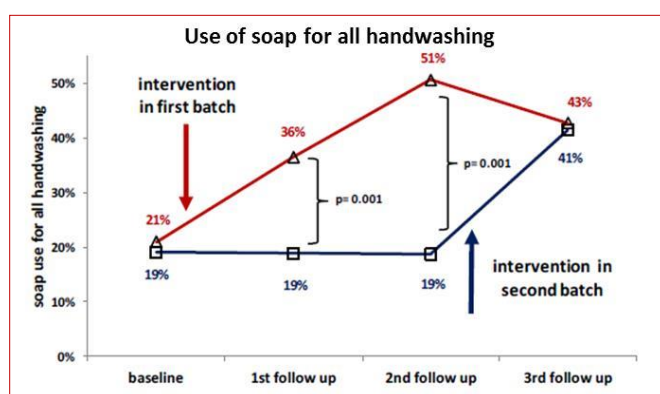
Finally Adam presented the outcome of an evaluation and the results of the campaign. The process evaluation revealed that although there were some early technical issues with the delivery of the intervention the intervention was basically delivered as planned. The headcounts at community events revealed that some 17 to 34% of the village population attended these events whereas exposure through self-reporting with the use of survey questionnaires revealed that more than 70% of the village population had been exposed to the campaign.

The outcome evaluation¹³ was carried out through a cluster-randomised trial in seven intervention villages and seven control villages. Hand washing practices were observed and changes in perceived norms were measured with the help of survey questions.



¹² More information and materials are available on the <http://www.choosesoap.org/> website.

¹³ For more information on the evaluation see the article Effect of a behaviour-change intervention on handwashing with soap in India (SuperAmma): a cluster-randomised trial available on: <http://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2813%2970160-8/fulltext>



Handwashing with soap at key events was rare at baseline in both the intervention and control groups. We identified strong evidence that, at 6 weeks' follow-up, handwashing with soap at key events was more common in the intervention group than in the control group. Restriction of the analysis to occasions with potential faecal contact (after toilet or child cleaning) showed much the same result, as did handwashing with soap before eating or food preparation, and overall

soap use for handwashing. At 6 weeks, there were substantial differences between intervention villages in handwashing with soap, suggesting a substantial initial heterogeneity in intervention effect. The last three villages to receive the intervention had much higher prevalence of handwashing with soap after intervention than did the earlier villages.¹⁴

The results of the evaluation on normative beliefs about handwashing with soap are shown in the following table.

In this village...	Intervention villages	Control villages
almost everyone HWWS before eating	35%	8%
almost everyone HWWS after defecation	36%	10%
people HWWS more than in other villages	98%	42%

Adam concluded his presentation by presenting the following main conclusions of the SuperAmma behaviour change campaign on handwashing with soap. Evidence suggests that behaviour change can be achieved by not focusing on health issues. It will however require creative inputs and small-scale intensive interventions. However as the results show (34% success rate after one year), there are still a lot of unwashed hands which means that short-time campaigns will not be sufficient to change everybody's behaviour.

Adam's presentation was followed by a question and answer session.

- ? What was the reason for not using mass media? Adam: we wanted to test a campaign that can be rolled out locally with limited resources, however ideally any campaign should include mass media channels.
- ? Why only 4 contact moments? Adam: our team was in each village for four days and afterwards we created a shorter version for the control villages of only two days. This makes it possible to scale up the approach.
- ? Why did you focus on nurture as a trigger? Adam: this had come out of qualitative research carried out in a number of countries. It is also a very positive trigger.
- ? What was the role of fathers and men? Adam: they were not specifically targeted and they were not seen as critical for the campaign. Even so they participated actively in the campaigns. A father figure is included towards the end of the film.
- ? Why was health not included in your messages and motivators? Adam: we thought that using other more emotional triggers would be more effective as we had unsuccessfully tried the health angle in

¹⁴ Extract taken from the above article [Effect of a behaviour-change intervention on handwashing with soap in India \(SuperAmma\): a cluster-randomised trial](#) by Dr. Adam Biral et al.

previous campaigns. Furthermore, people do know that HWWS is important so no need to emphasise again and again.

- ? How did you use video for formative research? Adam: my colleagues took large amounts of footage and observed what people were doing. I tend to use it more as stimulance for subsequent interviews.
- ? Whose behaviour did you observe and was there any bias as a consequence of observations? Adam: every member in the household was included in the observations. I don't know about observation bias. We have no real way of knowing that. In previous studies where we used the same method we did not find any bias. Possibly some courtesy bias might have occurred as a result of the campaigns. People were not aware that they were being observed and observers were not aware that there had been a HWWS campaign in the village.
- ? What evaluation tool was used, only observations? Adam: aside from observations, self-reporting was used to obtain information on normative beliefs what other people do in the village. Data on behaviour was based on the observations.

GROUP ACTIVITY | DEBATING GAME

Antoinette introduced the plenary group activity by explaining the rules of the debating game as shown in the following box.

Rules for the debating game

- 1) Participants individually decide whether to support the statement or not (pro or con)
- 2) The two debating teams (pros and cons) then get time to prepare their arguments
- 3) First debating rounds (fixed times 5, 3 and 2 minutes)
- 4) Retreat to re-organise your arguments and refute the arguments of the opposing group.
- 5) Second debating round (fixed times 3 and 2 minutes)
- 6) Retreat to re-organise your arguments, refute the arguments of the opposing group and make your closing statement
- 7) Finale debating round (fixed times 3 and 2 minutes)

Antoinette also gave a number of tricks as shown in the following box.

Tips and tricks for the debating game

- 1) Define what you are talking about
- 2) Listen very well to what the other group says!!!!
- 3) Use the diversity in your group to get arguments from many different perspectives
- 4) Divide roles

The first debating game dealt with the statement: **Does a detailed framework (like FOAM) guide us to design BCC or complicate us?**

- ☒ It is guiding us (all participants minus 5)
- ☒ It is complicating us (5 participants)

Individual participants took some time to look at the statements and to consider their own standpoint on whether they were going to support the statement or not. When the teams were formed – those in favour of the statement and those against – were given time to prepare for the upcoming debate. Two rounds of arguments and counter arguments were carried out. A team of three volunteers were asked to judge the arguments as well as the actual delivery of the arguments of the two teams. Their final judgement was as

follows: the team that felt that detailed frameworks like FOAM are providing guidance: 14 points; and the team that did not agree with the statement: 12 points.



Pictures: Debating game

The second debate dealt with the statement: **Do you need creative add companies to develop effective campaigns?**

- ☒ Yes we need (all participants minus eleven)
- ☒ No we don't need (eleven participants)

The same process was followed and the final judgement by the judges was as follows: the “yes” team: 14 points; and the “no” team: 12 points.

The third debate dealt with the statement: **Capacity for BCC design needs to be present primarily at:**

- ⇒ **Local level** (11 participants)
- ⇒ **National level** (all remaining participants)

The same process was followed and the judges scored the arguments and delivery as follows: the “local level” team: 13 points; and the “national level” team: 14 points.



Pictures: Debating game going on with pro and con team captains delivering their arguments



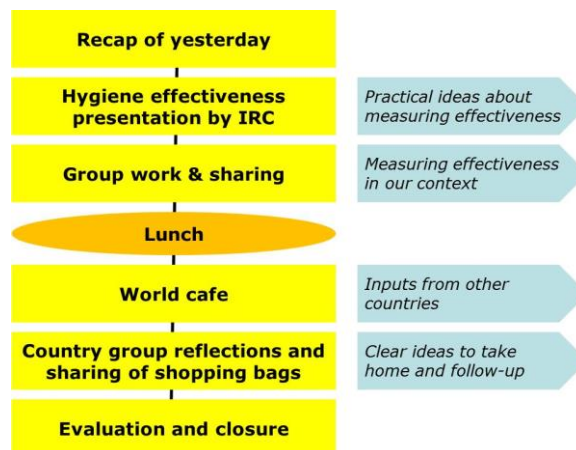
Day 4: Thursday 11 March 2015

The fourth and final day of the face-to-face learning event focused on the following two learning blocks:

- ➔ **Block IV: Monitoring and Effectiveness**
- ➔ **Block V: Country group work and wrapping up**

PROGRAMME OF DAY FOUR

Antoinette started the final day by saying that two topics will be discussed during the day, namely 1) monitoring and effectiveness in the morning; and 2) World Café and wrapping up in the afternoon. Antoinette then explained what was going to happen during the day in a bit more detail by showing the different elements as shown in the following figure.



RECAP | BCC SUCCESS FACTORS

The recap focused primarily on updating the success factors for effective BCC identified during the first day. Antoinette asked the country teams to discuss on the basis of what we have seen and heard during the past days whether there are any new success factors the teams want to add to the “wall of success”.

Presentation by country teams of **additional success factors**:

Laos

- Consider country context
- Long-term and focused campaigns
- Effective monitoring for measuring results
- BCC campaigns have to go hand in hand with service provision (e.g. soap for HWWS)

Bhutan #1 and Bhutan #2

- Monitoring for motivation
- Capacity building at all levels
- Apply (the best) design logic
- M&E system (monitoring)
- Commitment and capacity
- Non-health promotion
- National level policies to support BCC

- Explore commercial companies to support our work

Nepal

- Positive sensation
- Purity is a good driver (connect to religious beliefs)
- Nurturing as a motivator (SuperAmma)

Bangladesh

- Setting up communicating objectives
- Address
- Monitoring

Indonesia

- Right triggering
- Good quality of data, clear strategy, clear objectives, clear messages, good facilitator
- Understand local context
- Unique and interesting tools
- BCC should be participatory

Cambodia

- Clear design logic
- Services need to be available when starting BCC campaigns
- Contextualise
- BCC should be based on evidence
- BCC is not a standalone activity and must be integrated with other programmes and or activities



Pictures: Updating the “wall of success” with additional success factors for effective BCC

4

Monitoring and Effectiveness

INTRODUCTION TO BLOCK IV

Antoinette gave a short introduction to Block IV “Monitoring and Effectiveness” by showing the following matrix. The matrix provides four different options of how cost effectiveness of hygiene promotion can be classified, from cheap to expensive, and from less results to more results.

Antoinette explained that measuring effectiveness of hygiene promotion activities or programmes is very difficult.

Measuring cost effectiveness of hygiene promotion is even more challenging than hygiene promotion!

What is the purpose of measuring cost effectiveness? How and for what purpose would this type of information be used? How do we measure the results of hygiene promotion? Which costs do we take into account and how do we measure all the costs without going crazy?

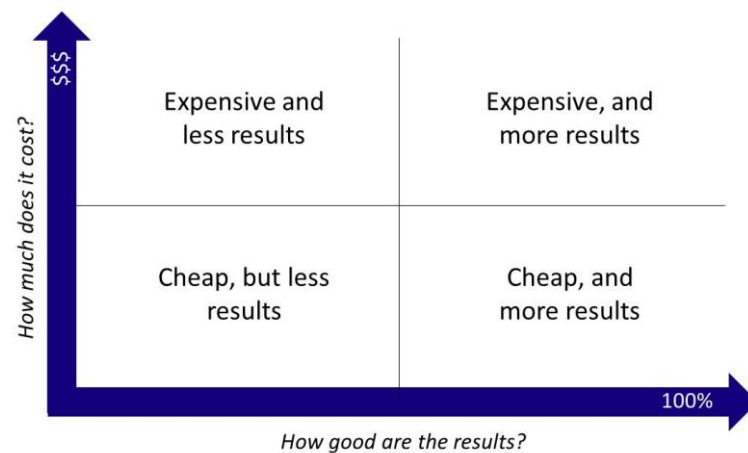


Figure: Cost effectiveness of hygiene promotion matrix

Problems in measuring results: what type of result do we measure?

- ➔ Whether people are now washing their hands? (behaviour objective)
- ➔ Whether people have changes their attitude towards hand washing? (communication/campaign objective)
- ➔ Whether people have heard the message? (outreach)

The three different results that can be measured are depicted in the following figure.



Figure: Different results of hygiene promotion activities

Hygiene promotion activities can be about different behaviours, different target groups, different communication objectives, etc. If hygiene promotion is part of a bigger programme, how do we know the results can be attributed to the promotion activities? Concluding the introduction Antoinette reiterated that it is difficult but worthwhile trying as we have not really measured the results of hygiene promotion activities so far. However she questioned whether the approach could be simplified.

PRESENTATION | COSTS AND EFFECTIVENESS OF HYGIENE PROMOTION IN BHUTAN

Ingeborg Krukkert presented an update on a cost effectiveness of hygiene promotion study being carried out in Bhutan led by IRC with SNV and the MoH. Ingeborg started by explaining the underlying reasons why hygiene effectiveness studies are being carried out, namely:

- It can guide the programme for improvements:
 - Where to adapt or refine hygiene interventions
 - Where best to allocate money to
- It can support decision makers at the Ministry of Health
 - More accurate information on costs and effectiveness of BCC interventions
- It can be used as input for a research grant for scaling it up to other districts or to other areas such as schools; and
- It can contribute to a credible evidence base on the cost-effectiveness of hygiene promotion which can be used to lobby and advocate for continued investment in hygiene promotion.

The hygiene cost-effectiveness study (HES) focuses on hygiene promotion interventions whereby the study aims to analyse and compare the costs and outcomes (results) of hygiene promotion interventions. In Bhutan the study focuses on three WASH related hygiene practices, namely: 1) toilet and toilet use; 2) hand washing with soap; and 3) use of safe water for drinking and cooking. The HES consists of the following elements:

- 1) Data collection on key hygiene behaviours
- 2) Data collection on costs
 - a. At various stages
 - b. By different stakeholders including households
- 3) Data analysis and sense making
 - a. Assess hygiene practice levels
 - b. Compare costs to the changes achieved in hygiene practice levels

Before data can be collected on the three key hygiene practices, **hygiene effectiveness ladders** (also called hygiene practice ladders) need to be defined. The hygiene effectiveness levels are used to analyse and compare the costs and outcomes of the hygiene promotion interventions. The hygiene effectiveness ladders consist of the following four levels:

- **Not effective** (unhygienic practice)
- **Limited** (in-between practice)
- **Basic** (acceptable practice)
- **Improved** (ideal practice)

The hygiene effectiveness ladders developed for and by SNV Bhutan are provided in Annex 6.

Flowcharts – which describe a logical chain of events or practices – are used as a decision-making tool to determine where a household fits in the different hygiene practice levels. The flowcharts also makes it easier to identify “points of failure” if any. The “points of failure” are basically points where households are not able to move up the hygiene effectiveness ladder. It makes it clear at what point of the ladder the biggest problems are: where are the main headaches? An example of a flowchart developed for the Bhutan hygiene effectiveness ladder is provided in Annex 7.

After the general introduction, Ingeborg showed a few slides with preliminary results from the baseline survey exercise. She then explained that the **costs of the hygiene promotion** interventions are to be obtained and analysed. Although it may not be easy at all times to find all the costs, they should include ALL costs associated with the hygiene promotion interventions:

- **At various stages:** before (start-up), during (implementation) and after (maintenance) completion of the intervention
- **By different stakeholders:** implementers, households and support costs (district and national)
- **For different types of costs:** financial costs (monetary investments) and economic costs (time spent)

Finally Ingeborg presented a summary of the steps that are to be taken to complete the hygiene effectiveness study successfully.

First step: data collection on key behaviours and costs

- ⇒ At HH: hygiene effectiveness level before and after the intervention by using the hygiene effectiveness ladders
 - Household surveys
 - Observational data
- ⇒ With government, implementers and non-government players:
 - Interviews
 - Project documents (budget and reports)
- ⇒ Market price data

Second step: data analysis

- ⇒ Assess hygiene behaviour changes before and after implementation per household
- ⇒ Place costs collected into categories (e.g. one-off costs, preparation costs, recurrent costs)
 - Compare costs against effectiveness of the intervention in hygiene behaviour change

The same is shown in the following figure.

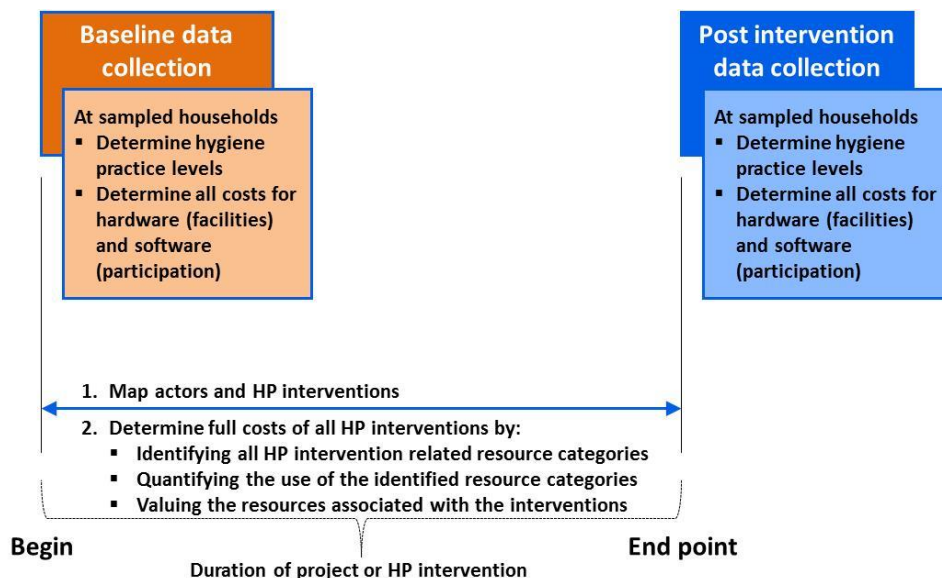


Figure: How to obtain all the required data for the hygiene effectiveness study¹⁵

Ingeborg's presentation was followed by a question and answer session.

- ? Where are we now and what remains to be done? Hygiene practice ladders were generated on the basis of data collected during the baseline exercise.

¹⁵ Overview used to introduce HES approach for SNV Cambodia during a baseline preparation workshop conducted in October 2014 by Erick Baetings.

- ? How do you measure handwashing with proxy indicators if there is no separate handwashing station but the bathroom next to the toilet is used? Timing of data collection: at the beginning; in the middle; and at the end of the programme as part of the regular monitoring data collection rounds.
- ? Is it possible to go one step further and look at the health impact of the hygiene promotion interventions? We could try to look at the health related data available at the Ministry. Stunting related data such as height of infants and small children might be useful to look at.

GROUP WORK | EXPLORING THE USE OF HYGIENE EFFECTIVENESS STUDIES

Antoinette introduced the group work and asked the country teams to explore the use of the hygiene effectiveness study for the different countries by carrying out the following:

1. Select one key hygiene behaviour
2. Do you have data about this behaviour?
 - a. Behaviour level
 - b. Communication objective
 - c. Outreach
3. What kind of cost data do you have? Think through the different steps of the intervention
4. What would you use that information for?

Presentation by country teams

Laos	
Q1: Select one key hygiene behaviour	Uptake of pit emptying services
Q2: Do you have data about this behaviour?	a. % of HH who use the services b. Everybody knows (knowledge) about and uses (behaviour) the services. Encourage people to use existing services. Focus is on improving existing services and creating more demand for these services with the aim to bring down the costs of these services. c. Target 100% of HH in our target area
Q3: What kind of cost data do you have?	No idea about costs but we can collect. Campaign costs are known.
Q4: What would you use that information for?	?

The team was asked how they are going to measure effectiveness of the campaign. We collect data on increase in knowledge, costs of services, and actual uptake of services. Antoinette said that it was interesting to see that part of the costs for marketing and promotion are born by the private sector. Will it be possible to include these costs?

Bhutan #1	
Q1: Select one key hygiene behaviour	Timely desludging of septic tanks
Q2: Do you have data about this behaviour?	a. Homeowners were target group b. Lack of knowledge about services. Timely desludging c. 300 HH changed their attitude; 15 HH made use of the desludging services. Mainly because services were not fully in place and costs were high. Lack of enforcement.
Q3: What kind of cost data do you have?	Cost data on strategy development, material development, campaign. In terms of actual costs we have rough estimates, but it would be good to have more accurate costs.
Q4: What would you use that information for?	?

The team was asked whether it would make sense to do a hygiene cost effective analysis knowing that the campaign was not that effective. Maybe it is not necessary in all cases to start with a cost-effectiveness study. Instead the focusing on improving service levels could be more relevant.

Nepal	
Q1: Select one key hygiene behaviour	Hand washing with soap
Q2: Do you have data about this behaviour?	a. Behaviour level: baseline survey; end-year monitoring; monthly reports b. Communication objective: no data available c. Outreach: no, we have planned
Q3: What kind of cost data do you have?	Cost data on project activity costs and monitoring costs
Q4: What would you use that information for?	information will be used to prioritise promotion activities, feed into district BCC strategy, and monitoring the strategy in old districts

The presentation ignited quite a bit of discussion on the need to collect data on a regular basis on outreach of promotion activities. Although most of the countries collect data on outreach of programme interventions, this type of data may not be regularly available.

Indonesia	
Q1: Select one key hygiene behaviour	Toilet use
Q2: Do you have data about this behaviour?	a. Behavioural level: 40% still OD b. Persuade or convince people to use a latrine c. 370,000 people population of the district (100%)
Q3: What kind of cost data do you have?	Costs: \$750 from district government and \$500 from national level. 4 villages. Training and triggering of cadres. Result: increase of 10% of people using toilet.
Q4: What would you use that information for?	information will be used to conduct triggering for religious leaders

Some participants were confused about the focus of the campaign. Is it about providing access to toilets or just the use of existing toilets? The team was informed that constructing a toilet and use of toilet are two different behaviours. For example if we are focusing on use, people could use the toilet of their neighbours. It is also important to consider what behavioural determinants are to be used to change behaviour (e.g. number of sick children, number of diarrhoeal cases, etc.). The team was also asked whether we have enough knowledge about the link between lack of toilets and diarrhoea. Antoinette reiterated that we need to know more about people's current practices, attitudes and what they think is convenient.

Bangladesh	
Q1: Select one key hygiene behaviour	Use of safe emptying of sludge at HH level
Q2: Do you have data about this behaviour?	a. Baseline data and secondary data b. Influence social norms c. 10-50% of HH in next two years
Q3: What kind of cost data do you have?	Formative studies, capacity building, campaigns, emptying services, monitoring and evaluation
Q4: What would you use that information for?	Inform decision making at household level and development of BCC practices

You are trying to increase the number of households that will make use of the services. You are going to organise a campaign to achieve this goal. Outreach here is about how many people have heard about your campaign. The team was informed that the study therefore should focus on the outreach of the hygiene promotion campaign, and not on the outreach of pit emptying services.

Bhutan #2	
Q1: Select one key hygiene behaviour	Handwashing with soap in schools
Q2: Do you have data about this behaviour?	a. Very little data available b. Measure access to soap so that students can change their behaviour. Access to handwashing station and soap. As education is free in Bhutan everyone expects the government to bring soap to the school. c. 60% health coordinators are trained. Knowledge is available but soap is missing. Only 60% of schools have a health coordinator.
Q3: What kind of cost data do you have?	Cost data on training of trainers, training and campaign materials, cascade trainings,
Q4: What would you use that information for?	To improve materials

Do children have access to soap? Does this change their behaviour? The team was informed that the intervention logic is not clear. Who will ensure that soap is available at schools? What is the role of the health coordinator in this? Health coordinators should give priority to HWWS and are therefore expected to find local solutions in each school so that soap is available for handwashing. It is the responsibility of trained health coordinators to ensure that soap is available.

GROUP ACTIVITY | DEBATING GAME

Similar to the debating games held in the afternoon of the third day, two more debating games were organised before lunch. The following two statements were debated:

- 1) No need to do hygiene cost effectiveness study when you are just starting with your behaviour change interventions or campaign
- 2) No need to measure outreach when you are measuring outcomes (changes in behaviours)

Some participants thought that the first statement was very confusing. It is the same as monitoring our programme results. You need to establish the situation at the start of the programme / interventions by collecting baseline data. At the end of the interventions you can then compare the behaviour change over the period of the interventions. It is useful but that does not mean that we have to do it for every single campaign. Antoinette threw in a final argument by asking whether HES could be used to get an idea of the costs for upscaling BBC campaigns.

WORLD CAFÉ

Antoinette started by introducing the World Café¹⁶ concept and then quickly explained the 'rules of the game' for the World Café session.

Purpose of the World Café

The purpose of the World Café is to provide a safe place for people to discuss diverse topics (issues, problems, etc.), share ideas, discuss diverse perspectives and experiences, connect with peers and 'experts', dream of solutions, and share the outcome with others.

General rules of the game

- ▶ Three rounds of 20 minutes each
- ▶ Each country (one table) has one or two country host (table owner). Each country defines a topic or problem they want to get advice on.
- ▶ All other participants are 'experts or consultants' and register with one of the six consultancy firms. Consultants are available for free to advise the countries. The consultancy firms are assigned to specific countries.
- ▶ Process for first round:
 - Country host gives a short introduction of the issue / constraint / challenge
 - This is followed by a table discussion; and
 - The main results or outcomes of the discussion are captured on paper by a note keeper.
- ▶ After the first round of discussions, the experts or consultants move around and pick another issue that they are interested in
- ▶ Process for second round:
 - Country host starts with a short introduction of the issues and a quick recap of what came out of the first round of discussions
 - This is followed by a table discussion; and
 - The discussion is wrapped up by capturing the main results or outcomes.
- ▶ Process for third round is the same as for the previous two rounds
- ▶ In a plenary session the table hosts give an overview of the main results of the table discussions.

The topics identified by the countries and the assignment of consultancy firms to the different countries are shown in the following table.

Country	Topic or problem to be resolved	Company		
		1 st round	2 nd round	3 rd round
Bhutan #2	Despite repeated BCC and O&M in place the toilet and hand washing facilities are defunct	Wow Consulting	Takin Consultancy	Meow Meow Consulting

¹⁶ **World Café** is a widely used method to discuss a wide variety of issues or topics. The World Café is a conversational process based on small group conversations that can be adapted to a variety of topics. The purpose of the World Café is to provide a safe place for people to discuss diverse topics (issues, constraints, challenges, etc.), share ideas, discuss diverse perspectives and experiences, connect with peers and 'experts', dream of solutions, and share the outcome with others.

Country	Topic or problem to be resolved	Company		
		1 st round	2 nd round	3 rd round
Bhutan #2	BCC done in whole district and resulted in 80% improved sanitation. What to do with last 20%?			
Indonesia	How to optimise the limited budget to increase more impact?	Takin Consultancy	Meow Meow Consulting	Blue Poppy
Bangladesh	People don't wash their hands after defecation	Druk Consultancy Services	Smart Sanitation	Poppy Consultancy
Nepal	How to address the current problem where there may be one school toilet for 200 students and 6 teachers?	Meow Meow Consulting	Blue Poppy	
Laos	How to deal with villages without water where households are not interested to construct toilets because water has to be collected from far?	Poppy Consultancy	Wow Consulting	Takin Consultancy
	How can we conduct HWWS campaign in schools where there is no water?			
Bhutan #1	Unable to change the behaviour of people with regards to solid waste management and human waste containment (septic tank) even though there have been many campaigns	Smart Sanitation	Druk Consultancy Services	Wow Consulting
Cambodia	How to reach the last 20% that do not have a toilet?	Blue Poppy	Poppy Consultancy	Smart Sanitation

Following the World Café sessions, the results as shown in the table below were presented by the different country teams in a plenary session.

Country	Topic or problem to be resolved	Advise received
Bhutan #2	Despite repeated BCC and O&M system in place the toilet and hand washing facilities are defunct	➔ Look at quality of materials and construction ➔ Design school toilets for specific ages ➔ Set up care and maintenance committee ➔ Give BCC messages through different persons ➔ Opt for more durable materials ➔ Change location of toilet (?) ➔ Establish sanction or punishment system ➔ Decentralised ownership by classes
	BCC done in whole district and resulted in 80% improved sanitation. What to do with last 20%?	➔ Assess what kind of people are among the 20% ➔ Establish community self-help groups ➔ Provide interest free loans to those that can afford ➔ Look at community action group (CAG) ➔ Establish coupon system for the poor <i>After meeting with the consultants the team thought of replicating the school income generation programmes</i>
Indonesia	How to optimise the limited budget to increase more impact?	➔ Analyse previous activities to select only effective activities ➔ Use volunteer trainer to train cadres ➔ Conduct CLTS approach instead of only providing training and combine with sanitation marketing

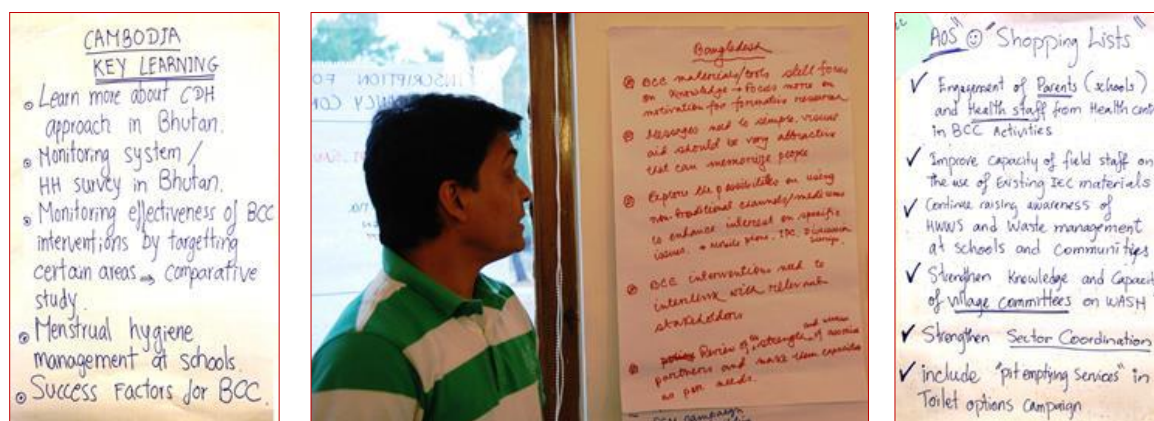
Country	Topic or problem to be resolved	Advise received
Bangladesh	People don't wash their hands after defecation	→ Focus BCC campaign on mothers / caretakers → Capacity building of health service providers and combine with other health services → Use mass media (25 tv channels) → Conduct formative research → Arrange BCC campaign → Capacity building at all levels → Develop monitoring system → Overcome social norms through BCC activities → Involve local leaders
Nepal	How to address the current problem where there may be one school toilet for 200 students and 6 teachers?	→ Communicate with MoE and other responsible government institutions → Include in the BCC strategy → Different break times for the different classes
	50% of toilets are not used	→ Build community toilets for the male → Involve leaders and establish supportive social norms
Laos	How to deal with villages without water where households are not interested to construct toilets because water has to be collected from far?	→ Collect rainwater or reuse kitchen wastewater → Introduce smart dry pit toilets → Conduct research on alternative sources of water that can be used for different purposes → Improve coordination between MoH and MoE
	How can we conduct HWWS campaign in schools where there is no water?	→ Install water storage tank / rainwater harvesting → Install donation box
Bhutan #1	Unable to change the behaviour of people with regards to solid waste management and human waste containment (septic tank) even though there have been many campaigns	→ Consider communal septic tanks → Identify BC pathway steps and analyse bottlenecks
Cambodia	How to reach the last 20% that do not have a toilet?	→ Establish community self-help groups → Introduce low-cost options → Obtain support from religious institutions → Utilise village WASH committees → Identify poor HH and mobilise support within the community → Use pressure related to ODF status → Provide loans to the poor or some sort of voucher system

GROUP WORK | COUNTRY SHOPPING BAGS

The final session of the BCC learning event consisted of the usual shopping bag exercise. Country teams were given time to review what they had learned during the learning event and then consider what lessons they would like to take home. It is expected that this cross-border learning will positively influence the practices in the different countries. The outcome of this session is presented in the following table.

Country	Content of shopping bag (learnings)
Laos	✓ Engage parents (schools) and health staff from health centre in BCC activities ✓ Improve capacity of field staff on the use of existing IEC materials ✓ Continue raising awareness of HWWS and waste management at schools and in

Country	Content of shopping bag (learnings)
	- communities ✓ Strengthen knowledge and capacity of village committees on WASH ✓ Strengthen sector coordination ✓ Include pit emptying services in toilet options campaign
Bangladesh	✓ BCC materials/tools still focus on knowledge; focus more on motivation for formative research ✓ Messages need to be simple, visual aid should be very attractive that can memorise people ✓ Explore the possibilities on using non-traditional channels/mediums to enhance interest on specific issues ✓ BCC interventions need to interlink with relevant stakeholders ✓ Review of the strength and weaknesses
Nepal	✓ BCC focus beyond knowledge ✓ BCC needs to look at the entire value chain ✓ Standalone BCC can't work ✓ Comprehensive tool kits for post ODF/TS to target all behaviours in a systematic way ✓ Monitoring to be added in the BCC strategy and agreed with the stakeholders about level of assessment ✓ Challenge of capacity when upscaling needs to be upgraded ✓ Internalisation by leading body/agency setting up norms or systems and even sanctioning if needed (positive way) ✓ Develop tools/materials matching with communication objective can be done in as short time with low costs ✓ Ownership of strategy may lead to better results ✓ Introduce cost effectiveness methodology at village level
Indonesia	✓ The importance of proper research of developing BCC evidence based strategies ✓ The methodology needs to be very participative ✓ Properly identify the target group and the motivator to mobilise ✓ The importance of social monitoring ✓ The cost-effectiveness methodology ✓ The challenge of transferring knowledge from district level to community level ✓ Involve different stakeholders in the dialogue about sanitation ✓ Additional inspiration about how to promote sanitation and hygiene in schools ✓ The importance of good coordination between religious leaders and line agencies ✓ The importance of good quality information ✓ The IEC connecting game from Laos ✓ Experimenting failing as soon as possible for learning and motivating purposes
Cambodia	✓ Learn more about Bhutan's CDH approach ✓ Monitoring system / HH survey in Bhutan ✓ Monitoring effectiveness of BCC interventions by targeting certain areas => comparative study ✓ Menstrual hygiene management at schools ✓ Success factors for BCC
Bhutan #1	✓ Monitoring of BCC activities ✓ Piloting scheduled desludging ✓ Opex cost recovery ✓ Stakeholder coordinator (TT & HPD)
Bhutan #2	✓ Leadership empowerment is essential ✓ The closer and the more accessible the WASH facility, the more cleaner the facility ✓ Instil sense of ownership ✓ Coordination and multi-sectoral involvement ✓ BCC materials should focus on motivation and not on knowledge



Pictures: Country shopping bags

SUCCESS FACTORS FOR EFFECTIVE BCC

During the final session of the day Antoinette presented the ten key success factors for effective BCC by summarising the issues put on the “wall of success”.

Ten “Success Factors” for effective BCC

- 1) Clear messages
- 2) Target audiences
- 3) Contextualised and evidence-based
- 4) Monitoring and follow-up
- 5) Political will and linking with others
- 6) Long-term campaign / perspective
- 7) No BCC without services
- 8) Good design and communication objectives
- 9) Capacity and good facilitation
- 10) Community participation

This short session concluded the four day learning event.

In the evening of Thursday 12 March 2015 the learning event was formally closed at a dinner and cultural event organised at Gangtse Palace in Paro.

--o-0-o--



Annexes

Annex 1: Participants list of Regional Learning Event on BCC for sanitation and hygiene

	Name	Country programme	Organisation	Position	Email
1	Dr Swapan Kuman Hawlader	Bangladesh	KCC Khulna City Corporation	Medical Officer	
2	Mr Kamrul Hassan	Bangladesh	SNV Bangladesh	BCC Advisor	khassan@snvworld.org
3	Ms Deki Tshomo	Bhutan	Comprehensive School Health Programme, DYS, MoE	Dy. Chief Programme Officer	dtshomo@gmail.com
4	Mr Sonam Dorji	Bhutan	District Health Sector, Dzongkhag Administration, Samtse	District Health Supervisor	dorjisonam13@yahoo.com
5	Mr Dorji Phub	Bhutan	Health Promotion Division, DoPH, MoH	Chief Programme Officer	dphub@health.gov.bt
6	Mr Gopal Hingmang	Bhutan	Health Sector, Chukha Dzongkhag	Sr. District Health Officer	gopal591970@gmail.com
7	Mr Phuppa Thinley	Bhutan	LNW Consulting	Consultant	phurpathinley@gmail.com
8	Mr Rinchen Wangdi	Bhutan	Public Health Engineering Division, DoPH, MoH	Chief Engineer	er.rinchenw@gmail.com
9	Mr Sonam Gyaltsen	Bhutan	Public Health Engineering Division, DoPH, MoH	Executive Engineer	sonamgalsen@gmail.com
10	Mr Lopen Passang	Bhutan	Religion and Health Project, Dratshang Lhentshog	Project Manager	passadratsang@gmail.com
11	Mr Ugyen Tshering	Bhutan	Religion and Health Unit, Dratshang Lhentshog	Programme Officer	yutee1982@gmail.com
12	Ms Thinley Dem	Bhutan	SNV Bhutan	BCC Advisor	TDem@snvworld.org
13	Mr Raj Kumar Bhattra	Bhutan	SNV Bhutan	Demand Creation Advisor	rkumarbhattra@snvworld.org
14	Mr Kiney Penjor	Bhutan	SNV Bhutan	Project Leader, Urban WASH	Kpenjor@snvworld.org
15	Mr Ugyen Rinzin	Bhutan	SNV Bhutan	Project Leader, Rural WASH	URinzin@snvworld.org
16	Ms Tashi Yetsho	Bhutan	TY Consulting	Consultant	tyetsho@hotmail.com
17	Mr Gem Tshering	Bhutan	Water and Sanitation Division, DES, MoWHS	Engineer	gtshering@mowhs.gov.bt
18	Ms Dechen Yangden	Bhutan	Water and Sanitation Division, DES, MoWHS	Chief Engineer	dechhey@gmail.com
19	Mr Phuntsho Wangdi	Bhutan	Water and Sanitation Division, DES, MoWHS	Executive Engineer	peewangdee@yahoo.com
20	Mr Mindu Gyeltshen	Bhutan	Engineering Sector, Chukha Dzongkhag	Municipal Engineer	
21	Mr Chreay Pom	Cambodia	MRD/Department of Rural Health Care	Director	chreaypom@gmail.com
22	Mr Pasuong Saokun	Cambodia	Provincial Department of Rural Development Kampong Speu	Deputy Director	pasuong.saokun2@gmail.com
23	Ms Petra Rautavuoma	Cambodia	SNV Cambodia	WASH Sector Leader	prautavuoma@snvworld.org
24	Ms Saing Sodany	Cambodia	SNV Cambodia	BCC Advisor	ssaing@snvworld.org
25	Ms Megan Ritchie	Global	SNV	Managing Director, WASH	mritchie@snvworld.org
26	Ms Antoinette Kome	Global	SNV	Global Sector Coordinator for WASH	akome@snvworld.org

	Name	Country programme	Organisation	Position	Email
27	Mr Pak Sumedi	Indonesia	District Health Office Lampung Selatan	Secretary	
28	Dr Hj. Nofli Yurni, M.Kes	Indonesia	District Health Office Pringsewu	Head of Disease Prevention and Environmental Health	
29	Ms Maria Carreiro	Indonesia	SNV Indonesia	Sector Leader WASH	mcarreiro@snvworld.org
30	Ms Rustina	Indonesia	SNV Indonesia	BCC Advisor	rustinarustina2@gmail.com >
31	Mr Sigid Cahyono	Indonesia	SNV Indonesia	STBM Coordinator	SCahyono@snvworld.org >
32	Ms Bounta Vongsouthy	Lao PDR	Lao Youth's Union of Atsaphon district, Savannakhet province	Deputy Head	
33	Mr Anoulack Louanglatbandith	Lao PDR	Provincial Environmental Health and Water Supply Division of Savannakhet	Head	lanoulack@yahoo.com
34	Ms Phetmany Cheuasongkham	Lao PDR	SNV Laos	WASH Advisor	pcheuasongkham@snvworld.org
35	Mr Aftab E. Alam Opel	Lao PDR	SNV Laos	Sector Leader WASH	aopel@snvworld.org
36	Mr Tikaram Khadka	Nepal	Rukumeli Social Development Service	District Program Coordinator	tikaram6@gmail.com
37	Ms Harishova Gurung	Nepal	SNV Nepal	Advisor	HGurung@snvworld.org
38	Mr Anup Kumar Regmi	Nepal	SNV Nepal	Programme Leader, SSH4A	AREgmi@snvworld.org
39	Ms Nadira Khawaja	Nepal	SNV Nepal	Sector Leader WASH	NKhawaja@snvworld.org
40	Mr Michael Rios	Regional	17Triggers	Chief Innovations Officer	mike@17triggers.com
41	Mr Erick Baetings	Regional	IRC	Senior Sanitation Specialist	baetings@ircwash.org
42	Ms Ingeborg Krukkert	Regional	IRC	Hygiene Specialist	krukkert@ircwash.org
43	Ms Nga Kim Nguyen	Regional	Resource Person / Consultant	BCC Specialist	ngakimnguyen@gmail.com
44	Ms Gabrielle Halcrow	Regional	SNV Regional	Programme Leader, SSH4A	ghalcrow@snvworld.org
45	Ms Fadila Kerrad	Regional	SNV Regional	Regional Programme Leader, Functionality	FKerrad@snvworld.org

Annex 2: Programme of the BCC face-to-face learning event

Date	Time	Activity
March 9 Monday	DAY 1	
	8.30	Registration
	9.00	Official opening
		Presentation of the programme
		Round of presentations
	11.00	BREAK
	Block I: Way Forward in Behaviour Change Communication	
		Introduction Block I
		Country group work on successful approaches to BCC
	13:00	LUNCH
	14.00	Presentation on SNVs formative research findings in Asia
	14:20	Plenary discussion about country priorities.
	15:00	BREAK
	Block II: Institutional Arrangements for Behaviour Change Communication	
	15:15	Explanation of field assignment and formation of mixed groups
	16:00	Presentation of the context of sanitation and hygiene in Bhutan
	16:30	Final preparation
	17.00	Closure
March 10 Tuesday	DAY 2	
		Field assignment
March 11 Wednesday	DAY 3	
	9.00	Welcome Day 3
		Consolidations of findings and recommendations in groups
	10.30	Presentation of group findings to a panel of Bhutanese representatives
		Reflection in country groups about block II
	13.00	LUNCH
	Block III: Designing Behaviour Change Communications	
	14.00	Introduction Block III
	14:30	Presentation by 17 Triggers
	15:00	BREAK
	15:15	Presentation on SuperAmma Campaign, London School of Tropical Hygiene
	15:45	Group activity
	16:45	Reflection in country groups about block III
	17.00	Closure for the day
March 12 Thursday	DAY 4	
	9.00	Programme of the day
		Sharing of yesterday's insights
	Block IV: Monitoring and effectiveness	
	9:30	Introduction Block IV
		Presentation on the Hygiene Effectiveness Study, IRC
		Group work
	11.00	BREAK
	11:15	Group work
	12:45	Wrap up block IV
	13.00	LUNCH

Date	Time	Activity
		Block IV: Country group sessions and wrapping up
	14.00	World café
	15.30	BREAK
		Country group reflections and sharing of
	17.00	Written evaluation and closing
	18.30	Dinner and cultural event

Annex 3: Summary of Dgroup discussions

Introduction

An email discussion was held on Behaviour Change Communication (BCC) for Sanitation and Hygiene from the 28th January to 27th February 2015. The discussion was moderated by SNV and brought together members of the urban and rural Sustainable Sanitation and Hygiene Dgroups as well as the Menstrual Hygiene Management (MHM) Dgroup. With a combined membership of more than 420 people across 42 countries the 78 contributions included perspectives from government, local partners and programme teams from both the Africa and Asia regions along with resource people in SNVs network interested in BCC. This summary document will be an input for a regional learning activity on innovation in behaviour change communication from 9-12th March 2015 as part of Sustainable Sanitation and Hygiene for All (SSH4A) Programme hosted in Bhutan in partnership with the Ministry of Health. This will involve participation from the regional programmes (Indonesia, Cambodia, Laos, Nepal and Bangladesh and knowledge partners (IRC, 17 triggers and LSHTM).

The three sub-topics for the discussion were

1. Where are we now with hygiene promotion?
2. How do we feel about promising BCC innovations in the sector? (Universal vs context specific, use of gadgets/marketing and monitoring effectiveness)?
3. What does it take to mainstream BCC innovations?

Summary BCC Dgroup discussion week 1, topic 1:

WHERE ARE WE NOW WITH HYGIENE PROMOTION?

Introduction to the topic

In this first block we asked you to discuss initial ideas of where we are now with hygiene promotion. Hygiene promotion has evolved considerably over the past 5-10 years. From its beginnings in health education and IEC there is now an increased understanding that hygiene promotion should start from an understanding of behaviour and behavioural motivators, and that hygiene promotion practice can learn from advertising and other persuasive communication. In short, increasingly programmes are integrating insights from behaviour change communication (BCC). But then, how does an understanding of behaviour actually influence our practice? Are we seeing these changes in practice at the local level or is the bulk of our attention, time and resources more typically "material centred" (typically IEC) rather than "behaviour centred"? For this first topic, we asked to share the activities that Dgroup members are doing around hygiene promotion. For example, which behaviours do they prioritise? What do they feel is most effective? Do they work with these behavioural motivators or "triggers" to change behaviours?

The topic was hygiene promotion in general, so any of the hygiene behaviours that people have been working on could be shared. We were not just talking about hand washing with soap, but also about ending the practice of open defecation, hygienic usage of latrines, safe handling of drinking water in the household, safe faecal sludge management or imp

Within this first topic there have been 41 contributions, from 28 people across 13 countries.

The questions for this topic were:

1. What does hygiene promotion practice look like in your context?
2. What do you feel is most effective?
3. What examples and lessons learnt would you like to share to illustrate this?

Summary of Dgroup discussions

Which behaviours did you talk about?

Of the 41 contributions, half focussed on both the use of toilets (or reducing OD) as well as hand washing with soap (HWWS). Only two contributions were exclusively about HWWS. There were many people who also talked about other behaviours, such as having a clean toilet, menstrual hygiene management (3 contributions mentioned this), and emptying of toilets/ sludge management (5 contributions mentioned this).

First of all, many people talked about the need for focus, but some people felt that hygiene promotion should combine several behaviours. For example, Herie Ferdian from Plan Indonesia feels that combining hygiene promotion with the CLTS triggering process is most effective in his area of work in NTT province in Indonesia. Also Tika Ram Khadka, from the Rukumeli Social Development Centre in the mid-western mountains of Nepal feels that hygiene is best addressed through an integrated approach. Saadia Yaqoob from UNICEF Pakistan explained the integrated PATS approach used: Pakistan Approach Total Sanitation including HWWS, toilet use, access to clean drinking water, and in addition to this triggering on menstrual hygiene management.

As mentioned, several people talked about the need for focus and also broader alignment around key messages. This aspect of alignment is mentioned by the different contributions from Nepal, Cambodia, Bangladesh and Uganda. It is clear that in some of these countries part of the success of CLTS is explained by the alignment around a single message and the broad social mobilisation at all levels (not just community level). In spite of this, most of you work in programmes that promote different behaviours at the same time, such as HWWS and maintenance of toilets.

From your stories it is clear that we cannot talk about BCC in general. The approach depends very much on the behaviour, and some behaviours require a combination of promotion and enforcement. Rustina Umar from SNV Indonesia and Nga Nguyen working as a BCC consultant in Asia, discussed about the use of toilets above fish ponds of which the fish is sold. The feeling is that this cannot be changed through BCC alone; it requires a combination of promotion and enforcement. Also Khamrul Hassan and Shahidul Islam from SNV Bangladesh both wrote about the need for enforcement of safe emptying, and for changing the behaviour of dumping of sludge in fish farms. Of course enforcement requires a legal basis to do so and also willingness of local authorities to enforce. Other behaviours though, such as HWWS, cannot be enforced, as Priva Kavre from SNV Rwanda points out.

Triggering or tailoring?

There was quite a debate around the need for triggering tools and the need to take time and understand communities. Both Fany Wedahuditama from the Ministry of Planning in Indonesia and Susy Soenarjo from SNV Indonesia mentioned the risks of “copy-paste” or “one-size-fits-all” of approaches in particular for aggressive methods like triggering. “Do your homework before your trigger” said Fany. They called for proper understanding and tailoring of approaches. Anne Joselin from DFAT in Indonesia reflected on the different motivators and gave the example that whilst “disgust” may work in some contexts, in others such as PNG a sense of belonging was also a factor that resonated. Also Jackson Wandera from SNV Tanzania, Hamissou Maliki from World Vision Niger, and Hari Shova Gurung from SNV Nepal all gave examples from formative research (or barrier analysis) to illustrate the importance of tailoring messages and tools. Also Robert Otim from SNV Uganda working on the Uganda National Handwashing Initiative, felt that it’s not a single approach that can be effective. And Bunleng Tan from SNV Cambodia illustrates how 2 different approaches are used in their programme depending on the village context.

Others however felt that more suitable tools for hygiene promotion are needed. Sam from Seeds of Hope International Partnership in Zambia felt that we should not settle for the idea that hygiene promotion takes time, perhaps “triggering” hygiene promotion similar to CLTS can be done. In 2012 he participated in the triggering of toilet behaviour and hand washing in a village in Zambia, which showed results in 10 days. Rustina asked whether tools are there, while Hilda Mutheshi from SNV Kenya asked whether any

campaign has ever focussed on a market based solution (gadget centred) for hand washing. In fact, there are examples of CLTS-type tools for the promotion of HWWS in Malawi, you can find this here:

[http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/How to Trigger HWWS Oct2013version.pdf](http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/How%20to%20Trigger%20HWWS%20Oct2013version.pdf)

Also, there are examples of where organisations tried to design a “desirable hand washing station product”, it was called the “happy tap”:

<http://www.watershedasia.org/handwashing/>

The question is of course always about effectiveness and sustainability. Hari Upadhyay from SNV Nepal, Giri Khatri from SNV Cambodia, Priva, all ask for a greater awareness of the fact that long term behaviour change requires time and dedication.

Skills more than tools

A number of people with strong field experience, Thinley Dorji consultant in Laos, Rustina, Phetmany Cheuasongkam from SNV Laos, Sodany Saing from SNV Cambodia, Rustina, Susy all pointed to the fact that the weakness part of the chain is in the interface between facilitator and target population (households). Good hygiene promotion requires skill, and not in the least the right attitude. Too often the quality of facilitators is not good enough, or the attitude is paternalistic. For hygiene promotion to work, we need to connect to people’s first and understand them in their context says Thinley. No matter how many of these “effective tools” we develop, it will all render useless without the right facilitators. Priva agrees with this. Susy calls for capacity building beyond training, providing more follow-up support and back-stopping. Phetmany explains the efforts to build CLTS capacity in her country, but no similar initiative has been taken for hygiene promotion. Hilda gives the example of the HIV Behavioural change campaign that was effective because it managed to get people talking about HIV among themselves. Ultimately word of mouth is most effective she says.

The importance of broad alignment and engagement of leadership

Another aspect which is emphasised by many is the importance of a broad alignment and engagement of different types of leadership. This can be local authorities, traditional leaders, women’s groups that have good outreach, and also, like the contributions from SNV Cambodia explain religious leaders. Pao Him explains how linking of hygiene messages to Buddhist writings and the engagement of Monks for hygiene promotion has changed dynamics. Lekh Shah from SNV Nepal explains how weekly monitoring of households by female community health workers in Nepal has created change. Ratan Budhatoki from SNV Nepal describes a number of activities and says that the most important thing is systematic activities which are shared by all.

Sophorn Khaim from SNV Cambodia points to the importance of having a BCC strategy adopted by the Ministry, which is designed for the whole country. Shahidul mentions that Bangladesh has a National Hygiene Promotion Strategy, which helps. The challenges are still though to achieve proper engagement from local government and sufficient resources for hygiene. Robert Otim also talks about the importance of mainstreaming. Hari Shova explains the approach in Nepal which is a combination of 3 things: 1) group and individual activities such as triggering, drama, interactions, 2) social mobilisation working with leaders and different networks 3) advocacy with leadership to promote an enabling environment (stick & carrot).

Measuring effectiveness of hygiene promotion

Aftab Opel from SNV Laos rightly points out that there is hardly any information at all about the effectiveness of different hygiene promotion approaches or tools. Conclusions from different studies are all the same, very difficult to demonstrate effectiveness. He quotes the latest Randomised Control Trial (RCT) in Tanzania published by the World Bank in January 2015, which shows no effect of a large scale hand washing campaign. Susy also mentions this challenge. In Indonesia hygiene promotion has received less and less attention because no tangible results could be shown. She mentions that just measuring outreach without effectiveness of behaviour change is not sufficient. Hilda agrees. Robert mentions that

there was an aggressive mass media campaign in Uganda that at least managed to change some of the attitude towards hand washing with soap: 95% no longer thinks it's a trivial thing.

Summary BCC Dgroup discussion week 2, topic 2:

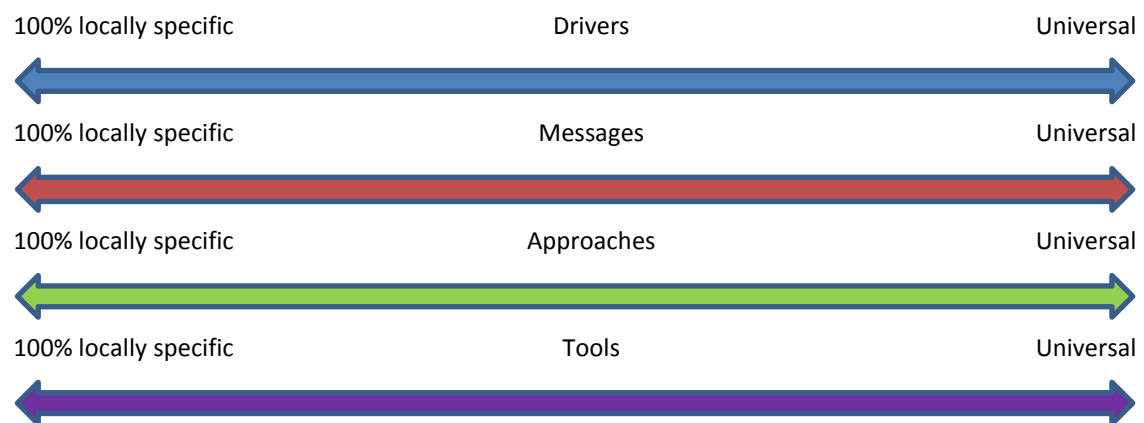
HOW DO WE FEEL ABOUT PROMISING BCC INNOVATIONS IN WASH?

Introduction to the topic

Drivers are the motivations for behaviour change, for example in CLTS the motivator is disgust (or pride). Messages are framed on the basis of the driver, for example: "You are eating other people's shit". Of course for one driver, there are different possible messages. Approaches are vaguer, but within this discussion I'm referring to what guides your decisions about the design of your hygiene promotion work. PHAST is an approach, CLTS, and some of the other examples below are in essence also approaches. Tools are the methods you use in implementation, such as mass-media promotion, certain triggering tools, the way you may use drama or songs, or the way you engage local authorities.

To find out about drivers, it's important to do formative research. For messaging, often a creative agency is hired, who then comes up with different possible messages. In approaches, there are many, and it's often guided by what one knows or has been known to be effective in the country. Tools are shared through toolkits, etc.

The question is whether we can expect universal answers, guidance or solutions on any of these 4 things from all the BCC innovations that are ongoing. And also, how you would feel about that. If there were some universally or near universal answers, it may make our work easier to scale – in theory. The idea may sound outrageous to you, considering the importance of cultural and other differences. However, many of us work with CLTS that is basically proposing one universal driver ("disgust"), an almost universal approach and an almost universal set of tools. Only messaging is significantly adjusted locally. I would like to hear from you whether you expect universally valid innovations on any of these 4.



Some people say that a number of drivers are universal for the human kind, namely those in our most basic part of the brain that have to do with human survival. For example, Val Curtis from the London School of Hygiene and Tropical Medicine (LSHTM) says that behavioural motivators like disgust and nature (to care for children) could well be universal to the human kind (See the Evo-eco model <http://www.hygienecentral.org.uk/research-behaviour.htm> and the SuperAmma campaign <http://www.superamma.org/index.html>). The research that this group is doing may well come up with a number of almost universal drivers that others can simply take and adjust.

Another aspect of this set of work is that a lot of our hygiene behaviour is part of a particular setting and a routine. The idea is that a new behaviour should fit within a routine in order to be sustainable.

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

There is a stream of thought that assumes that behavioural change can be motivated by a tangible, desirable device. So instead of promoting a tippy-tap which is a low-cost DIY hand washing device, time and money is invested in developing an aspirational beautiful hand washing device that people can buy.



Picture from www.tippytap.org



Picture from www.watershedasia.org/

Also for other behaviours products or gadgets can be developed that are aspirational. It is thought that this could motivate behavioural change. Do you expect more behavioural change oriented gadgets from BCC innovations and would you want to use those in your programme?

When measuring effectiveness of hygiene promotion, a distinction should be made between measuring the communication objective and measuring the behaviour itself. Like Robert Otim said in the first week, the campaign in Uganda did manage to change the attitude towards hand washing with soap (the communication objective of the campaign), but this was not sufficient to result in behaviour.

As hand washing is such a private behaviour, it's difficult to measure. SNV uses observation of hand washing stations and presence of soap, as a proxy indicator for behaviour. There are also other methods, such as putting sensors inside the soap, self-reporting by households or having someone sit for 12-24 hours in the house to observe behaviour. Obviously there are downsides to all these methods, not in the least related to reliability and costs. Innovations for measuring effectiveness of hygiene promotion are needed. Other behaviours would require different ways to measure effectiveness.

In this discussion topic there have been 26 contributions, from 23 people across 16 countries from both the Africa and Asia regions. We've canvassed ideas from the lessons behind the marketing of toothbrushes, to diamond shaped cereal packets to using motorcycle taxis as outreach tools for menstrual hygiene messages.

The discussion questions for this topic were

1. To what extent do you expect universal BCC drivers, messages, tools or approaches from innovations?
2. What do you expect from approaches that develop gadgets to motivate behavioural change?
3. What kind of innovation would you like to see in the area of measuring effectiveness of hygiene promotion?

Summary of Dgroup discussion

Which BCC drivers, messages, approaches or tools are you already working with and talking about?

The most commonly mentioned drivers used emotions in terms of disgust, shame or embarrassment. This is linked to the use of CLTS and hand washing triggering approaches shared by many of the participants in the first discussion topic. Adaptations on this included Yamane's example from Ethiopia of a teacher using visual aids to prompt guilt with a class of students.

Wamunyima shared examples of the use of a wide range of tools that are used in Zambia and familiar to many of the contributors including celebrating national events, quizzes, role plays, cultural songs, demonstrations, radio programs, champions and also the local context example of "punishments" for non-conformists used by local leaders. Thinley Dem in Bhutan added the examples of multi-stakeholder meetings and sanitation fairs whilst Kamrul added IEC materials and visual aids. Selamwit in Ethiopia felt that peer-to-peer learning could prove to be an important tool in working with girls on menstrual hygiene management. Whilst Ratan in Nepal questioned why we weren't working more closely with mobile phone companies to reach the youth demographic.

Beatrice and Robert shared creative outreach strategies in terms of working with local artists - musicians, comedians, drama groups and as ambassadors. Beatrice added the examples in Rwanda of road shows and road bicycle racing. Whilst in Uganda they were exploring Minibuzz, a mobile TV program that is being promoted by Made in Africa TV MIATV <http://miatv.co/> and is in Kenya and Tanzania also. Finally, Pasquina with SNV in South Sudan shared the example of developing menstrual hygiene messages that communicated the role of parents, teachers and school boys in supporting girls during menstruation and integrated them with Christmas carols, distributed to business motorcyclists (boda boda riders) on flash disks so that they played it as they ride during business hours within Torit and Magwi counties.

Universal or context specific expectations?

There was support for the concept that there are universal drivers (with clarifications) and common approaches but that tools and messaging needed to be more localized and context specific. Nadira in Nepal felt that universal drivers made a lot of sense in that there are certain behavioural motivators that are universal for mankind (and some that are context specific) but that messages and tools in particular have to be context specific to be effective. Robert felt that realistically, there is emerging commonality across the globe of approaches, tools, messages but we can't know the usefulness of a BCC innovation unless it has been put to the test. Whereas Tikaram, Nepal surmised that triggering may be universal but not trigger tools.

Hans shared Eawag's perspective drawing from a health psychology background in that drivers of behaviour change are principally universal and are steered by health risk awareness, attitudes, emotions, social pressure, ability beliefs (see the RANAS model of behaviour change). But while these determinants are universal their concrete meanings are population specific. Therefore we can use the model as a blueprint but have to check the meanings and frequencies for each target population, which is something that resonated with several participants.¹⁷

Aftab with SNV Laos felt that our knowledge is still shallow and did not expect we would be at a stage yet to claim anything universal. We have to keep experimenting and learning. Several contributors reinforced the discussion on the first topic with the need for tailoring and formative research to identify context specific drivers. Thinley Dem, from Bhutan felt formative research had been valuable for the national programme in understanding the behaviour and the views of the target group in developing messages. Hilda also discussed the differences in motivators and barriers in settings and in target groups e.g. children/adults.

¹⁷ Further information http://www.eawag.ch/forschung/ess/gruppen/ehpsy/index_EN

There was a range of views on health as a universal driver, or not. Hilda shared examples of different countries where the health of a child was found to be a motivator for caregivers including Peru, Senegal and Bangladesh. Thinley Dem however shared that moving beyond health messaging was found to be more effective in Bhutan. Similarly in the southern belt of Nepal, Nadira shared the perception from a partner that people didn't understand or respond to health messages but they are very religious so we need to link sanitation to religious and cultural festivals.

Martin discussed the use of slightly different approaches within a common overall approach and the importance of follow-up and sustainability. Innovations need not only to trigger the change but then communities need to be further stimulated to continue in order to sustain the change. Lindiwe highlighted that setting standards for universal approaches such as CLTS by the Ministry of Health in Zimbabwe has proved costly and is hindering progress. Cost also being a barrier to innovative tools raised by Beatrice with the example of using road shows, bicycle races and concerts in Rwanda.

Gadgets and marketing aspirations

Several participants had experience with innovations relating to approaches that develop and market devices or gadgets to change behaviours. Janita shared WaterShed's experience in developing and marketing devices such as hand wash stations and a planned marketable latrine shelter in Vietnam and Cambodia to address structural barriers. The approach to marketing - which has moved from health messaging - is to promote new and positive associations such as modernity, high status, etc. to change social norms. The expectation of the innovation is that in the act of purchasing it (1) ensures the use of it by guaranteeing that people attach value to the product and/or HWWS, and (2) empowers people to make their own choices and take responsibility for their actions. Lindile in Zimbabwe raised the popularized girl friendly latrines and reusable menstrual hygiene pads, which are waiting on approval from the Ministry of Health in Zimbabwe.

Several felt that we could learn from the experiences of the advertising industry with products and how markets can play a role in behaviour change. Hilda felt that one cannot stick to one motivator and that we should learn from the way advertising companies keep re-branding, changing colour, changing product e.g. 'new Nivea' to avoid the motivator becoming stale. Aftab gave the example of toothbrushes and menstrual hygiene materials – products that are not new but that companies continue to invest in advertising for. In particular they potentially could reach corners of the market such as poorer households that are yet to be reached. The challenge Aftab found is how can the poor afford these products or how could these products be at the price people can afford? Nadira reminded us that even advertising messaging respond to cultural context with examples of ad campaigns in different countries. She felt though that once behaviour becomes a habit, gadgets are irrelevant. However, in order for behaviour to become a habit, gadgets may serve as an incentive.

Fany from Indonesia took Aftab's argument further in that we needed to learn from the toothbrush manufacturers specifically on how they add more value to something that everybody already knows and uses, so that they have bigger share of the market each year. So using the creative example of cereal shapes, while the product matters, more important is the idea behind it and the process of designing the new high value toothbrush. How can we design BCC to be less boring and catch people's attention?

Innovations in measuring effectiveness

In the first topic the discussion raised the importance of measuring the process and not just the exposure to a campaign for example. There was less discussion in this topic relating to the kind of innovation you would like to see in the area of measuring effectiveness of hygiene promotion. Aftab also was not confident that we should be working with universal indicators giving the example of the proxy indicators for hand washing with soap used in the DHS and MICS, which he felt did not work so well in many contexts.

Three examples of innovations were shared. Firstly Thinley Dem shared the hygiene effectiveness study, which has commenced with IRC in Bhutan and includes collecting data on time and money spent on hygiene promotion by the households and institutions but felt that more was needed to be known.

WaterShed shared an innovation in progress with their plan to evaluate the actual usage of their hand washing devices using electronic sensors to control the water level and the usage of soap.

Finally, Hans shared the example of not only measuring whether the behaviour changed but also whether the targeted determinants changed. From this we can learn whether our interventions did what we wanted them to do.

Summary BCC Dgroup discussion week 3, topic 3:

WHAT IT TAKES TO MAINSTREAM INNOVATIONS

Introduction to the Topic

In the previous topic we have been discussing our expectations of innovations in the WASH sector in BCC, drawing on examples locally and internationally. The challenge is that there is limited comparative analysis on what works or leads to sustained hygiene practices and hand washing rates. Most research on hygiene promotion effectiveness measures the health impact or outcome, but not, for example, the costs or perspectives on the ease of implementation. Implementation in turn is perceived as being resource intensive and time consuming and questions of capacity, scalability and sustainability remain.

For this final topic on *what it takes to mainstream innovations in BCC* we have had 11 contributions from 10 participants in nine countries.

The guiding questions for this final topic were

1. How to mainstream innovations in BCC in WASH programmes?
2. What do you see as constraints and enabling factors for mainstreaming innovations in your context?
3. What or who should be driving the process? For example what is the role of local government?

Summary of Dgroup discussion

How to mainstream innovations in BCC in WASH programmes?

One of the first points of discussion focused on **leadership and buy in**. Mike began this with his contribution that if we want to change the behaviour of people at the bottom of the pyramid, we need to change the behaviour of the people at the top first. For real progress or new innovations to be mainstreamed, it starts with the heads and hearts of leaders. Several participants picked up on this. Phyrum felt that process is needed to get buy in and “to get the politics right from the start”. You can have every good innovation but for example if the government doesn’t want it to be on the billboard than the impact is not realized. Dorah from Uganda agreed that there has to be leadership at the top but **ownership** is also important, without it such direction from above may end up becoming more enforcement.

Ingeborg and Susy both brought the perspective of **effectiveness**. Susy reflected that exposure to effective and evident-base innovations would see increased uptake by local government. When they see the results then they will invest. Ingeborg shared further information on the study in Bhutan that collect data on the costs of hygiene interventions compared to the behavioural outcomes to provide a further dimension to effectiveness. Tshering from Bhutan felt that being gender sensitive and socially inclusive in our approach is crucial to achieving effectiveness and sustainability of our BCC interventions.

Befekadu and Ratan discussed aspects of the institutional arrangements, the key actors and roles and working with for example the existing structures, sector reviews, plans and strategies.

Constraints for mainstreaming innovations

Mike felt that the private sector using the example of advertising agencies and the social sector could work better together and use the same language. The lack of rigor in developing the campaigns in comparison to the investment in the formative research was raised as an example as was opting for the cheapest option which may not turn out to be the best in the long run. Phyrum added that it is a compromise as the money spent in social sector is largely public money so you couldn't bypass the procurement rule "value for money".

Ingeborg was not convinced that we need yet another innovation to make behaviour change last but rather the constraint may be in having good communication skills and in knowing whether or not the "old" or the "new" was effective. Linked to Ingeborg's contribution Befekadu from Mozambique felt that costs, lack of resources and affordability of options presented constraints to the sector. Ratan in Nepal and Aftab in Laos linked it to the low priority given to the issues related to hygiene and in investing in BCC approaches. Aftab felt that more and better collaboration between practice and researchers and more **evidence** from large scale hygiene campaigns would overcome what he saw as very limited knowledge about what works and what does not in terms of BCC.

Aversion to risk was raised in different ways. Mike argued that the greatest risk to innovation is not taking chances at all. Susy believed that we are too accustomed with conventional ways of doing BCC activities and are hesitant to try new things.

Enablers for mainstreaming innovations

The constraints also presented enablers. Good decision makers know the difference between true risks (i.e. involving too many stakeholders at the wrong time or not hiring a good ad agency) and good risks (creating a campaign that triggers emotions, but may be somewhat controversial). Susy, Aftab and Befekadu linked it again to buy in and limited evidence. There would be more buy in to support innovations if the innovations are user-friendly (methodology wise), cost effective and evidence based.

Harmonising approaches was presented as an opportunity to overcoming the tendency for organizations create their own BCC strategies, plans, and BCC tools once every few years, which may not be the best use of resources. Examples of other opportunities included the provincial and the national WASH platform where by both government and key WASH actors (including NGOs) meet to harmonize approaches and develop programs/plans.

The government was seen as the key actor to be driving the process. Befekadu explained that this was linked to the specific actors at different levels and their roles. For example in Mozambique, Ministry of Water should consider BCC in the national program/plans and monitor the effectiveness of BCC; district WASH actors should test innovation through allocating sufficient resources and also monitor the effectiveness; posts and localities who are very close to community should mobilize community, organize learning events etc. CBOs including religious institutions also should play roles.

In the Indonesian context, Susy felt the local government, specifically the relevant technical sectors such as the District Health Office (DHO) – with cooperation with other sectors such as Community Empowerment (*Pemberdayaan Masyarakat Desa*, PMD), Women Empowerment, Education, and People Welfare (*Bidang Kesejahteraan Masyarakat*, usually under the office of District Authority/*Bupati*), should lead the process. Women's organization such as PKK should be involved as they have constituents until the grass rote level, which are the centre of the application of innovations.

Variations on the government role included Hilda's example of HIV programmes and felt it was linked to understanding the target audience, where they are and what interested them and there it was clear who was best placed to engage. Mike shared that in the private sector its ad agencies and design firms that drive the process.

Annex 4.1: SaniFOAM cheat sheet



Focus

- **Desired behaviour:** The behaviour that needs to be changed, i.e. ceasing open defecation, upgrading to hygienic latrines, handwashing with soap, etc.
- **Target Population:** The group that, in most cases, that needs to be targeted to adopt the behaviour. In some instance, the target group could be someone who has to enable the behaviour to occur, for example, a mother needs to feel that allowing her children to use soap is not wasteful so that her child is able to handwash with soap.

Opportunity

1. **Access/Availability:** Products and services present in community
2. **Product Attributes:** What people like about a product (latrine)
3. **Social norms:** Rules that govern or influence a community – what everyone is doing so why can't I?
4. **Sanctions:** Explicit punishments or fines for engagement in behaviour.

Ability

5. **Knowledge:** facts accumulated through learning about objects, actions, and events which are true or not
 - a. **Skills:** knowledge needed to build one's own latrine
6. **Self-efficacy:** Confidence in their ability to carry out a behaviour (drive a car, build a latrine)
7. **Affordability:** actual or perceived ability to pay for product/ service or the opportunity cost of doing a behaviour (time, \$)
8. **Social Support:** Social support is the physical and emotional comfort given to individuals by family or community members, friends, co-workers and others. Social support can take several forms: physical, emotional or informational.
9. **Roles and Decisions:** The person(s) within the household who takes the lead or and has some Influence

Motivation

10. **Beliefs/attitudes:** Opinions of a product or behaviour which may or may not be true (individual level)
11. **Values:** Beliefs shared by group or community about what is good, desirable and not.
12. **Emotional/physical/social drivers:** Feelings of pride, disgust, shame from doing or not doing a behaviour (status, shame disgust)

13. **Willingness to pay:** How much households or individuals are interested in paying for a product or service (cash or credit).
14. **Competing priorities:** Competing demands for resources that will affect behaviour including food, shelter, water, health fees school fees, weddings, cell phones, etc.
15. **Intention:** Intention represents an individual's plan on whether or not to engage in a certain behaviour.

Annex 4.2: FOAM cheat sheet



Focus

- **Desired behaviour:** The behaviour that needs to be changed, i.e. ceasing open defecation, upgrading to hygienic latrines, handwashing with soap, etc.
- **Target Population:** The group that, in most cases, that needs to be targeted to adopt the behaviour. In some instance, the target group could be someone who has to enable the behaviour to occur, for example, a mother needs to feel that allowing her children to use soap is not wasteful so that her child is able to handwash with soap.

Opportunity

1. **Access/Availability:** Products and services present in community.
2. **Product Attributes:** What people like about a product.
3. **Social norms:** Rules that govern or influence a community – what everyone is doing so why can't I?

Ability

4. **Knowledge:** Facts accumulated through learning about objects, actions, and events which are true or not.
5. **Social Support:** Physical and emotional or informational comfort given to individuals by family or community members, friends, co-workers, and others.

Motivation

6. **Beliefs/attitudes:** Opinions of a product or behaviour which may or may not be true (individual level).
7. **Outcome expectations:** The benefits or disadvantages of adopting a behaviour/buying a product.
8. **Threat:** A person's assessment of their risk of getting a disease and their risk of dying from it.
9. **Intention:** Intention represents an individual's plan on whether or not to engage in a certain behaviour.

Annex 5: Team compositions for field assignments on Tuesday 9 March 2015

Group A: Chukha Small Towns

1. Kinley Penjor
2. Gopal Hingmang
3. Dorji Phub
4. Dechen Yangden
5. Dr. Hj. Nofli Yurni, M.Kes
6. Rustina
7. Chreay Pom
8. Nadira Khawaja
9. Aftab E. Alam Opel

Group B: Thimphu Schools

1. Thinley Dem
2. Phetmany Cheuasongkham
3. Anoulack Louanglathbandith
4. Phupa Thinley
5. Deki Tshomo
6. Rinchen Wangdi
7. Ingeborg Krukkert
8. Saing Sodany

Group C: Monasteries

1. Raj Kumar Bhattra
2. Phuntsho Wangdi
3. Lopen Passang
4. Ugyen Tshering
5. Sonam Gyaltshen
6. Michael Rios
7. Tikaram Khadka
8. Nga Kim Nguyen
9. Harishova Gurung

Group D: Thimphu City

1. Tashi Yetsho
2. Gem Tshering
3. Erick Baetings
4. Maria Carreiro
5. Kamrul Hassan
6. Swapan Kuman Hawlader
7. Anup Kumar Regmi

Group E: Paro

1. Ugyen Rinzin
2. Fadila Kerrad
3. Pak Sumedi
4. Sigid Cahyono
5. Petra Rautavuoma
6. Pasuong Saokun
7. Bounta Vongsouthy
8. Sonam Dorji

Annex 6: Hygiene effectiveness ladders developed for and by SNV Bhutan

Hygiene practice levels	Latrine & use	Handwashing with soap	Safe drinking water management
Improved	- Sanitary toilet is used: separates users from faecal matter - Toilet is maintained (cleanliness) and all HH members have access to toilet	- Handwashing facility within 10 m from toilet - Water available - Soap or substitute available - Prevents re-contamination - HH members know 2 critical times for handwashing	- Drinking water always comes from an improved source - Water is collected safely - Water is stored safely - Water is drawn in a safe manner - Water is treated
Basic	- There is a toilet or shared toilet - Toilet is used as toilet - Toilet is sanitary: separating users from faecal matter BUT not all HH members have access	- Handwashing facility within 10 m from toilet - Water available - Soap or substitute available - HH members do not know 2 critical times (after defecation and before eating)	- Drinking water always comes from an improved source - Water is collected safely - Water is stored safely - Water is drawn in a safe manner BUT water is not treated
Limited	- There is a toilet or shared toilet - Toilet is used as toilet BUT it does not separates users from faecal matter	Handwashing facility within 10 m from toilet AND water BUT no soap or substitute	- Drinking water sometimes comes from an improved source - OR - from a safe source BUT - not collected safely - OR collected safely BUT not stored safely - OR stored safely BUT not drawn safely
Not effective	- There is no toilet - OR - There is a toilet or shared toilet BUT it is not used as a toilet	- Household members have no specific place to wash their hands within 10 m from toilet - OR - There is a facility BUT no water available (at the moment)	Drinking water comes from unimproved source: surface water OR unprotected spring OR dug well

Annex 7: Example of a flowchart for the hygiene practice “toilet and use of toilet”

