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

Theme 1 - Programming for scale
Discussion led by Suvojit Chattopadhyay

Summary Week 1 | 22-28 September 2015 | By Tracey Keatman

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Introduction
The Water Supply and Sanitation Collaborative Council Community of Practice on Sanitation and Hygiene in Developing Countries (WSSCC CoP) and the global Sustainable Sanitation Alliance (SuSanA) have come together to hold a joint three-week thematic discussion on sanitation and hygiene behaviour change programming and sustainability.

This is the first time the two networks have come together to host an online collaborative learning event. Both platforms have over 5,000 members each working in WASH and other related sectors. Furthermore, this thematic discussion has been an opportunity to bring together these two global communities to share learning and to explore links between research and practice on behaviour change.

The discussion takes place concurrently on both platforms; with a coordinator (Tracey Keatman / author of this summary) ensuring that content is shared across both communities. The discussion
is divided into three inter-linked sub-themes\(^1\) to further explore how behaviour change can be better understood and improved to ensure health and WASH outcomes are sustained. The first week focused on ‘Programming for scale’ and was expertly framed and driven by Suvojit Chattopadhyay, a consultant focused on monitoring and evaluation.

Suvojit initially highlighted that the sanitation challenge is a complex and “wicked problem”. The key challenge for us in the WASH sector is to induce lasting behaviour change:

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

Suvojit also noted that practitioners in the WASH sector should:

- Avoid target-driven hardware interventions which will neither change behaviour, nor create social cohesion – yet construction should be done well, have usable and lasting designs, and implemented in a way that promotes local ownership;
- Learn from effective marketing (social or otherwise) to reach each and every person – in that way there is more likelihood of having total inclusion, which is required for 100% total sanitation and hygiene coverage;
- Recognise that conventional approaches are not working and that there should be a focus on personal and environmental sanitation and hygiene as a whole (not just ensuring that communities are ODF) and also on starting ‘at scale’ rather than settling for incremental coverage.

With these calls to action, Suvojit posed the following questions to the SuSanA and WSSCC-CoP global communities:

1. What are some successful examples of successful scale-up? How did these models address the issues of inclusion and equity? In terms of implementation, how have these models been able to create an iterative model that avoids blueprints?
2. In the cases of successful scale-up, were programmes initiated and sustained by governmental or non-governmental actors? What are the key elements of a successful partnership? How can we strengthen national ownership?
3. What is the role of the private sector – for example, in financing, communications, sanitation marts – in implementing sanitation at scale?

Members of both online platforms expressed their delight at how WSSCC and SuSanA had come together to discuss this theme – which is of key importance as we head towards the confirmation of the Sustainable Development Goals and their focus on universal access. This summary note brings together key discussion points that were raised throughout the week.

**Defining ‘for scale’ in sanitation and hygiene programming**

As anticipated, there was a good level of debate trying to understand what ‘scaling up’ means in different contexts for sanitation and hygiene; and therefore programming for scale depends on

\(^1\) Week 1 on ‘Programming for scale’; week 2 on ‘Sustainability for behaviour change’; and week 3 on ‘ODF and slippage’.
having a clear, coherent and accepted definition – which is not necessarily understood or agreed upon by all. As Elisabeth von Muench said:

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

In addition, Alexis D’Agostino introduced the challenge of defining scale-up in the context of nutrition programmes, saying:

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

Suvojit pointed out that not only are the linkages between sanitation and nutrition critical, the challenges in such complementary sectors may provide important lessons that are transferable to scaling up sanitation.

**What does it mean for WASH practitioners? Expanding? Integrating?**

Suvojit started by saying that sanitation hardware interventions need to be ‘right’, with usable and lasting designs and implemented in a way that promotes local ownership (Lalita Pulavarti similarly commented on this point).

To scale up or replicate interventions on a large scale, sanitation hardware supply and hygiene education (which can lead to behaviour change) require tailored efforts as they probably will not happen at the same pace nor be comprehended together as a health improvement ‘package’. This is the primary challenge when considering programming for scale – the different elements of WASH programmes do not scale up in the same way or through the same mechanisms.

As Peter Bury highlighted there is a need to distinguish between but also promote integration of sanitation and hygiene (whereby hygiene education can influence behaviours and hygienic practices) and not treat them as separate activities. Roland Werchota added that behaviour change at scale alone would not necessarily mean that scale is also reached on access to sanitation.

Aisha Hamza also noted that hygiene can never be sustained without adequate water – so the focus remains on water quantity too. Roland also agreed:

“Improvement in health depends therefore more on sanitation once a minimum of clean (utility) water is available.”

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

**Access to adequate and equitable sanitation and hygiene for all**

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

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

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

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

Does this mean scaling up hygienic sanitation practices always means reaching 100 percent of the population? Peter Bury questioned this and asked how this has happened in the past (in places such as London). Behaviour change cannot happen overnight; perhaps take-up happens gradually in ripples as Peter suggested. Other questions raised by Peter dealt with how to reach 100 percent of hygiene education at scale due to population growth, people forgetting, and the need for ongoing education in schools and through media. Access for all surely implies ongoing action to ensure changed hygiene behaviours and practices are sustained.

Peter’s questions highlighted the importance of drawing lessons from historical development in communities and urban agglomerations that have historically tackled the sanitation problem successfully, while being conscious of the magnitude and urgency of the problem today.

**Ingredients for successful scale-up**

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

There was an example provided of how partnerships and convergent action are central to scaling up – Anand Shekhar told shared how the Ministry of Drinking Water and Sanitation, the Government of India and the Global Sanitation Fund have announced the [Shillong Declaration](https://www.dip.gov.in/documents/10184/56754/Shillong_Debate_Notes.pdf) on ‘Promoting Sustainable Partnerships’. In addition, the process of achieving ODF status in Nadia District in West Bengal (see [sabashouchagar.in](http://sabashouchagar.in) for more) required that stakeholders share ‘key values’ to ensure success at scale. These values include decentralisation, joint planning, co-financing and collective action.

Several people commented on how there is not a one-size-fits-all approach and that there is a need to look beyond the WASH sector more, to integrate efforts with those of others working on livelihoods (as Kitchenme Bawa noted and Suvojit agreed).

**Stakeholders’ responsibilities and relationships**

As highlighted by Suvojit and Godwin, sanitation campaigns need to be locally-led and sustained by local governmental or collective community resources plus inter-ministry buy-in and coordination (the latter point added by Roland). Achieving this is easier said than done. For example, Anand noted that:
“Generally, programmes of development organisations are guided by values which may or may not match and converge with others. Scaling up demands scaling up of core set of values that promote sustainability of benefits.”

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

Suvojit prompted a debate on the role of public health engineers – their role in the design and execution of services and also for budget holding. Lalita Pulavarti provided an example from India:

“We had an opportunity to visit six districts in Orissa and six in Tamil Nadu (India) last year as a part of a BMGF funded project to study Citizen Voices in the implementation of the Nirmal Bharat Abhiyan (NBA) in India. Yes, in Orissa the Executive Engineers (of a joint WATSAN department) are still in charge of the sanitation program. However, this does not mean that they are paying attention to structural or design issues either! It only means they are in charge of the money that flows in through the scheme. They sub-contract the building of the toilets to empanelled ‘NGOs’ (who are actually local contractors) who build large numbers of sub-standard toilets that don’t survive. To my knowledge, no Executive Engineer actually visited to inspect the toilets built. Sub-contracting (and the resultant kickbacks), and not giving ownership to the citizens to get the toilet built themselves (due to scale issues/labor issues [skilled masons, etc.] or any other reason) is killing the scheme. Unless this changes under SBM, we will see more of the same in India.”

Godwin raised the challenge of finding the right “mechanisms for institutionalizing hygiene/sanitation behaviour change i.e. by setting initiatives that bring in accountability to local leaderships and communities at large.”

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

Closing words

Suvojit asserted at the start of the discussion that scaling up approaches is critical and that, as practitioners, we need to keep learning about how to effect systemic hygiene behaviour change in different contexts. At the end of the week, he provided readers with his ‘six step formula’ to a successful sanitation and hygiene campaign:

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

Discussion contributors
Anand Shekhar, Team Leader at NRMC, Executing Agency, Global Sanitation Fund in India
Kitchinme Bawa, WSSCC Steering Committee member: Middle/Northern & Western Africa at Water Supply and Sanitation Collaborative Council
Peter J. Bury, Consultant, Development Processes
Alexis D’Agostino, M&E Specialist at John Snow Research and Training Institute
Roland Werchota, GIZ
Aisha Hamza, Sanihyg education initiative (SAHEI)
Anwer Sahooly, Senior Institutional Development Consultant (freelance consultant at German International Cooperation Agency (GIZ))
Lalita Pulavarti, Senior Manager, Protects at Public Affairs Foundation
Godwin, a WASH Specialist and Consultant
Hitesh Chakravorty, India
Tracey Keatman, Partnerships in Practice

Reference materials
http://www.gsdrc.org/docs/open/HDQ1097.pdf
Shillong Declaration: Promoting sustainable partnerships (2015)

Websites:
On the sanitation efforts in Nadia District in India: http://sabarshouchagar.in
Sabar Souchagar means “toilets for all” in Bengali
On defining scale in nutrition projects:
https://www.spring-nutrition.org/publications/briefs/defining-scale-nutrition-projects
On ongoing to scale on nutrition behaviour
http://finalmile.in/behaviourarchitecture/category/social-behaviour
On the link between malnourishment levels and sanitation coverage:
The Research Institute for Compassionate Economics: [http://riceinstitute.org/](http://riceinstitute.org/)

On effectiveness of a rural sanitation programme in Odisha, India:

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

On a private sector initiative funded by Infosys in Karnataka, India:

Post by Roland Werchota on the need to rethink certain WASH paradigms: