

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

Theme 2 – Sustainability for behaviour change

Summary Week 2 | 29 Sep – 06 October 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-themes¹ to further explore how behaviour change can be better understood and improved to ensure health and WASH outcomes are sustained.

The second week focused on 'Sustainability for behaviour change' by exploring the social and behavioural norms and dynamics that influence hygiene practices – specifically, handwashing and the use of sanitation facilities. By way of definition:

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

The following questions were posed to the SuSanA and WSSCC-CoP global communities:

1. From your work and perspective (and in your context), what are some of the key behaviour change techniques that work for increasing handwashing and / or increasing the use of sanitation by all household members?
2. How can we influence and transform social norms around hygiene practices so that they are sustainable? What are some of the challenges you have faced?
3. What areas do we need to learn and know more about?

The discussion focused on sharing and learning from the experiences, knowledge and expertise amongst the two platforms. This summary note brings together key discussion points that were raised throughout the week.

Learning from week 1 – programming for scale

Several points from the previous week of discussions informed discussions on sustaining behaviour change. They include:

- Scaling up hygiene behaviour change efforts are complex due to: “the very nature of careful social engineering required to bring about (lasting) 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 Chattopadhyay)
- Hygiene education (leading to behaviour change) requires a different time frame than, say, sanitation hardware delivery, and it may not be comprehended as part of a health improvement 'package'.
- Behaviour change programmes do not scale up in the same way or through the same mechanisms as water and sanitation supply activities.
- There is a need to keep learning about how to effect systemic hygiene behaviour change in different contexts.
- There is a need to accept that scaling up hygiene education will not always mean reaching 100% of the population due to population growth, people forgetting, the need for on-going education in schools and through media, etc.
- The WASH sector should work more with non-traditional partners / experts – such as anthropologists, sociologists and psychologists – in sanitation programming, to better understand the determinants of mass behaviour patterns and work with the private sector to learn more about innovative communication campaigns.

¹ Week 1 on 'Programming for scale'; week 2 on 'Sustainability for behaviour change'; and week 3 on 'ODF and slippage'.

Active consideration of social and behavioural norms

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

“Health behaviours should be engrained in one’s already existing everyday culture. Scaring tactics do not work and people including children do not believe that they will ‘die just like that’ if they do not use a toilet or wash their hands. BUT why are we pushing for handwashing to happen – to avoid diarrheal and other related communicable diseases. This alone has taught us at IWSD to look at the subject in a more holistic manner. In other words, handwashing must always be discussed in relation to other hygiene enabling behaviours.”

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

Sam French and other contributors noted the value of **influencing the young** so that hygienic practices become routine behaviour.

Context is key

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

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

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

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

Nabil noted that many other activities were undertaken to **create an enabling environment** for the success of these interventions such as training health promoters to conduct awareness sessions, training pharmacists to produce chlorine using WATA kits, training latrine construction workers and plumbers, building demonstration latrines in pilot areas, etc. The short-term evaluation of sanitation interventions showed many valuable learning points, including that:

theatre as a means of mass communication did not have a major impact on access to sanitation and therefore has a limited potential without consistent follow-up; awareness using local agents is an effective technique, but proper follow-up and monitoring from local, provincial and central sanitary authorities is necessary; and, the first awareness sessions to households were more effective than follow-up sessions planned according to the approach proposed.

Behaviour change is a long-term, slow process that does not happen uniformly – additionally, several contributors noted that the **time limits of many local NGO interventions are too short** (Edith Kamundi). [Analysis by 3ie](#) showed that:

"Barriers to behaviour change depend on the stage of the project. Many studies assess the health benefits of initial uptake of safe water, hygiene and sanitation technologies and practices. But few studies consider sustained use. The early project period may be characterised by enthusiasm over the new technology or promotional activities. Enthusiasm may diminish in the late project period but project staff are still around to resolve issues with respect to cost and availability of the hardware supplies. Although external support ends during the early post-project period, the promotional messages may still be fresh in people's minds. However, influential household members who were sceptical may reassert their domination during this phase. And finally, in the late post-project period stockouts, technology failure or poor maintenance systems can pose a serious threat to sustained adoption."

The 3ie-supported [systematic review](#) also found that:

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

IWSD, GIZ, Concern Worldwide, WaterAid and 3ie contributions all highlighted the value of taking a holistic, multi-pronged approach to increase the potential for behaviour change to be sustained. Where there is information, education and communication (IEC) provided to communities in various media plus practical support to ensure there is an enabling environment, the techniques used appear to have more chance of success and may be better sustained.

Behaviour change techniques: examples and challenges

Hygiene promoters – who does what?

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

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

Tom Davis suggested however that the focus on using paid professionals for health promotion is unfounded and referred readers to [this paper](#), where it was found that projects using Care Groups had double the adoption of handwashing with soap as projects that did not use Care Groups. Care Groups rely on volunteers.

Susan Davis also contributed to this point by highlighting a study that compared CLTS to the Community Health Clubs approach (Whaley and Webster, 2011).

"Whilst both approaches effectively encouraged measures that combat open defecation, only health clubs witnessed a significant increase in the adoption of hand washing. However, CLTS proved more effective in promoting latrine construction, suggesting that the emphasis the CHCs place on hygiene practices such as hand washing needs to be coupled with an even stronger focus on the issue of sanitation brought by CLTS."

Systemising behaviour change

Ways to systematise behaviour change techniques and to understand social norms have been developed. One such system was shared by Professor Hans-Joachim Mosler from Eawag – the “RANAS” framework that seeks to provide a process for systematically mapping potential behavioural determinants (based on human psychology) and then linking them practically to specific behaviour change technologies. With such frameworks, practitioners are able to develop a tailored, context-specific approach.

Tom Davis also referred readers to the different determinants found for the 18 Barrier Analysis studies on handwashing with soap shown on the Food Security and Nutrition Network's [Behavior Bank](#).

Designing approaches

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

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

Planning and monitoring for behaviour change

Franck Flachenberg noted that some programmes “*just jump from behaviour change objectives straight to the activities, without giving much thought to why people do what they currently do and what may be preventing them from adopting the hygiene behaviours promoted.*” Hence, using tools that more systematically analyse barriers and drivers towards behaviour change should be planned into programmes from the start, and subsequent behaviour change campaigns should be based on the context.

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

Takudzwa Noel Mushamba highlighted that the “*absence of cases or low prevalence of water and sanitation diseases is not necessarily and indicator of ‘improved behaviour’*”. He drew attention to the [epidemiologic triangle](#), which shows the linkages between the agent of disease, the host and the environment noting that:

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

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

Behaviour change in the Sustainable Development Goals

Finally, Hanna Woodburn from The Public-Private Partnership for Handwashing (PPPH) noted that during UN discussions on the adoption of the SDGs “*when behaviour change was mentioned as being key to achieving these goals responses were often abstract*”. She also drew participants attention to the PPPH Handwashing Behaviour Change Think Tank event held at AfricaSan4 in Dakar, Senegal, which looked at three big ideas in hygiene behaviour change: emotional motivators, behavioural settings, and the science of habit.

Discussion contributors

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Takudzwa Noel Mushamba

Tom Davis, Chief Program Officer, Feed the Children

Susan Davis, Improve International

Nivedita Mahotra, Urban Management Centre (UMC)

Tracey Keatman, Partnerships in Practice

Reference materials

Cavill, S. with Chambers, R. and Vernon, N. (2015) ‘Sustainability and CLTS: Taking Stock’, *Frontiers of CLTS: Innovations and Insights* Issue 4, Brighton: IDS

www.communityledtotalsanitation.org/reso...nd-clts-taking-stock

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

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

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

Websites:

Here's an interesting blog article looking at behaviour change from a different perspective:
thisisyoke.com/successful-behaviour-change-campaigns

Take a look at some of UNICEF's work here: www.unicef.org/wash/index_43107.html

Specifically on handwashing, please find the many resources of The Global Public-Private Partnership for Handwashing available here: globalhandwashing.org/resources-main/

Saw WSSCC post this on Twitter and thought it might be of interest to those engaged in this conversation: <http://blogs.3ieimpact.org/making-wash-behaviour-stick/>

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

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

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

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