Strengthening Behavior Change Communication in RWSSP-WN Phase II

Assessment and Recommendations

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ACRONYMS AND ABBREVIATIONS

BCC	Behavior change communication
DOLIDAR	Department of Local Infrastructure Development
DWASH CC	District Water Sanitation and Hygienic Coordination Committee
FGD	Focus group discussion
GOF	Government of Finland
GON	Government of Nepal
IDI	In-depth interview
MICS	Multiple Indicator Cluster Survey
NPR	Nepali Rupees
O&M	Operation and maintenance
OD	Open defecation
ODF	Open defecation free
RWSSP-WN II	Rural Water Supply and Sanitation Project in Western Nepal, Phase II
SDA	Small Do-able Actions
SP	Support Person
VDC	Village Development Committee
VWASHCC	Village Development Committee Water Sanitation and Hygienic Coordination Committee

1. BACKGROUND

1.1 THE CONTEXT

Rural Sanitation in Nepal

The Government of Nepal (GoN) aims to achieve universal access to sanitation facilities by 2017. Reaching this goal is likely to be a formidable challenge, in particular in the rural parts of the country. By 2011, 62 percent of households had access to basic sanitation facilities (Nepal Census, 2011). However, Multiple Indicator Cluster Survey (MICS) data show that just 39 percent of rural Nepali households used some form of improved sanitation in 2010 (Central Bureau of Statistics & Unicef, 2012). Among those who do not use an improved form of sanitation, open defecation is prevalent. In 2010, 58.7 percent of rural households defecated in the open (Central Bureau of Statistics & Unicef, 2012).

The Rural Water Supply and Sanitation Project in Western Nepal Phase II

The Government of Finland (GoF) is supporting the GoN in its efforts to achieve universal access to sanitation facilities, among other things via its support to the GoF's *Rural Water Supply and Sanitation Project in Western Nepal Project (RWSSP-WN).* Currently in its second phase, the RWSSP-WN aims – among other targets - to declare the Terai districts of Kapilvastu, Rupandehi, and Nawalparasi Open Defecation Free (ODF) in sustainable manner without subsidy by the end of the project. According to MICS data, 45.7 percent of households (rural and urban) in the Terai region used an improved latrine by 2010, while most of the remaining households defecated in the open.

To date, changing sanitation behaviors and increasing household latrine construction have proven far more challenging in the Terai region than in the mountain regions of Nepal. BCC strategies and tools which have worked well in other parts of Nepal have been less successful in the Terai, where the RWSSP-WN II is providing support to the districts of Kapilvastu, Nawalparasi, and Rupandehi. Factors which may make behavior change more challenging in this region are significant landless and transient populations (the region borders India). Other factors that could be influencing behavior change are limited space for sanitation facilities, toilet preferences, the complexity of the toilet building process, etc.

The RWSSP-WN Phase II Sanitation and Hygiene Behavior Change Strategy

The RWSSP-WN Phase II aims to achieve total sanitation and hygiene behavior change in the target communities. To achieve this goal, the project has developed a two-stage strategy:

> **Stage 1**: Community led sanitation behavior change
>
> The target of this first stage is to bring about household sanitation behavior change (i.e. stopping open defecation, construction and consistent use of toilets by all household members). Behavior change is achieved via a so-called 'trigger-based' approach, which is applied at both community and individual level.
>
> To implement the triggering activities at community and household level, the RWSSP-WN trains VWASHCC members and local support persons[1] on how to plan for and apply a number of different 'triggering tools' (see table one below). The VDC

[1] These Support Persons are recruited and remunerated by the DDC but with the support of RWSSP-WN. Their main role and responsibilities are to work with core VDCs (selected to receive more intensive support by the project) to plan for and implement WASH activities, including triggering, as well as monitor progress and results.

stakeholders and support persons, in turn, train a group of volunteers from all wards in the VDC on the use of these triggering tools. Typically, two volunteers are selected in each ward and trained. Following this training, these ward level volunteers will then carry out community and individual level triggering activities in their local area with support from the VWASHCC and the RWSSP-WN support persons. These triggering activities are intended to lead to sanitation behavior change and the achievement of an open defecation free community via the following process[2]:

- Entire community analyses their own sanitation situation
- A sense of collective shame, disgust and helplessness creeps in
- Community is compelled to think and act
- Community resolves to eliminate open defecation
- Natural leaders emerge
- Collective local action is initiated towards total behavior change in sanitation

Triggering activities are supplemented by behavior change communication via other channels, including street drama, rallies, radio broadcasts, etc.

The intended final outcome of this triggering process is the achievement of open defecation free wards and VDCs. Once a VDC has been ODF-declared (after a verification process), the second stage of behavior change starts.

Table 1 Community and individual triggering tools

Community triggering tools	Individual triggering tools
Walk of Shame Defecation mapping Calculation of feces/GUHU Calculation of feces/GUHU ingested by a person Cost of illness Respect to occupation Flow diagram for water contamination Respect of women Holy ignition Open defecation and begging Feces/GUHU to mouth transmission Water quality testing	Privacy If she/he had toilet at home Peer group pressure Fear Economic reason Demonstration effect Health Infidelity Reward/Incentive

Stage 2: Total sanitation and hygiene behavior change

Following ODF declaration, the second stage of behavior change opens. This stage focuses on promoting five hygiene and sanitation behaviors, including:

- Hand washing with soap or cleaning agent at four critical times
- Safe disposal of feces
- Safe handling and treatment of household drinking water
- Regular nail cutting, bathing, cloth washing, daily combing, proper tooth brushing

[2] RWSS-WN Phase II. 2011. *Lead TBC Facilitators Manual*.

- Proper waste management in and out of home

The main strategy used to bring about these targeted changes in behavior centers on consultations and negotiation at the household level with the Small Doable Actions (SDA) approach. The SDA approach seeks to bring about behavior change via the following process[3]:

- Identify feasible incremental steps that move people from the current hygiene and sanitation practice toward the ideal practice
- Identify existing hygiene and sanitation good practices to be reinforced and congratulate the householder
- Identify practices to be improved and negotiate the options
- Visit families to find out how families are able to practice the new behavior

Selected natural leaders, lead mothers, teachers, health workers and FCHVs are intended to play key role in this process. These community members are trained on how to implement the SDA approach and will proceed to visit each household. A specific method – called GALIDRAA – for how to conduct these household visits has been developed (see box 1 below).

The intended final outcome of stage 2 is total sanitation and hygiene behavior change. The RWSSP-WN's model of behavior change thus assumes that a mass movement will be set in motion by triggering in the Terai communities, where the activity is carried out and that this mass movement – supplemented by radio messages, videos, etc. – will lead to ODF. Following ODF, small SDA household visits will be the main vehicle for behavior change. Figure one provides a visual demonstration of the RWSSP-WN's model of behavior change.

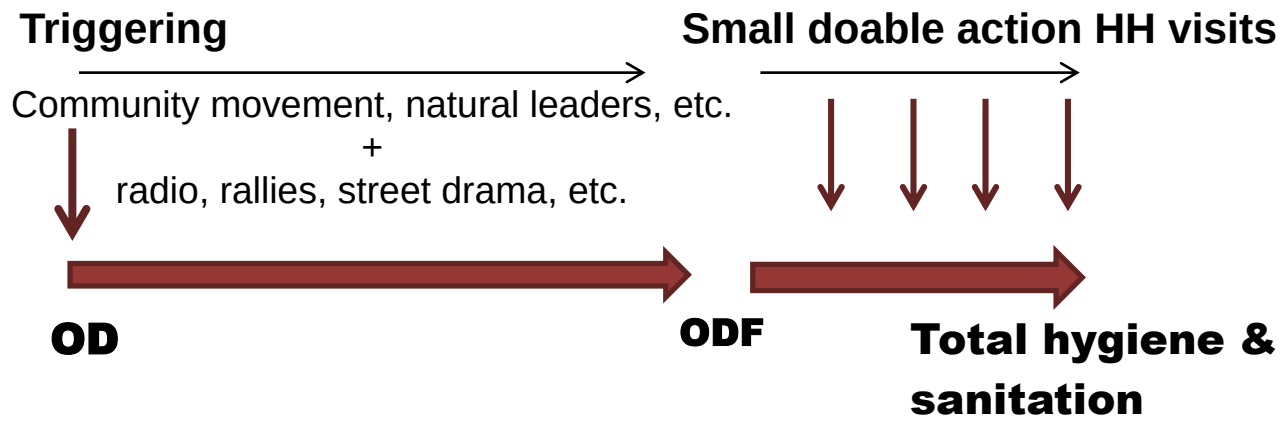
Box 1 THE GALIDRAA METHOD FOR HOUSEHOLD VISITS

The GALIDRAA method has been developed by RWSSP-WN to help trained community volunteers to effectively carry out household visits. The method aims to help the volunteers remember the key steps to negotiate hygiene and sanitation behavior change with the household, including:

G	**GREET** the householder; ask about the family, work, the farm, current events etc. to build rapport. Tell the householder where you come from and your intension. Take permission to stay for a few minutes and discuss a few issues while they are working.
A	**ASK** about current H and S practices and other health issues.
L	**LISTEN** to what the women/men in the house say.
I	**IDENTIFY** potential barriers to change from what is said by the women/men.
D	**DISCUSS** and suggest women/men the different options to overcome the barriers
R	**RECOMMEND and NEGOTIATE** SDAs.
A	**ASK** them to repeat the agreed upon actions
A	Make an **A-APPOINTMENT** for a follow-up visit

[3] Adopted from: Mugambi, E. & Bery, R. 2013. *Promoting Healthy Hygiene and Sanitation Practices for People Living with HIV and AIDS*. WASHPlus Project. Retrieved online at http://www.washplus.org/sites/default/files/kenya_wash_hiv-wedc2013.pdf

Figure 1 RWSSP-WN Project model of behavior change



1.2 THE ASSESSMENT

Purpose and Specific Objectives

The purpose of this study was to assess and provide recommendations which can help strengthen the effectiveness of the RWSSP-WN II's behavior change communication (BCC) activities aimed at improving sanitation practices and toilet access in three Western Terai districts (Kapilvastu, Nawalparasi, and Rupandehi districts).

In order to achieve this goal, the assessment specifically sought to determine:

a) To what extent have the Program's BCC strategy and activities been effectively implemented; and
b) To what extent do the RWSSP-WN's BCC strategy, messages, and activities adequately respond to the drivers of and barriers to improving household sanitation behaviors in the target population

The study specifically focuses on the following behaviors:

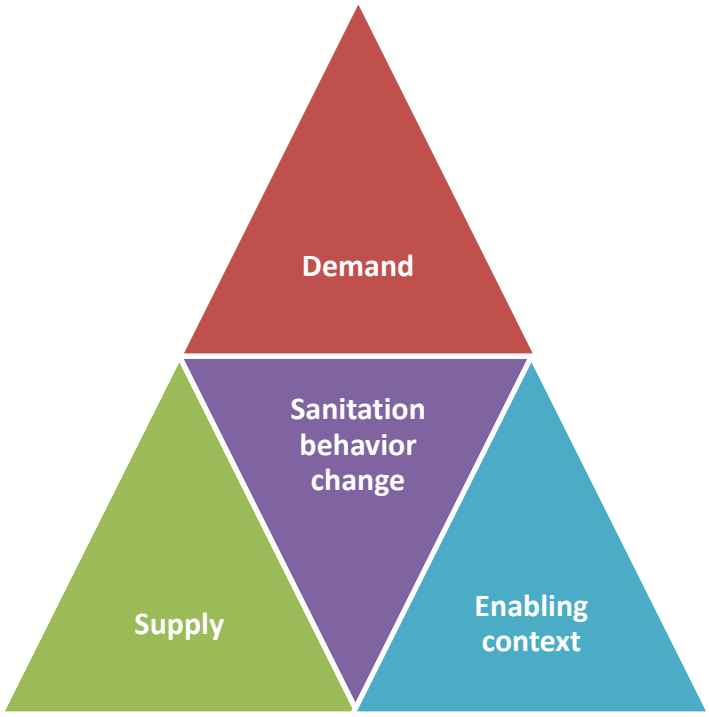
- Ending open defecation
- Toilet investment and construction
- Consistent toilet use
- Safe operation and maintenance of toilets

Assessment Design and Methodology

Analytical Framework and Assessment Components

Guided by the Water and Sanitation Program's (WSP) theory of sanitation behavior change, this assessment sought to consider drivers / facilitators and barriers to sanitation behavior change and BCC effectiveness related to the demand for improved sanitation behavior, the sanitation supply chain, and the enabling environment (figure two).

Figure 2 According to WSP's theory of change, bringing about large scale sanitation behavior change requires effective demand creation, an efficient sanitation supply chain, and an enabling environment



Within each of these areas, a set of critical questions guided the design of the assessment. These questions included:

Demand	• Do those who do not use improved sanitation have the opportunity to change? • Do those who do not use improved sanitation have ability to change? • Do those who do not use improved sanitation have the motivation to change?
Supply chain	• Are toilet building service providers and suppliers able to provide affordable and desirable toilets? • How complex does the existing sanitation supply chain make the sanitation shopping process?
Enabling environment	• Do decision makers and implementers understand the program's approach? • Do decision makers prioritize sanitation? • Do decision makers buy into and prioritize the RWSSP-WN's BCC approach?

The above key questions guided the development of interview and focus group discussion instruments. The focus of the assessment lay on the assessment of factors affecting the demand for stopping open defecation and building toilets in the target population. For this part of the assessment, the SaniFOAM framework for sanitation behavior change guided the detailed development of the assessment tools (figure three). Developed by WSP and partners, SaniFOAM is a conceptual framework for analyzing and understanding sanitation behavior change. The letters "FOAM" stand for: focus, opportunity, ability, and motivation. SaniFOAM is designed to assist programmers to identify the key factors (determinants) which influence the practice of a desired behavior (e.g. usage of a toilet) in a target population.

Figure 3 SaniFOAM behavior change framework.

Source: Devine, 2009

Assessment Sites and Participants

The assessment was carried out in seven VDCs in the Terai districts of Kapilvastu, Nawalparasi, and Rupandehi, of which two had been declared open defecation free (ODF). Both Hindu and Muslim groups were present in the assessment VDCs (table two, below).

Table 2 Assessment VDCs

Districts	VDC	ODF	Religious affiliations
Kapilvastu	Sisawa	Yes	Muslim, Hindu
	Rangapur	No	Muslim, Hindu
	Baluhawa	No	Hindu
Nawalparasi	Rampuruwa	Yes	Hindu
	Bhujuwa	No	Hindu
Rupandehi	Chodki Ram Nagar	No	Muslim, Hindu
	Silautiya	No	Hindu

A qualitative study design was applied. Interviews and focus group discussions (FGD) were carried out with the following participant groups:

Demand	*Female doers* *Male doers*	Defined as adults who own and use an improved toilet

	Female non-doers *Male non-doers*	Defined as adults who practice open defecation (regardless of toilet ownership status)
Supply	*Masons* *Suppliers*	
Enabling environment	*Field level BCC implementers* *VWASHCC members*	

Table three, below, provides an overview of the field research activities. A total of 17 FGDs and 31 interviews were carried out.

Table 3 Overview of field research activities

District	FGD				Interviews				
	Doer	Non-doer	Mixed	VDC VWASHCC	Doer	Non-doer	Triggerer	Mason	Supplier
Kapilvastu	2	3	1	2	6	5			
Nawalparasi		1		2	5	2	2	1	2
Rupandehi	2	1	2	1	2	3	3		
Total	**4**	**5**	**3**	**5**	**13**	**10**	**5**	**1**	**2**
	17				**31**				

Assessment Limitations

As is often the case, this assessment has a number of limitations. They include:

- Subsidies for sanitation were available or had been available recently in each of the VDCs where we carried out our interviews and FGDs. The availability of such subsidies may have worked to bias the answers we received, as some participants may have anticipated that the assessment team was in a position to provide such subsidies. To avoid such bias, we made sure to clarify that we were not affiliated with any form of subsidy providing program.
- Because material subsidies were or had been provided on a very large scale (to hundreds of households) in the assessment VDCs, a 'true' sanitation market situation did not exist. For this reason, we were unable to learn where – for example – households would purchase concrete rings and how they would transport them.
- We were able to interview only a small number of masons and suppliers; not enough to get a detailed view of the supply chain situation at community level. Importantly, we did not meet with any ring producers, all of whom currently are contracted by the VDCs to produce rings in bulk. The information we obtained about the sanitation supply chain in the three districts is therefore less rich than what we had hoped for. We sought to partially make up for the lack of service provider and supplier interviews by asking doers and non-doers questions about the sanitation market.

- Many of the interviews and FGDs were done with translation, in a few cases even with three-way translation. This has undoubtedly reduced the richness of some of the data collected. However, we hope that some of this richness has been regained through the extensive sharing and discussion of field findings and observations which took place between the assessment team (one of whom did speak Nepali and did understand the local language spoken) and the RWSSP-WN staff who supported us throughout the field work.

2. ASSESSMENT FINDINGS

2.1 IMPLEMENTATION OF THE BCC STRATEGY

Key findings

√ Triggering has not been systematically and widely implemented. As a result, many community members have not been 'triggered'.

√ Many volunteer triggerers have become inactive soon after their training.

√ Triggering activities have been well implemented and *can* make a strong impact.

√ VDC and VWASHCC members do most of the sanitation promotion – their approach is mostly to 'educate' and blame / threaten those without toilets.

√ VDCs do use a variety of communication channels to promote sanitation; however, community resources could be better mobilized to integrate sanitation promotion into their activities / work.

√ Door-to-door visits by VDC officials and VWASHCC members is the main BCC approach used – but one for which the RWSSP-WN has not method, tools, and guidance.

√ The current process monitoring and supervision mechanisms are insufficient to alert the RWSSP-WN's management team to BCC / triggering implementation issues.

To answer the question of why the RWSSP-WN's BCC strategy has not resulted in the anticipated level of behavior change in the Terai, we first sought to assess to what extent the strategy and its tools were being efficiently and effectively applied.[4] Overall, we found that the BCC strategy is far from being implemented as planned and that this could be one of the major factors behind the lack of results seen. Specifically, our findings show:

Triggering has not be widely and systematically implemented

Interviews with community members, triggerers, and VWASHCC members quickly revealed that the scale of triggering has been much smaller than intended both geographically and in terms of the number of individuals reached. In terms of the geographic scale, triggering appears to have been carried out in some clusters and wards only. Further, where triggering had been implemented only some community members appeared to have been exposed. As such, a majority of the community members we interviewed had not experienced triggering first hand.

[4] Since none of the RWSSP-WN supported Terai districts and only few of the VDCs have been ODF-declared, this section focuses on findings related to the first stage of the BCC process.

Where triggering activities have been implemented, they have not been – as normally prescribed – events which involve a full community of individuals.[5] Rather, just 1-2 members of each household had been invited.

Many trained volunteers become inactive soon after training

For its broad implementation, the BCC strategy relies on a large number of ward level volunteers (triggerers), who have been trained to carry out BCC and trigger fellow households. We found that many of these volunteers become inactive shortly after receiving the training. This is likely to be among the key reasons why triggering has been implemented on a smaller scale than anticipated. As an example, we learned that only one of 18 trained 'triggerer' volunteers was still active in Chodki Ram Nagar VDC, Rupandehi district six month after the training.[6] In this and the other study VDCs, triggering activities mostly appeared to have been implemented by RWSSP-WN support persons. Unfortunately, we were unable interview former triggerers and, thus, could not learn why they had discontinued or never started their work. However, identifying and addressing the factors behind the high rates of volunteer discontinuation would be critical to strengthen the likelihood that future BCC activities are efficiently implemented.

When implemented triggering activities make an impact

A positive finding is that triggering activities – when done – have been effectively applied. (However, as was noted above, many triggering activities appeared to have been led by the RWSSP-WN support persons). Community members who had been exposed to triggering activities reported that the experience had made a strong impression on them. Community members reported having been exposed to and affected by the following activities: walk of shame, glass of water, feces calculation, and defecation mapping/community mapping. Those who had been exposed to the first three activities reported feeling disgusted and convinced that they were eating feces. The female community member, who had been exposed to defecation/community mapping, reported feeling ashamed of her toilet-less status in front of her peers. Among those exposed to triggering tools, several reported taking action to build or complete their toilet shortly after the exposure.

[5] The aim of inviting the full community to the triggering event is to bring about an instant, community wide change in the social norms related to open defecation. To achieve this, the community must be 'ignited' together by the shock and disgust produced by the triggering activities.

[6] Moreover, this volunteer triggerer had now moved away from the VDC to study in a nearby town.

Photo 1 Defecation mapping motivated this woman from Rampuruwa VDC, Nawalparasi, to build a toilet

Negative BCC messages are common

The RWSSP-WN's triggering approach calls for BCC facilitators to refrain from 'educating' villagers and telling them what is good and bad. In actuality, VDC and VWASHCC members, who do most of the door-to-door sanitation promotion, tend to engage in such 'educating' and often focus on negative, blaming messages. The assessment team had the opportunity to see this play out when non-doer FGDs were joined by VWASHCC members. On these occasions, the VWASHCC members loudly blamed non-doers for their ignorance and backward ways and lectured them about the need for a toilet.

A variety of communication channels are used, more could be utilized

The RWSSP-WN's BCC strategy calls for the use of a variety of communication channels. We learned that VDCs, indeed, have used different channels to promote household sanitation, including street theatre, mass rallies, radio broadcasts, community meetings, and loudspeaker messages. However, many potential channels for promoting household sanitation were underutilized. In particular, existing community groupings and organizations could be better mobilized to integrate sanitation promotion into their work and activities. Figure four, below, shows an overview of these potential community resources. We found that many of these resources were now – at best – only loosely involved in the movement to end open defecation in some of the study VDCs.

Figure 4 Local community groups which could be mobilized in the ODF movement. Source: Bishwa, N. P. 2014. *Study to Identify Appropriate Approach and Strategies for Sustainable Sanitation Intervention in Terai*. Report prepared for ESDMS/DWSS

In addition to the above, the assessment team also noted in the study communities a complete absence of visually oriented BCC materials.

Improvised door-to-door visits in lieu of triggering

Rather than triggering, door-to-door sanitation promotion is the BCC activity which the study VDCs mostly rely on. The RWSSP-WN does not have a method, tools, and guidance for how to conduct door-to-door visits with the objective of supporting households to become open defecation free and build a toilet. Absent such method, tools, and guidance, VDCs and VWASHCCs have come up with their own approach. Typically, their approach is to monitor the sanitation status of each household, educate them about their need for a toilet, and threaten with them with sanctions if they do not build one. While such approach often brings results in terms of toilet construction, it does not necessarily lead to behavior change. (See further below).

Process monitoring and supervision

The monitoring and supervision mechanisms which are currently in place appear not to be sufficient to be able to keep the RWSSP-WN management team abreast of the type, timing, and scale of the BCC activities being implemented. This makes is difficult for the RWSSP-WN to identify problems with triggering / BCC implementation in a timely fashion.

2.2 ENABLING CONTEXT FOR BCC STRATEGY IMPLEMENTATION

Key findings

- √ Decision makers at all levels display a strong awareness of and commitment to achieve the nationwide ODF target by 2017.
- √ Some VDC leaders have been intensely involved in sanitation / ODF promotion.
- √ VDCs have allocated substantial resources to household sanitation.
- √ However, almost all the budget for sanitation is spent on subsidies, which remain the focus of sanitation promotion efforts. It should be noted that the RWSSP-WN does not promote or support this approach.
- √ Strong pressure to achieve ODF on time means that VDCs seek to reach the target by 'hook or crook', i.e. by almost any means available.
- √ In the rush to achieve ODF, the number of toilets built has become the focus.
- √ VDCs have no plans for what happens after ODF has been declared and may perceive this as their 'final destination'

A second important consideration for the assessment is the extent to which an enabling environment exists for a) the effective implementation of the BCC strategy and b) bringing about the intended outcomes with the BCC strategy.

Enabling Factors

Several very critical enabling factors were in place in the three Terai districts and the specific study VDCs, which together resulted in a strong drive to promote ODF and toilet construction. These factors included:

Strong commitment to achieve ODF by 2017

The Government of Nepal's (GON) Sanitation and Hygiene Master Plan from 2011 has set the ambitious goal of achieving universal access to toilets by 2017. Our interviews and interactions with district and VDC leaders as well as district and VDC WASH Coordination Committees (VWASHCC) showed that decision makers and implementers at both levels are keenly aware of and committed to reaching this goal by or before the target date.

VDCs have set in all resources to achieve the target

Many of the VDCs had dedicated considerable attention and resources to achieving the ODF target on time. In at least four of the seven VDCs, where we did interviews, this meant that the VDC budget had allocated all or most of the VDC's annual budget to the promotion of household sanitation. In some VDCs, such as Bhujuwa in Nawalparasi, VWASHCC members and local organizations/clubs (such as Child Clubs) had been extensively mobilized to monitor toilet construction and use on a regular basis.

Strong involvement of VDC leadership

In VDCs where ODF had been achieved or substantial progress towards the target made[7], the VDC leadership – the VDC chair specifically – had played a very active role in promoting and

[7] This included, specifically, Bhujuwa and Rampuruwa VDCs, Nawalparasi, and Sisuwa VDC, Rupandehi.

monitoring the toilet construction. Often, VDCs chairs had gone door to door to convince households to stop OD and build a toilet. In Rampuruwa VDC, the chair reported he had gone as far as picking up the feces after those who continued to defecate openly and place it on their doorstep.

Challenges

Although the above enabling factors resulted in a strong focus on sanitation in the VDCs, another set of contextual factors pose a serious challenge to the implementation of the RWSSP-WN's BCC strategy. These include:

Subsidies remain the focus of sanitation promotion efforts

In Nawalparasi and Kapilvastu districts – and in Rupandehi district until recently – efforts to achieve ODF in the VDCs visited centered on the provision of in-kind subsidies. In all the study VDCs, toilet subsidies were or had been made available to all households, regardless of their wealth status. Though a clear no-subsidy policy is in place at the national level, VDCs had allocated and, mostly, used their local budget to provide such subsidies on a vast scale, with little money spent on other promotional activities. It is important to note that the RWSSP-WN does not promote or support this approach.

As an example, out of a total budget of 1.2 million NPR allocated for sanitation in 2013 in Rampuruwa VDC, Nawalparsi, just 60,000 NPR had been used for communication activities.[8]

VDC leaders provided a number of reasons why they had made the decision to provide subsidies on a large scale. These included: 1) the previous VDC chair has introduced the policy and they did not feel they could achieve results if they discontinued the policy, 2) they felt pressure to introduce subsidies because subsidies were given in neighboring VDCs and / or in India, 3) they had first introduced the subsidies to ensure that ultra poor households could gain access, but then all households had demanded the subsidy, and 4) national and district leaders had put pressure on them to utilize subsidies to reach the ODF target. Often a combination of explanations were given.

Pressure to achieve ODF – whether by 'hook or crook'

The strong pressure to achieve ODF by the target date seems to have led to a situation where local leaders seek to do so by 'hook or crook'. Though they reported implementing some communication activities – such as street rallies and theatre – their efforts to reach the ODF target had come to center a subsidy-sanction approach. That is, subsidies for the toilet underground structure was given to all households and various forms of sanctions / punishment were used to pressure the subsidy recipients to use the materials they were given to build the underground structure and to put a superstructure on the facility.[9] Typical sanctions included withholding public support, such as pensions, or refusing to provide VDC services to

[8] The Sanitation and Hygiene Master Plan appears to open up for the local leadership to allocate their own funds by allowing the principle of a "Locally Managed Financial Support Mechanism". The Master Plan thus states: "A community fund may be established to promote hygiene and sanitation and to stimulate ODF initiatives. This fund may be mobilized in the form of reward-recognition/ revolving fund/ incentives as appropriate locally. A community can make its own decision to locally mobilize the fund and generate local resources in addition to support from government or other external agencies in a way to ensure the access of poor, disadvantaged and marginalized groups to toilets and achieve ODF status in the given area." (Government of Nepal. 2011. *Sanitation and Hygiene Master Plan*)

[9] Also households which had not received a subsidy were threatened with sanctions lest they build a toilet.

members of households which did not have a toilet. In terms of the number of toilets built, this approach appeared to yield fast results. However, it was evident that toilet construction under the threat of sanctions often did not equal sanitation behavior change. As such, we observed a large number of toilets built as a result of the subsidy-sanction approach, which had no superstructure or one that gave no privacy and, as such, were unlikely to be in use.

Hardware in focus, behaviors out of focus

In the study VDCs, the primary push observed was one focused on the construction of toilets. That is, local leaders and VWASHCCs appear mostly to be focused on reaching the point where all households have some form of toilet structure. Much less attention is paid to promoting the universal and consistent use of these toilets for defecation by adults and children. We learned of systematic monitoring of behaviors (i.e. use of toilets) only in Bhujuwa VDC, where Child Clubs and Ward WASHCCs were involved in this monitoring.

Is ODF seen as the 'final destination'?

While VDC leaders and VWASHCCs were very preoccupied with reaching ODF status (effectively, universal household toilet ownership) by their respective target dates, few seemed to have given much thought to what was to happen after the ODF declaration. As such, there may be a certain risk that they consider their job to be done when all households have toilets. Our observations suggest that the target remains far from achieved when all households have toilets and that considerable risk of a return to open defecation exists. A case in point was ODF-declared Sisuwa VDC, Kapilvastu, where we observed a substantial number of facilities without super structures. The leader of the VWASHCC explained that the toilets had had temporary super structures earlier, but that these had been destroyed by rain and wind. Our visit took place several months into the dry season; at which time the affected households should have had plenty of time to put up replacements. Presumably the owners of these toilets had returned to open defecation.

Low expectations to the target population

A theme which came up again and again our interviews with local authorities was the perception that those belonging Madhesi ethnic group were particularly resistant to change and unlikely to change their behaviors voluntarily. Many saw punitive measures and threats as the only viable approach: *"People in our communities don't hear if you pray joining hands but will listen to you if you have a stick at your hand"* (VWASHCC member, male, Sisuwa VDC, Kapilvastu district).[10] It is possible that having low expectations from the outset could be one of the factors that is driving VDC chairs and VWASHCCs to resort to subsidies and punitive measures, before having given BCC a fair try.

2.3 DETERMINANTS OF SANITATION BEHAVIOR CHANGE IN THE TERAI

Two final questions asked were: a) what constitute the main determinants of sanitation behavior change (cessation of open defecation and construction and use of a toilet) in the three Terai districts and b) to what extent do – and can[11] – the current BCC strategy and tools take these determinants into account. In this section, we first present our findings regarding the behavioral determinants which drive and comprise barriers to sanitation behavior change,

[10] Interestingly, this was a belief many community members had internalized. For this reason, many of them also felt that punitive measures were necessary. However, like in any other community, people in the villages visited were sensitive and sought to conform to the norms of their social network.

[11] It should be noted that not all, in particular, barriers to behavior change can be addressed via behavior change communication. For example, if households have difficulty finding masons to build a facility, training of such service providers would be in order.

respectively. We then look at the extent to which they are addressed by the current BCC strategy and tools.

Behavioral determinants driving sanitation behavior change

What drives or facilitates the adoption of new, improved sanitation behaviors and toilet construction among households in the three Terai districts? Our findings suggested the following:

Access and availability[12]: Masons capable of building a toilet can be found everywhere

None of the households which had built a toilet reported any difficulty in finding a qualified mason to build their facility. In addition, many households had family members with construction experience. Where extensive construction activity was happening, as was the case with Rampuruwa VDC, Nawalparasi, households did report a shortage of masons during this period. Hiring a mason was reported to cost 500-600 NPR / day.[13]

Access and availability: Supplies needed to build a toilet are available

Households that had built toilets in the study villages reported that they had been able to buy the necessary supplies. In the villages visited, the supplies are generally available in the VDC or nearby. Customers living near the border tend to buy the goods for toilet construction in India, because prices are lower and there is a greater selection.

Social norms[14]: When people see their neighbors changing, they change too

Scientific research has shown that our behaviors to a very large extent are determined the norms of the social networks in which we are embedded (Christakis and Fowler, 2011). This dynamic could also be observed in the VDCs where we interviewed men and women with and without toilets. In VDCs where an increasing number of households were building and using toilets – such as Bhujuwa and Rampuruwa VDCs, Nawalparasi – residents had begun to see having and using a toilet as the social norm. Some doers explained that they had built a toilet because they saw everyone around them do the same and did not want to be "left behind" (Toilet owner, woman, Chodki Ram Nagar VDC, Rupandehi). Those who were "left behind" shared that they now felt that a social stigma was attached to open defecation, which they had not felt when everyone engaged in the practice:

> *"Open defecation was common before, but now many people use toilets. We feel ashamed that we are still defecating in the open" (Non-doers, women, Bhujuwa VDC, Nawalparasi).*

Women appeared to perceive a shift in the social norms surrounding open defecation and feel a need to conform to these new norms sooner than men. This is likely because open defecation – even where it is universally practiced – is associated with great risk of embarrassment and shame for women (*see further below*).

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[12] According to the SaniFOAM framework, access and availability refers to the fact that products, services, and assets/resources that enable hygienic latrine construction must be accessible and available to households, if they are to have the opportunity to practice hygienic sanitation (Devine, 2009).

[13] It should be noted that we did not have the opportunity to discuss what type of training the masons had received and assess their knowledge about toilet designs and O&M.

[14] According to the SaniFOAM framework "social norms – whether observed or inferred – are the tacit rules that govern how individuals in a group or society behave. Social norms may that permit or sanction specific sanitation practices may influence sanitation behavior" (Devine, 2009).

Sanctions[15]: Make people build toilets, but not everyone goes on the use them

Many of those who had built toilets pointed to sanctions or the threat of sanctions as being one of the key reasons why they had done so: "*If we did not build a toilet, then we could not get birth certificates, social security benefits, etc.*" (Toilet owner, Sisuwa VDC, Kapilvastu district). Our findings suggest that such sanctions or threats of sanctions is a tool that districts and VDCs are increasingly resorting to in their drive to reach ODF status by 2017 or sooner. In most cases, the measures VDCs resorted to was denying or threatening to deny households services, such as pensions, permits, passports, and citizenship, unless they build a toilet. In many cases, VDCs had used sanctions to try to force households to utilize the toilet building materials they had been given as a subsidy.

Sanctions may be an appealing measure for decision makers to resort to, because they lead to immediate results in terms of the number of toilet facilities constructed. However, our findings suggested that this practice – in addition to being ethically questionable – often does not result in an actual and sustainable improvement of household sanitation practices. Where households had built toilets exclusively as a result of sanctions, we observed that many were unlikely to be in use because they lacked a super structure or because the super structure erected did not provide any level of privacy (e.g. wall consisted of a transparent sari).[16]

Photo 2 Subsidized toilet without superstructure, Kapilvastu

[15] According the SaniFOAM framework sanctions "refer to explicit rules in relation to sanitation. If enforced, sanctions may act as barriers to unhygienic sanitation practices and drivers of hygienic latrine acquisition" (Devine, 2009)

[16] The field research team drove through an ODF declared ward in Rupandehi, where the superstructures of a number of toilets built by the road side consisted of transparent saris wrapped around wooden poles. Not even providing a modicum of privacy, it is hard to imagine that these toilets are in use.

Photo 3 Subsidized toilet with incomplete superstructure, Rupandehi

Knowledge: Having seen and tried a 'modern' toilet

Men have greater opportunities to travel than women in the Terai communities we visited. As such, a significant proportion of adult household members have travelled in order to work outside their villages, to nearby towns, India, the Middle East, or South East Asia. A number of men and women we interviewed answered that the idea to build a toilet came after a male family member had seen and tried toilets during their travels. The remittances sent back by fathers, husband, or sons are also among the main sources of financing for household toilet construction.

Affordability[17]: Availability of additional income (esp. remittances)

Farming constitutes the main income for households in the area. However, most households own and farm a small land area and crop yields are not sufficient to sell for income. The availability of additional income (beyond farming) is a facilitator of improved sanitation practices. That is, households appear more likely to act on their desire to stop open defecation and use a toilet, if there is additional income available. As such, the remittances sent back by fathers, husband, or sons working outside Nepal are among the main sources of financing for household toilet construction.

Beliefs and attitudes[18]: Open defecation seen as undesirable

Doers and non-doers alike appear to see open defecation as an undesirable practice. When asked about the benefits of open defecation, non-doers frequently responded that there are no benefits to the practice at all and that using a toilet is preferable. However, this common perception (attitude) tends to influence behavior only when a large number of community members have adopted the use of toilets. Where most community members continued to

[17] Affordability refers to a household's ability to pay for a sanitation product or service or to engage in a sanitation behavior (Devine, 2009).

[18] Attitudes and beliefs refer to individuals' understanding and perceptions of i) sanitation behaviors, ii) those who practice them, and iii) sanitation products and services. Beliefs are not necessarily factually correct and can work to prevent as well as motivate hygienic sanitation practices (Devine, 2009).

defecate in the open, non-doers rather saw open defecation as a regrettable but unavoidable practice.

Values[19]: Protecting women's modesty is of outmost importance, especially that of young daughters and daughters-in-law

Among both the Hindu and Muslim Madhesis, a very strong value is placed on preserving women's dignity and modesty in general and especially in the case of daughters approaching marriageable age and young daughters-in-law. To preserve their modesty, women therefore go to great lengths to avoid being seen openly defecating by anyone from the opposite gender, in general, and their fathers-in-law and other high status males in particular. In some cases, family members described the need to accompany young daughters and daughters-in-law for open defecation in order to protect them from potential dangers and prying eyes. The arrival of a new daughter in law had, indeed, prompted some families to build a toilet.

Emotional driver[20]: Shame

> *"If your father-in-law or other important people pass and see you openly defecating, a woman's suffering is unimaginable. It is like being dead."* (Female doer, Muslim, Sisuwa VDC, Kapilvastu district)

Both men and women talked about feeling shameful about open defecation; however, they agreed that the shame felt if they were seen defecating in the open (by someone from the other gender) is much greater for women. Privacy is a minor concern for men. All of the non-doer women we interviewed described going to great lengths to avoid the shame of being seen by someone from the opposite gender, including getting up early or waiting until dusk for open defecation. Immediately after harvest and rainy season were described as times of the year where open defecation is especially difficult for women, because it is difficult to find a sheltered spot for open defecation. Women, who have and use a toilet, emphasized their ability to protect their dignity and prevent shame as one of the main benefits of their toilet.

Another potential source of shame for both men and women without toilets is visiting relatives. Doers described feeling relieved that they no longer need to fear the shame of welcoming visiting relatives without having a toilet for them to use.

Physical driver: Safety - snakes in rainy season, dangers lurking in the dark

Safety is something both men and women non-doers worry about – and a feature which doers appreciate in their toilets. Both male and female non-doers mentioned being worried about snakebites, especially in rainy season. Because of the fear of shame, women wait until darkness to defecate (if they cannot go in the morning), but some expressed worry about their safety at night. Among the specific concerns they mentioned were, again, snake bites, insect bites, and being assaulted.

[19] Values are central and enduring ideas shared by the members of a community about what is good or desirable and what is not. In relation to sanitation, values that favor or are consistent with the adoption of hygienic sanitation practices can motivate individuals to act (Devine, 2009).

[20] Drivers are strong – positive or negative – thoughts and feelings that motivate behavior. Drivers may be associated with unmet emotional, social, or physical needs (Devine, 2009).

Physical driver: Comfort

Again, open defecation can be associated with great physical discomfort for women, who are only really able to defecate in the early morning and late afternoon/evening – at other times of the day, they must 'hold it.' If women *must* go during the day time, they have to stop defecating and stand up immediately if seen by any man. One of the women we interviewed shared that she once had had to disrupt her open defecation four times and then return home with unfinished business. A toilet, thus, has the potential to make women's lives a lot more physically comfortable. Though men do not have to deal with similar issues, many of them see toilets as being more comfortable than open defecation in rainy season specifically.

Physical driver: Convenience

We found that what men particularly appreciate about having a toilet is convenience – i.e. the convenience of not having to leave the home for defecation and, in some cases, the convenience of having a toilet and bathroom facility in one. However, our findings also suggest that men mostly appreciate this benefit they after they have had the opportunity to use a toilet and / or have built and used a toilet by their household. As such, two of our male interviewees explained that they were building a second toilet, because they current toilet was placed in the garden and they desired the convenience of not even having to leave their house for defecation. What men find convenient about having a toilet is that they do not have to leave their house for defecation, that they can save time, and that it relieves them of difficulty of defecating during rainy season (when it is often difficult to find places to openly defecate due to flooding).

Women too appreciate the convenience that having a toilet near the household affords, not least because their need for greater privacy often dictates that they need to walk further away from the home than men for open defecation. As women are also tasked with accompanying children for defecation, they also appreciate the time saved here:

> *"When I am cooking something in the kitchen and I need to go to toilet I can do it in few minutes. But, in the past I had to go a long distance and come back. It was a big loss. Because of time saving, we are able to send our children to school in the right time. It used to take 15-20 minutes to reach to the defecating site."* (Female doer, Chodki Ram Nagar VDC, Rupandehi district)

Social driver: Desire for status and prevention of gossip

Generally, having and using a toilet (as opposed to defecating in the open) was not seen as prestigious.[21] However, our findings suggest that status and prestige are important considerations when households make purchase and investment decisions. For example, female FGD participants explained that they ask their husbands to buy new saris for them, because wearing good quality saris gives their family status and protects them from gossip:

> *"We need new saris. If we don't wear good quality saris, other people will say that our family is dirty" (Female non-doer, Rangapur VDC, Kapilvastu district).*

In the case of men, large landholdings, houses, and vehicles are considered to give prestige. We also noted that men, who said they were planning to build a toilet, often had plans to build a very large and expensive facility, possibly because they perceived such a facility to be associated with some degree of prestige. In several cases, the male head of a household

[21] An exception was a group of Muslim female doers in Kapilvastu, who cited prestige as being among the reasons they built a toilet.

which had built a toilet with a subsidy revealed plans to build an expensive septic tank toilet and bathroom facility. When asked about his motivation, one man answered:

> *"Now, my toilet is like dal bhat, but I would like some pickles, meat, and vegetables too" (Male doer, Baluhawa VDC, Kapilvastu district)*.[22]

Social status and prestige are also key reasons why households prioritize investing in their sons' education. More education confers greater social status and the parents of a son with greater social status can ask for a bigger dowry when it is time for him to get married.

Emotional/physical driver: Disgust

A limited number of study participants reported having been exposed to triggering activities, such as the walk of shame and feces calculation. They all reported feeling shocked and disgusted upon realizing how steeped in shit their community was and how this literally meant that they were eating shit. Some reported that they had built a toilet almost immediately after their exposure.

Barriers to sanitation behavior change

What make up the main barriers to the adoption of new, improved sanitation behaviors and toilet construction among households in the three Terai districts? In this area, our findings suggested the following:

Access and availability: Land availability and ownership issues

Many Terai settlements are densely populated clusters surrounding by vast tracts of agricultural land. Within the settlements, residential plots are often small and a number of the doers and non-doers with which we spoke reported that finding spot to build a toilet can be a challenge.[23] In some cases, households are unable to build a toilet due to such limited land availability. Efforts to address this barrier were identified in none of the communities visited.

As families grow, it is common to divide up the land and give a piece for each son. Where land plots have been informally divided among family members, ownership issues pose a barrier to toilet construction, until the land ownership arrangements have been formalized.

Access and availability: Toilet material shopping and transport is complicated

Though toilet construction materials and sanitary ware are generally available within a reasonable distance, shopping for them can be complicated as households reporting having to go to up to four different suppliers to buy the needed materials. Typically, cement, brick, and sanitary ware are purchased from different suppliers. This shopping process may be further complicated and/or prolonged, where suppliers do not have the required materials in stock. In most cases, suppliers do not arrange for the delivery of the purchased materials to the customers home. Rather, customers must arrange and pay for the transport. Many households reported transporting the materials to their home on bicycle. If longer distances had to be covered, some brought the materials by bus.

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[22] It should be noted that the same man had left his subsidized ring toilet without a super structure for two years and just recently had added a simple super structure

[23] A lack of space for building a toilet is not the only problem arising from small residential land plots. Finding a site on which to build the toilet at a safe distance from the household water source is another. The assessment team also observed that most toilets were sited considerably closer to the household water source than the 30 meters which is recommended by the World Health Organization. As the most common type of toilet built is one with flush to a soak pit, the risk arises that the household drinking water source could be contaminated.

Social norms: 'Everyone does it'

Though open defecation is seen as less socially desirable than having and using a toilet, most non-doers do not consider their open defecation to be a big deal because of the perception that open defecation is a common and longstanding practice in their village: *"Out of ten households in the village, nine defecate outside"* (Non-doer, female, Rangapur VDC, Kapilvastu district). In particular, many community leaders, such as teachers, political party representatives, and members of the VWASHCCs, continued to defecate in the open as well, thus signaling that there is nothing reproachable about the practice: *"How can the leaders teach us what to do, when they don't even have a toilet themselves"* (Non-doer, female, Rangapur VDC, Kapilvastu district).

Knowledge: Non-doers lack accurate knowledge about – and overestimate – toilet costs

In some cases, non-doers lacked knowledge about toilets, construction materials, and their cost. Those without toilets tended to estimate the cost of building a toilet facility as higher than those who already had such a facility. For example, non-doers estimated the cost of a toilet with flush to a concrete ring soak pit and a superstructure made from local materials to be 12,000-15,000 NPR, when such a facility could be built for 6,000 NPR or less. Some estimated the cost of a brick superstructure alone to be 15,000 NPR, which was more than what some doers had paid for their facility and its brick superstructure. Women, in particular, seem to lack this type of knowledge. Even women from households with toilets were in some cases unable to speak to the cost of the facility, presumably because all construction matters and matters of finance are the domain of male household members. With an absence of knowledge even among women who have toilets, it may be difficult for women from non-doer households to obtain accurate information about the options and cost of building a toilet via their social networks.

Knowledge: Not knowing what to do when the pit is full

A lack of knowledge about proper toilet operation and maintenance (O&M) pose a threat to consistent and continued use of the toilets which have been built. In particular, households appear to lack information about what to do if and when their toilet pit has filled up. In some cases, doers were reported to use their toilets only during bad weather and at night and otherwise defecate in the open as they had previously done, because they were concerned that the toilet pit would fill up too quickly. In one ward of Rampuruwa VDC, Nawalparasi, we learned that four toilets had become dysfunctional, because the pits had filled. Only one of the affected households had emptied their pit; the other three households had presumably returned to open defecation.

Knowledge: 'I could not have imagined'

"Before I had a toilet, I could not have imagined the benefits of having one," a Taru woman shared with us during one of our focus group discussion. In many Terai communities, the number of households with toilets has until recently been zero or in the single digits. Men and women in these communities have had limited opportunity to experience the benefits of having a toilet or to hear about these benefits from peers. Absent such inspiration, it may be difficult for them to truly imagine the benefits of having and using one.

A similar absence of inspiring examples may make it difficult for men and women to imagine how they could build a toilet, which is low in cost, attractive, and durable at the same time.

Roles: Women feel the greatest need for a toilet, but men control family finances

As described earlier, there are many challenges and discomforts associated with open defecation for women. We found women to be keener than men for their households to build a toilet. They were frequently the first in the family to propose doing so. However, another clear finding was that men control the family finances and, thus, decide whether or not to spend money on a toilet. Further, men are also responsible for getting the toilet built.

If the male head of household feels no need for a toilet, our findings suggest that women's ability to influence household decision making about toilet construction is limited. In several cases, female non-doers explained that they were unable to put a superstructure on a subsidized toilet underground structure, because their husbands were refusing to buy the necessary materials and build it.

Affordability: Grand toilet facility plans

In some cases, non-doers stated that they had not build a toilet yet, but that they had plans to build a septic tank toilet with a bathroom. In the case of some better off households and households with migrant labor income, the ambition to build a grander – and hence more expensive – toilet facility could mean that they postpone toilet construction.

We noted that households which built toilets without a subsidy often built a septic tank toilet. When asked about their reason for choosing this option (instead of the concrete ring pit), they invariably answered that the septic tank had greater capacity and would fill up at a slower pace.

Photo 4 In Rampuruwa VDC, Nawalparasi district, we spoke with the male head of the last household to build a toilet in one ward. Though his wife, mother, and daughter in law all wanted a toilet, it took pressure from neighbors and local authorities, before he finally agreed to build it. However, the toilet's location in uneven terrain behind the home made it difficult to access for the elderly mother and four months after it was built, the toilet remained without a roof.

Affordability[24]: Options for how to finance a toilet are limited

Limited options for how to finance the construction of a toilet could present a barrier for some households, in particular in a context where subsidies are not widely available. Currently, those who had financed all or part of their toilet facilities generally reported that they had sold crop or used remittances sent home by a family member to pay for the facility. Some suppliers will let customers pay part of their order late; however, no other credit or loan arrangements appear to be in place for households wishing to build a toilet. While the opportunity to take loans from private money lenders exists, community members explained that they do not wish to take such loans to build a toilet due to the high interests on these loans.

Beliefs and attitudes: A toilet is too expensive; it's only for the wealthy

In some cases, non-doers believe that a toilet is a very expensive facility and something only wealthy and educated households have. This group of non-doers believes that building a toilet will never be within their financial capability and therefore tend not to consider the possibility. Because they believe a toilet is something only the wealthy can afford, they do not reach out to other households to learn about toilets and their construction costs.

Beliefs and attitudes: 'A low cost superstructure will collapse in rainy season'

A common idea among both doers and non-doers is that superstructures made from low cost materials will collapse in rainy season and have to be redone. To save time and effort, it is therefore felt that a brick – or cement block – superstructure is necessary. However, few doers have given much thought to the use of durable low cost materials, such corrugated iron sheets[25] or the adobe-like material traditionally use for local homes. The belief that a brick super structure is necessary combined with erroneously high estimates for what such a superstructure would cost to build may be among the key reasons why toilets are seen as unaffordable.

When observing which and how low cost materials had been used to make superstructures, however, it is perhaps not surprising that target group members could come away with the impression that they are at risk of imminent collapse. The superstructure seen in the photo below is a typical example. In the communities visited, there were few examples of examples of attractive and robust low cost superstructures which could have inspired target group members to think otherwise.

[24] Affordability refers to a household's – real or perceived – ability to pay for a sanitation product or service or to engage in a sanitation behavior (Devine, 2009).

[25] We found only one instance where such material was used by a family with a child with a mobility disability. They shared with us that the cost of their superstructure had been 1,000-1,200 NPR.

Photo 5 Low cost superstructures often looked like the one in the photo above. It is hardly surprising households could come away with the impression such superstructure could collapse in rainy season.

Competing priorities: Every other expenditure is more important

When deciding how to spend their funds, most households appear to put little priority on a toilet. From our interviews and observations in the study villages, households often choose to spend any disposable income on items that will confer status on the household (e.g., large houses, land, new saris, jewelry, etc.) or on items (gold, saris, etc.) or activities (private education) which can help to improve the marriage prospects of their children.

Willingness to pay: Waiting for a subsidy

Rather than go ahead and invest in a toilet when they have a demand, households prefer to wait for a subsidy. As such, many non-doers explained to us that the reason they had not yet built a toilet was not that they like defecating in the open, but that they were waiting to receive a subsidy: "*We don't like to defecate in the open, but we are waiting for the subsidy"* (Female non-doer, Rangapur VDC, Kapilvastu district). Several of the households interviewed had plans to build a septic tank toilet, but had not taken action to do so, because they were waiting to receive the material subsidy for a concrete ring flush toilet. When asked why they were waiting for the material subsidy for a concrete ring flush toilet, when they were planning to build another type of toilet, one household answered that they wanted to use the materials to build a 'temporary' toilet first.

Willingness to pay: A toilet is not something that you pay for

Years of toilet subsidies have created the attitude among households that a toilet is not something they should have to pay for themselves in terms of either money or effort. Even after receiving a full subsidy, many households appeared unwilling to invest time and money in building a superstructure. We observed that a large number of household toilets without superstructures, even several years after having been built. In interviews and FGDs, these owners often claimed that they had not built a super structure for their toilet due to a lack of money and time, even though a super structure could be made from local materials at no or little cost and in a very short time. However, they showed little interest in a low cost superstructure that would allow them to start using their toilets: "The VDC only gave us materials for the underground structure. Nobody gave us materials for the super structure, so we did not build" (Non-doers, female, Sisuwa VDC, Rupandehi district).

In fact, years of supply and health education driven sanitation programming appears to have left many villagers with the **attitude** that a toilet is something you build for the sake of the

government, not something you do because you feel you need it. Because many people feel they are building a toilet for the sake of the government, they also feel that it must be up to the government to pay.

Further, subsidies are seen by many community members as a handout to which they are entitled, rather than as support that will help them to abandon open defecation. As a result, they will request – and receive – the subsidy regardless of whether they need it and have any intention of it or not. That is, many of those who receive the subsidies appear to have no motivation to change their sanitation behavior. The assessment team observed and learned of cases of households with existing toilets, which had been given a subsidy, and many cases of households where the materials had been left unused.[26]

Photo 6 A subsidized concrete ring lies unused by the home of an elderly woman who has no intention of using it

Behavioral drivers and barriers in the BCC strategy and implementation

Table four below provides a rapid analysis of the extent to which and how the behavioral drivers and barriers identified are currently taken into consideration in the BCC strategy and/or BCC activities.

Overall, the analysis suggests that there is substantial room for the BCC strategy and implementation to tap into what drives individual and households to change their sanitation behaviors. In particular, individuals and households' desire to conform to what they perceive to be the social norm is currently not tapped into much. The many strong physical, emotional, and social drivers, which do and can propel a shift from open defecation to toilet usage, are also not much taken advantage of – and those without (the habit of using) toilets could be better helped to imagine the benefits. In particular, testimonials, messages, and visuals are absent which could help men – who are the primary decision makers in the household – to imagine the benefits they could experience from having a toilet.

Barriers to behavior change – such as a lack of knowledge or the existence of erroneous beliefs – are also not addressed in an extensive and systematic fashion to bring households to feel that that path to changing behavior is easier and less expensive than anticipated. It

[26] Local authorities had sought to address this problem by using sanctions to force people to complete their facility. However, the missing or inadequate superstructures of many of the toilets, which were built as a result of such measures, suggested that they still remained unused.

should be noted, however, that a number of the barriers identified cannot be addressed via BCC primarily.

Table 4 Behavioral drivers and barriers: Are they considered in the BCC strategy and implementation?

BEHAVIORAL DETERMINANT		Considered in BCC strategy and implementation	
Category	**Description**	**Yes / partially / no**	**How**
Drivers / facilitators of change			
Social norms	When people see their neighbors changing, they change too	Partially	Collective triggering tools seek to shift collective perception of what is normal. When toilet use increases, defecation / village mapping made non-doers feel they were 'falling behind'.
Sanctions	Threats make people build toilets, but not everyone goes on the use them	No	
Knowledge	Having seen and tried a 'modern' toilet	No	
Affordability	Availability of non-farm income (esp. remittances)	No	
Values	Protecting women's modesty is of outmost importance, especially that of young daughters and daughters-in-law	Partially	"Privacy" is suggested as one of the individual trigger tools (i.e. message focus). In Rampuruwa VDC, Nawalparasi, one trigger reported appealing to women's need for privacy. Otherwise, this value/driver had not been tapped into extensively. No standard messages are proposed.
Emotional / social / physical drivers	Shame	Partially	As above
	Safety - snakes in rainy season, dangers lurking in the dark	Partially	"Fear" is suggested as an individual triggering too. This driver has not been tapped into extensively and no standard messages are proposed.
	Comfort	No	
	Convenience	No	
	Desire for status and prevention of gossip	Partially	Not specifically addressed in BCC strategy / tools, but one triggerer mentioned appealing to "you ask your wife to wear a veil, but everyone can see her bum" (Nawalparasi). Otherwise, this driver has not been tapped into extensively. No standard messages are proposed.
	Disgust	Yes	Community triggering tools aim to create disgust and do so successfully.
Barriers to change			
Access and availability	Land availability and ownership issues*	No	
	Toilet material shopping and transport is complicated*	No	
Social norms	'Everyone does it'	Partially	Collective triggering tools seek to shift collective perception of what is normal.
Knowledge	Non-doers lack accurate knowledge about – and overestimate – toilet costs	No	

	Not knowing what to do when the pit is full	Partially	Triggerers appear to have been trained on toilet O&M and are able to give advice.
	'I could not have imagined'	No	
Roles	Women feel the greatest need for a toilet, but men control family finances	Partially	VDC staff and triggerers, in some cases, appeal to men to build a toilet for the benefit of the women of the household.
Affordability	Grand toilet facility plans	No	
	Options for how to finance a toilet are limited*	No	
Beliefs and attitudes	'A toilet is too expensive; it's only for the wealthy'	No	
	'A low cost superstructure will collapse in rainy season'	No	
	'I am building a toilet for the government, not for me'*	No	
Competing priorities	Every other expenditure is more important	No	
Willingness to pay	Waiting for a subsidy*	Yes	The BCC strategy calls for a no-subsidy approach; however, VDCs are not following this approach in practice (with the exception of Rupandehi, where a no subsidy approach recently has been agreed to by all VDC chairs).

* This behavioral determinant cannot be addressed via BCC alone; other types of interventions will be needed.

3. KEY CONCLUSIONS

In the following, we summarize the main conclusions with regards to the implementation of the RWSSP-WN's BCC strategy, improving the enabling environment for its implementation, and enhancing the strategy itself.

3.1 BCC STRATEGY IMPLEMENTATION

Conclusion no. 1: The scale of BCC implementation is smaller than planned
Currently the RWSSP-WN's BCC strategy is not being implemented in the three Terai districts as it has been laid out in the project's Lead TBC Facilitators Training Manual. Most importantly, triggering is yet to be done widely and systematically. Albeit triggering activities were reported to have led to behavior change, they had therefore still had limited impact. Our findings suggest that low levels of activity among volunteer triggerers is the key reason for the limited scale of triggering activities and that a monitoring and supervision system which could have alerted RWSSP-WN management team to this challenge is currently not in place.

Further, while VDCs did use a number of different communication channels to promote ODF and toilet building, many potential channels – such as community based organizations and clubs – are underutilized.

Conclusion no. 2: VDCs rely on mostly on the methods they know best – not the RWSSP-WN BCC strategy
The bulk of sanitation promotion currently appears to be done by VDC chairs and staff as well as VWASHCC members. To achieve the ODF target, they rely on the methods and messages that are known to them. As such, ODF and toilet 'promotion' is mostly done via door-to-door visits – or interactions at the VDC office – and frequently centers on blaming messages and threats of sanctions if not toilet is built. Beyond triggering activities in the community (and at a later stage SDAs, methods, messages, tools, and guidance for what to do – in particular during household visits – are missing.

3.2 ENABLING ENVIRONMENT FOR BCC IMPLEMENTATION AND IMPACT

Conclusion no. 3: The current focus on subsidies and sanctions could make getting results with the RWSSP-WN BCC approach difficult
Currently, subsidies play a central role in VDC efforts to reach ODF / 100% household toilet coverage in Nawalparasi and Kapilvastu – and have done so until recently in Rupandehi. Our findings suggest that the effectiveness of BCC activities that seek to motivate households to build toilets (such as triggering) become far less effective, when subsidies are made available. In this context, households will not only postpone building a toilet until they receive a subsidy, but often come to see a toilet as 'something you build for the government' instead of a facility that can enable them to change sanitation behavior.

Conclusion no. 4: Getting VDCs to change course could be challenging due to political and time pressure to reach ODF targets
Districts and VDCs are under immense political and time pressure to reach the ODF target set. Getting them to truly change course is likely to be a big challenge. Rupandehi district has led the way showing that VDCs can be brought to agree to a no-subsidy policy. However, in the VDCs visited in Rupandehi sanctions now appeared to have replaced subsidies as the main 'promotion' strategy. A lot of advocacy and technical/capacity building support may be needed steer VDCs onto the path of BCC.

Conclusion no. 5: The focus on behavior change is slipping

In most VDCs, the rush to achieve ODF has become more of a rush to reach 100% toilet coverage and actual *behavior change* appears to be less of a consideration. VDCs primarily focus their efforts – subsidies and sanctions – on making households build toilets, not on making them feel a need for and use the facilities. Some VDCs appear to have been declared ODF even where toilet facilities do not guarantee a modicum of privacy (i.e. they are unlike to be in use). Lack of true ODF and the absence of plans for how to reinforce ODF in the VDCs, which had already been ODF declared, points to a danger that ODF could remain a widespread reality even after the three Terai districts are declared ODF.

3.3 BCC STRATEGY EFFECTIVENESS

Conclusion no. 6: BCC messages are mostly negative and 'educational' - they do not tap into strong potential behavior change drivers

Contrary to what the BCC strategy recommends the focus of VDC and ward level BCC efforts are negative messages that 'educate' non-doers about the need to change their ways and build a toilet. These messages have not been tested with the target group and appear to have no impact in terms of motivating non-doers to change. Current BCC taps into the potential drivers of behavior change in the target group – the value placed on women's modesty, shame, desire for status – to only a very limited extent (see table four). Further, almost all communication is verbal, [27] although visuals with benefit could be used to communicate complex messages, appeal to the target groups' emotions, and serve as repeated reminders (e.g. if displayed in locations that see a lot of people traffic).

Our findings point to the following as the strongest potential drivers of sanitation access for women and men, respectively:

Women	• Perceiving having and using toilet as social norm (being left behind) • Shame / embarrassment / protecting one's modesty • Desire for status and prevention of gossip about family
Men	• Convenience and comfort of having a toilet near or in the home • Desire for status • Protecting modesty of, in particular, young women in the family

Conclusion no. 7: BCC activities and messages leave potential barriers to sanitation behavior change unaddressed

Barriers to behavior change – such as a lack of knowledge or the existence of erroneous beliefs – are not addressed in a systematic fashion. However, barriers – such as a lack of cash during certain parts of the year – may leave a household unable to build a toilet and, thus, cease open defecation, even though household members have the motivation to change.

Our findings suggest that addressing the following key barriers could be critical in helping many households move up the sanitation ladder:

- Complex sanitation shopping process
- Lack of accurate knowledge about toilet costs
- Lack of knowledge about attractive low cost toilets (especially super structures)
- Belief that only a brick / cement block superstructure will survive rainy season

[27] It should be noted that some VDCs mentioned using street drama and videos.

- Not being able to imagine benefits of a toilet
- No information about or availability of toilet financing options (other than subsidy)

Conclusion no. 8: No strategy for what to do when triggering does not happen or does not work as intended

The current BCC strategy assumes that a sanitation movement spontaneously will arise after triggering and propel everyone to become ODF and build a toilet. For this reason, there is no strategy, guidance, and tools for what to do between when triggering has been implemented and community ODF has been achieved. However, triggering is not always implemented as planned or does not always work as intended, and behavior change does not always materialize. In the absence of a strategy, guidance, and tools from the RWSSP-WN, what happens *after* triggering or *instead* of triggering is now up to each VDC (with a focus on sanctions and negative messages as a result). Figure five provides an overview of the change process as it currently takes place.

Figure 5 RWSSP-WN Phase II actual sanitation behavior change activities and process

4. RECOMMENDATIONS

Recommendation 1: Advocate with VDC, district, and – if needed – national level leaders for a no-subsidy policy

Our findings suggest that subsidies are a critical obstacle to true sanitation behavior change. For triggering activities to become effective, VDCs must abandon their subsidy approach.[28] As community members often demand toilet subsidies because 'those in the next door VDC receive subsidies', *all* VDCs must agree to stop subsidies at the same time. Rupandehi district's good example and the success some VDCs have already had in becoming ODF without the use of subsidies should be used in this effort.

At both district and VDC levels, the leadership reported having experienced pressure from higher levels to adopt a subsidy approach. It may therefore also be necessary to take advocacy for a non-subsidy approach to a higher level.

Recommendation 2: Develop a pre-triggering strategy

A pre-triggering strategy should be developed to help ensure a) that potential challenges to the implementation of the triggering and BCC activities are identified and addressed and b) that key stakeholders prepare and plan efficiently for the actual triggering event as well as follow up communication activities at VDC, ward, and cluster level. A step-by-step pre-triggering guide should be developed. The guide should take its starting point in the RWSSP-WN's and DoLIDAR's existing guidance for planning for triggering and BCC activities at VDC and ward levels. In an early stage, a quick enabling environment assessment for each VDC and - if possible – ward should be made. Such an assessment will allow programmers to identify VDCs / wards, where they can get quick results, and in this manner put pressure on the VDCs / wards that are lagging behind. The analysis could / should also allow programmers to identify potential challenges in a VDC / ward and address these early on.

Recommendation 3: Enhance and expand the implementation of triggering

The RWSSP-WN should seek to increase the scope and scale of triggering. To do, so several actions are suggested, including a) identify reasons for triggerer inactivity, b) mobilize additional community groups / clubs in the effort, and c) strengthen trigger monitoring and supervision.

Recommendation 3a: Investigate reasons for triggerer inactivity and how to improve retention rates

To better understand the challenge of inactive volunteer triggerers, the RWSSP-WN should carry out additional research to establish the level and timing of drop out among the trained triggerers. The research should also seek to a) determine the main reasons for triggerer inactivity and b) identify shared characteristics of triggerers who continue to carry out activities (to guide volunteer selection going forward).

Recommendation 3b: Identify other community groups which could be mobilized

[28] It should be recognized that there will likely be households in every community that are simply too destitute to afford toilet construction. VDC leaders and VWASHCCs often appeared to think it necessary to consider these households first and hence introduced subsidies. However, once it had been introduced, all households demanded the subsidy. A better approach may be to consider how to bring the poorest households onto the sanitation ladder much closer to the point at which the community will be ODF and let the community take the lead on how to support these households.

To avoid relying solely on trained volunteers, the RWSSP-WN WASH Advisors and Support Persons should work with each VDC prior to triggering to identify and mobilize the most active community organizations / clubs to become part of the sanitation promotion effort. Explore whether these organizations/clubs could provide support for and/or implement triggering activities as well as what role(s) they could play.

Recommendation 3c: Strengthen trigger monitoring and supervision
At the moment, an effective feedback loop from ward and VDC level to the RWSSP-WN management level appears to be missing when it comes to the location and scale of triggering activities. This situation appears to have made it difficult for the RWSSP-WN to detect that triggering activities were not happening at the scale intended. Having in place effective feedback mechanisms could help the RWSSP-WN to have a good sense of where triggering is being implemented and at what scale – and, hence, address problems of inactivity earlier.

Recommendation 4: Develop a post-triggering BCC strategy

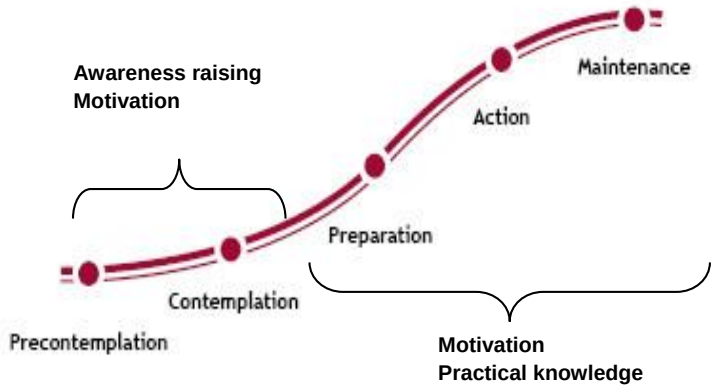
RWSSP-WN should develop a strategy for BCC after triggering has taken place (i.e. a post-triggering strategy). The strategy should specifically focus on motivating households to change via messages that tap into the drivers of change and identifying and addressing barriers which may keep each household from changing behavior. While some households may change behavior instantaneously after being exposed to triggering, others may not do so for a variety of reasons.

The focus of sanitation BCC should be appropriate to where in the behavior change process non-adopters find themselves. A useful model for understanding sanitation behavior change is Prochaska and DiClemente's Stages of Change model according to which individuals typically go through five stages when changing behavior: pre-contemplation, contemplation, preparation, action, and maintenance (see figure six below).

Figure 6 Prochaska and DiClemente's stages of behavior change model

The focus of communication to promote toilet acquisition will differ according to which of these stages of change non-adopters find themselves. Figure seven below shows what the focus of sanitation BCC should be at each stage of this process. Further, the table in annex B gives a general description of each stage of change, what it means in terms of sanitation behavior change, and what type of communication typically will be required at each stage.

Figure 7 Stages of change and the focus of sanitation BCC



It is proposed that the post-triggering BCC strategy comprise of two main components: a) an integrated communication campaign and b) households and small group level consultation.

Recommendation 4a: Collaborate with a creative agency or other organization with relevant experience to develop an integrated communication campaign

An integrated communication campaign is essentially a series of coordinated communication activities which revolve around one concept and convey a shared set of messages. An integrated campaign can work to ensure that the target group is exposed to a set of tested and effective motivational messages repeatedly (via multiple channels). The findings of this study regarding the drivers of and barriers to behavior change should be used to inform the development of the driving concept of the campaign. The findings should be condensed into a creative brief, which is intended to help guide the contracted organization / agency in the development of the central concept and BCC activities/materials. Communication objectives are a central component of the creative brief and a set of such objectives have been provided in Annex C. The communication concept and all communication materials and activities developed must be pre-tested with the target audience before they are finalized, produced, and used.

RWSSP-WN may wish to share with the contracted organization the sanitation marketing materials and activities recently developed by WSP and iDE in Cambodia to serve as inspiration. The Cambodia materials have been made to tap into slightly different drivers of sanitation behavior change, namely prevention of loss of face, and fit a different cultural context. However, key themes in the materials – loss of status in the eyes of neighbors / city relatives and loss of a daughter / daughter in law's dignity/honor – are likely to resonate with the rural Terai audience. Two examples of the imagery from the campaign can be seen below.

Figure 8 The loss of status that comes with not having a toilet may also be a driver for sanitation behavior change in the Terai communities (Source: WSP/iDE)

Figure 9 The Cambodia campaigns employs visual storyboards. One tells that story of how the family's beautiful daughter was seen defecating by men from the village. Families in the Terai villages were similarly concerned that their teenage daughters or young daughters-in-law would be seen. (Source: WSP/iDE)

Recommendation 4b: Do remember to target men in BCC too

Men are the primary decision makers regarding expenditures in the family, but clearly feel a lesser need for a toilet. For this reason, BCC must seek to make men feel they *too* need / want a toilet. This could be done by tapping into drivers of sanitation behavior change among men, especially the convenience and comfort of having a toilet in or near the home, and by seeking to associate having a toilet with high status (and vice versa), which is another strong driver of behavior in the target communities.

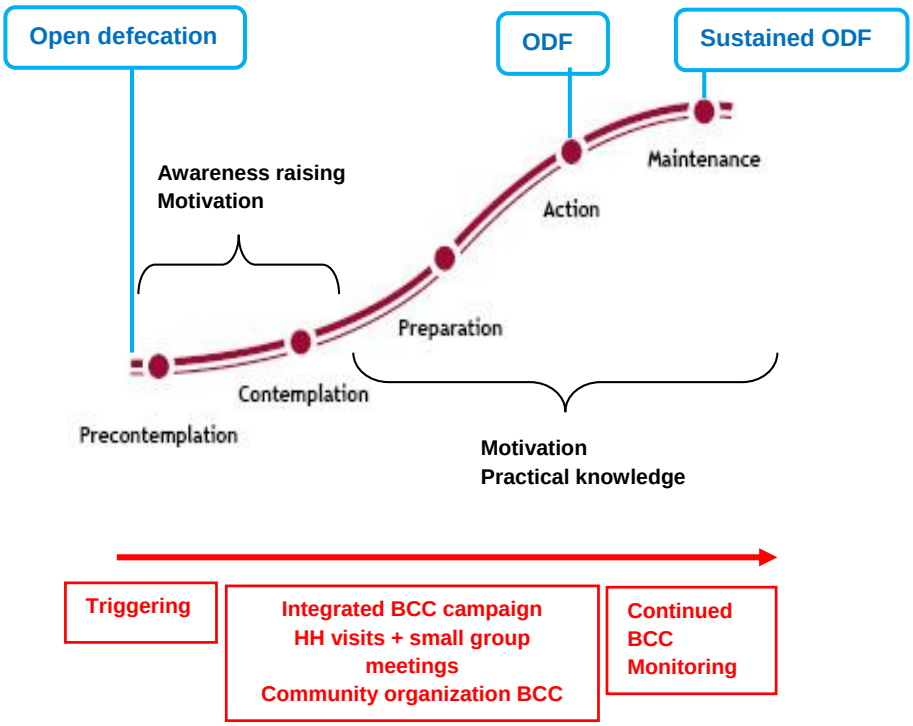
Recommendation 4c: Develop a strategy, approach, and tools for sanitation BCC at household and small group level

Develop post-triggering strategy which includes small group meetings and/or HH visits. A method for how to conduct the HH visits should be in place and might with benefits be modeled on the SDA approach. The primary aim of household visits should be to identify and address the specific barriers to sanitation access experienced by each household, while group meetings should seek to address shared barriers and generate peer pressure for change. The main messages of the communication campaign should also be integrated into these activities.

Recommendation 4d: Develop a strategy, methods, and tools for community group involvement

To effectively involve community clubs and organizations in the sanitation promotion effort, the RWSSP-WN must have in place a strategy for the involvement of these actors, including when to involve them, to what purpose and with what objectives, with what target group(s), etc. Furthermore, the RWSSP-WN must develop methods and tools which the community organizations / clubs can use to guide and implement their work. It is, furthermore, preferable that they are trained in their use.

The figure below illustrates the sanitation behavior change process and the types of BCC approach proposed for each stage of change.



Recommendation 5: Consider toilet financing opportunities

Little attention is currently being paid to households' capacity to finance a toilet structure, perhaps in great part owing to large scale provision of subsidies. However, a non-subsidy program must have a financing strategy, i.e. a strategy for how to enable households to pay for their toilets. The findings from this study suggest that toilets are currently financed from the following sources remittances, sales of crop, and labor income. Households could be targeted more intensively for behavior change and toilet building immediately before and when they

have income from these sources. E.g. a commitment to build a toilet could be sought shortly before the harvest season and/or immediately before and after a family member returns from having worked abroad. To develop a financing strategy that takes into consideration the very different financial circumstances of households in the Terai communities, a more thorough scan of other potential sources of financing – such as micro credit loans – is recommended.

Recommendation 6: Address barriers to change by empowering non-doers with knowledge and experience

Our findings suggest that a complex sanitation shopping process, a lack of accurate information about designs and costs, and an inability to imagine the benefits of toilets are barriers to sanitation behavior change. To address these barriers, the RWSSP-WN II could consider the following:

- *Toilet information materials*:
  Develop a set of toilet information materials with pictures of different toilet options and bills of quantity. Because too many options will make the sanitation shopping and decision making process even more confusing, seek to limit the number of options promoted via these materials. Posters showing toilets and their bills of quantity can be hung, for example, at the VDC office, health post, school, and other high-traffic buildings. If suppliers are willing, they may also be displayed by their store. Those who promote sanitation behavior change in household visits and small group meetings should also be provided with a set of toilet information materials (e.g. a flip chart with options).

  To ease the conversation about the toilet models and to give them a strong profile, consider branding them under a set of (related) names. Use brand names that connote status.

- *In-village or in-VDC demonstration models*:
  Consider training local masons on how to build the specific toilet models promoted. As part of the training, the masons could build a set of the toilets in each VDC or a number of toilets in each village. Doing so will help villagers to imagine their benefits. It is best if the toilets can be built, for example, for volunteer triggerers that do not currently have a toilet. (Because the toilets are test models and villagers need to have access to see and use it for a while, the triggerers could be offered a discount on the price, but they should not receive the toilet for free). It is not recommended that the toilets are built as public facilities unless an excellent O&M arrangement can be put in place. Absent such O&M arrangement, the toilets are likely to become disgusting, negative advertising for sanitation.

Recommendation 7: Increase the independence and rigor of ODF verification to return the focus to behavior

The focus on sanitation behavior appears to be slipping and decision makers appear more concerned about counting the number of toilets built rather than monitoring and promoting their use. At the moment, Terai VDCs appear able to declare themselves ODF, even though open defecation is evidently still taking place. It is proposed that the RWSSP-WN explores options for increasing the rigor and independence of the ODF verification procedure, as more rigorous demands for ODF declaration could go a long way in restoring the focus on toilet *use*. VDCs should not be able to declare themselves ODF solely based on the number of toilets built up to the plinth level.

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ANNEXES

ANNEX A: RWSSP-WN PHASE II BCC RENEWAL ACTION PLAN

	ACTIVITIES	RESPONSIBLE	DEADLINE
Recommendation 1: Advocate with VDC, district, and – if needed – national level leaders for a no-subsidy policy			
1.1	Prepare no-subsidy advocacy strategy	To be determined	
1.2	Implement no-subsidy advocacy strategy	To be determined	
Recommendation 2: Develop a pre-triggering strategy			
2.1	Prepare enabling environment checklist for VDC and ward levels to a) identify and address potential barriers to BCC and its effectiveness and b) enable the VWASHCC and SPs to start with the easier to trigger / change wards (to obtain results quickly and create a sense of competition among wards in the VDC)	National BCC consultant (to be determined)	
2.2	Develop step-by-step guidance for pre-triggering preparation in ward or cluster (including usage of enabling environment checklist)	National BCC consultant (to be determined)	
Recommendation 3: Enhance and expand the implementation of triggering			
3.1	Strengthen trigger retention rates: Carry out interviews / FGDs with current and former triggerers as well as Support Persons to identify the reasons for triggerer inactivity and how to improve retention rates	To be determined	
3.2	Active community organization scan: Work with DWASHCCs and some VWASHCCs to collection information about the organizations and programs which are active in the core VDCs and could integrate sanitation messages/BCC into their work.	To be determined	
3.3	Strengthen trigger monitoring and supervision (see National consultant follow up TOR)	National BCC consultant (to be determined)	
Recommendation 4: Develop a post-triggering BCC strategy			
4.1	Prepare Creative Brief to be used as a basis for the development of the integrated communication campaign		
4.1.1	Develop communication objectives for the ODF / toilet building campaign (using SaniFOAM findings) (*see annex C*)	Consultant (to be determined)	
4.1.2	Identify main points of communication exposure for individuals in the core VDCs	National BCC consultant	

	ACTIVITIES	RESPONSIBLE	DEADLINE
4.1.3	Decide on potential communication channels to utilize (e.g. radio spot, posters)	RWSSP-WN staff and select VWASHCC members	
4.1.3	Write up Creative Brief to be used by Creative Agency (or other contracted organization)	Consultant (to be determined)	
4.2	Develop integrated communication campaign		
4.2.1	Develop TOR for and contract advertising agency (should including concept development, pre-testing of concepts, and campaign material production)	RWSSP-WN staff supported by national consultant with marketing experience	
4.2.2	Work with advertising agency to develop communication concept (The big / key campaign idea)		
4.2.3	Pre-test communication concepts with target audience (to be done by advertising agency with supervision from RWSSP-WN)		
4.2.4	Revision to communication concepts (if required)		
4.2.5	Develop communication materials (not yet finalized)		
4.2.6	Pre-test communication materials with target audience		
4.2.7	Revise communication materials (if required)		
4.3	Develop a strategy, approach, and tools for sanitation BCC at households and small group level	To be determined	
4.3.1	Identify most appropriate and effective agents / organizations to conduct small group and door-to-door promotional activities at community / HH level	To be determined	
4.3.2	Develop methodology for a) small group and b) door-to-door ODF / toilet promotion *Notes:* *i) Should include but not be limited to: a) sequence of activities during visit, b) key messages / drivers, c) typical barriers and strategies to address* *ii) Door-to-door approach may be modeled on SDA approach*	To be determined	
4.3.3	Develop tools for a) small group and b) door-to-door ODF / toilet promotion	To be determined	
4.3.4	Develop training curriculum for small group and door-to-door ODF / toilet promotion	To be determined	

	ACTIVITIES	RESPONSIBLE	DEADLINE
4.4	Develop a strategy, methods, and tools for community group involvement (Please see preparatory activity described in under point 3.2 above)	To be determined	
Recommendation 5: Consider toilet financing opportunities			
5.1	Carry out a scan of sanitation financing options (credit, revolving funds, etc.)	To be determined	
5.2	Prepare a strategy to guide and assist (via non-subsidy financing options) non-doers to finance their toilet facility	To be determined	
Recommendation 6: Address barriers to change by empowering non-doers with knowledge and experience			
6.1	Develop toilet information materials		
6.1.1	Identify suitable toilet options, at least ½ of which are with low cost super structure	Local consultant (to be determined)	
6.1.2	Prepare bills of quantity for each option	Local consultant (to be determined)	
6.1.3	Prepare visual materials (posters, flipcharts, etc.) with pictures of each option and bills of quantity (not too many options in one poster) – include a brand name for each option	Local consultant (to be determined)	
6.1.4	Pre-test materials and brand names with target group	Local consultant (to be determined)	
6.2	Build in-village / in-VDC demonstration toilets (further action points to be developed if RWSSP-WN wishes to follow this recommendation)	To be determined (to be determined)	
Recommendation 7: Increase the independence and rigor of ODF verification to return the focus to behavior			
7.1	Explore options for how to strengthen the independence and rigor of the ODF declaration process	To be determined	

ANNEX B: STAGES OF CHANGE AND THE FOCUS OF SANITATION BCC

Stage	General description	In sanitation terms	Communication focus
Pre-contemplation	Person is not aware of the behavior and/or the need to change; they are unaware of the benefits of change and the negatives of not changing.	Non-adopter unaware of toilets and/or the benefits* of having and using a toilet.	*Raising awareness* • What is a toilet • Benefits* of toilets • Toilets as a social norm *Motivation* • Benefits* of toilets (drivers) • Disadvantages of current defecation practice (drivers) • Toilets as a social norm • Ease of change (e.g. cost can be less than you think)
Contemplation	Person has become aware of benefits of change and considers changing. They are still not sure that the benefits of change outweigh the benefits of maintaining their current behavior	Non-adopter considers building a toilet, but is still not convinced that building one is better than maintaining existing practice.	*Motivation* • Benefits* of toilets (drivers) • Disadvantages of current defecation practice (drivers) • Toilets as a social norm *Knowledge* • Available products • What available products cost
Preparation	Person is ready to take action	Non-adopter prepares to build toilet.	*Motivation* • Benefits* of toilets (drivers) • Disadvantages of current defecation practice (drivers) *Knowledge* • Available products • Where to buy them • What the products cost • How to finance
Action	Person takes action to change	Non-adopter builds and uses toilet.	*Motivation* • Benefits* of toilets (drivers) *Knowledge* • Available products • Where to buy them • What they cost • How to finance
Maintenance	Person maintains new behavior	New adopters keeps using toilet for defecation.	*Motivation* • Benefits* of toilets (drivers) • Toilet use as a social norm

Note: * “Benefits” refer to the benefits as seen from the target group’s subjective perspective, not to health or other objective benefits.

ANNEX C: PROPOSED COMMUNICATION OBJECTIVES

Background

What Are Communication Objectives

Communication objectives articulate what you want your (behavior change) communication to do. They specify what you would like your target audience to feel and know or believe as a result of having been exposed to the communication. Findings from formative research into the behavioral determinants that drive sanitation (or other) behaviors are used to inform these objectives.

How Are They Used

Communication objectives are meant to give direction to your program's communication efforts by clearly stating what it is that you are seeking to achieve (and, thus, also making it clear what you are *not* seeking to achieve). They should help you prioritize among possible communication activities as well as delineate your key message(s) and content.

Proposed Communication Objectives

Assumed Target Audience

Rural Terai women and men who are currently practicing open defecation

Proposed Communication Objectives

As a result of the communication campaign, target group member will...

Know...	... the actual cost of 2-3 different toilet options and what materials are needed to build them
	... how to make a solid and attractive super structure at a low cost (preferably they should have been exposed to examples of such)
	... how they can save up to build a toilet (or "how they can finance a toilet")
	... that subsidies are a thing of the past
Believe...	...that open defecation is becoming less and less common and that they will be "left behind" unless they build and use a toilet (change in social norms).
	... that others will think less of (gossip about) them and their family if any family member defecates in the open.
	... that their life would be far more comfortable and convenient with a toilet (esp. men).
Feel...	... that having and using a toilet will protect their family from embarrassment and loss of social status.
	... that a toilet is a priority investment.

ANNEX D: PROPOSED FRAMEWORK AND INDICATORS FOR MONITORING BCC

What to Measure

Ideally, you should measure five things to see if what you are doing is having an impact. The five things are listed in the flowchart below. It is important that you verify exposure to the BCC activities, accuracy of targeting, and exposure to the planned messages also, since your planned BCC is unlikely to have an impact if activities have not been implemented or have not been targeted correctly/widely.

WHAT TO MEAURE	1. **Implementation**: Have the planned BCC activities been carried out?	2. **Targeting**: Did the BCC activities reach the intended target group? Is the reach of BCC as wide as intended?	3. **Exposure**: Have those who participated in the activities been exposed to the planned messages / content? (I.e. was it done as planned) Which of the planned messages / content have they been exposed to?	4. **Knowledge, belief, motivation outcome**: What impact has the BCC had on the knowledge, beliefs, and motivation of those who were exposed?	5. **Behavior outcome**: What impact has BCC exposure had on behavior?
HOW TO MEASURE IT	• Periodic reports on: what activities were carried out, where, how many times, and with how many participants • Frequent spot checks to verify accuracy of reporting, consisting of: a) unannounced visits to planned BCC activities and b) spot check surveys with HHs in target communities	• Periodic reports on the number and characteristics (gender, ethnic group, etc.) of BCC participants • HH spot check surveys – questions about exposure to BCC to verify that the intended target audience was reached	• Occasional supervision of BCC activities (RWSSP-WN WASH advisors and support persons). • Activity exit interviews with BCC participants • HH spot check survey – questions on messages / content included	• Activity exit interviews with BCC participants • Occasional surveys and FGDs in targeted communities to assess knowledge, perceived norms, and motivation. (*Ideally, there should be baseline for comparison OR or data collection in comparison communities (not exposed to BCC)*)	• Periodic reports on sanitation coverage • Spot checks to verify toilet access reports *Note: In reality, you measure changes in access and not the impact BCC exposure. Comparing changes in exposed and non-exposed communities can give an indication of the effect of exposure, but is not enough to establish causality.*

TOOLS NEEDED	• Activity report form(s) • BCC activity observation checklist • HH spot check survey questionnaire	• Activity report form(s) • HH spot check survey questionnaire	• BCC activity observation checklist • BCC activity exit interview form	• BCC activity exit interview form • Knowledge, belief, motivation FGD guide • Standard knowledge, beliefs, motivation survey questionnaire	• Toilet access reporting forms • Toilet access spot check forms

Proposed BCC Objective Indicators and Data Sources

Target group(s)			
1.	Adult and youth open defecators of Madhesi origin, who live in the Terai region (*primary target group*)		
2.	Adult and youth open defecators of non-Madhesi origin (Tharu, Pahari) (*secondary target group*)		
Behavior change objective			
A.	Open defecator households build and all household members consistently use improved latrines for defecation		
B.	Open defecator households with an existing latrine substructure complete their latrine (with a super structure which is adequate for privacy) and all household members consistently use the facility for defecation		
Behavior change communication objectives As a result of the communication campaign, target group member will...		**Indicator**	**Potential data source(s)**
Knowledge			
1.1	Know the actual cost of 2-3 different toilet options and what materials are needed to build them	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs that can correctly identify cost of 2-3 specific toilet facilities promoted by program (unaided)[29]	• Activity report form(s) • Activity exit interviews • HH survey
1.2	Know how to make a solid and attractive super structure at a low cost (preferably they should have been exposed to examples of such)	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to such low cost facility • Outcome: Number of HHs who can recall of at least one low cost super structure promoted by project and explain how to make it (unaided) (See footnote 1)	• Activity report form(s) • Activity exit interviews • HH survey

[29] Ideally, RWSSP-WN should have a baseline survey with which to compare OR conduct comparison surveys in control communities (i.e. those who have not been exposed to the BCC). If comparison communities are used, RWSSP-WN should take care to ensure that they are similar to the intervention communities (in terms of socioeconomic and ethnic profile, open defecation rates, etc.).

1.3	Know how they can save up to build a toilet (or "how they can finance a toilet")	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs who can identify at least two ways of financing a toilet (unaided) (See footnote 1)	• Activity report form(s) • Activity exit interviews • HH survey
1.4	Know that subsidies are a thing of the past	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs who state that subsidies are not given (See footnote 1)	• Activity report form(s) • Activity exit interviews • HH survey
Social norms, beliefs			
2.1	Believe that open defecation is becoming less and less common and that they will be "left behind" unless they build and use a toilet (change in social norms).	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs who agree with the statement that OD is becoming less and less common. (See footnote 1) – must be complemented by qualitative data	• Activity report form(s) • Activity exit interviews • HH survey
2.2	Believe that others will think less of (gossip about) them and their family if any family member defecates in the open.	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs who express concern that others might gossip about them due to a lack of toilet (See footnote 1) – must be complemented by qualitative data	• Activity report form(s) • Activity exit interviews • HH survey
Motivation			
3.1	Believe that their life would be far more comfortable and convenient with a toilet (esp. men).	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information	• Activity report form(s) • Activity exit interviews • HH survey

		• Outcome: Number of male survey respondents who feel that an improved latrine brings convenience and comfort (See footnote 1) – must be complemented by qualitative data	
3.2	Feel that having and using a toilet will protect their family from embarrassment and loss of social status.	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs who feel having a toilet is necessary to maintain social status (See footnote 1) – must be complemented by qualitative data	• Activity report form(s) • Activity exit interviews • HH survey
3.3	Feel that a toilet is a priority investment.	• Process: *to be determined based on BCC activities planned* • Output: % of surveyed BCC participants who report exposure to information • Outcome: Number of HHs who put a toilet as their highest investment priority (See footnote 1) – must be complemented by qualitative data	• Activity report form(s) • Activity exit interviews • HH survey