DGROUP DISCUSSION "SCALING UP OF RURAL SANITATION AND HYGIENE"

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INTRODUCTION

This is the summary of an email discussion held on the WASH Asia Dgroups platform from the 23rd of October till the 19th of November 2012. The discussion was moderated by SNV Asia knowledge network, and involves 165 WASH practitioners from different countries in Asia. Forty two contributions were written over the course of the discussion. The discussion aims to bring together examples and perspectives of practitioners from the field with perspectives from people working at international level. It also aims to reflect together on new ideas and best practices in sanitation and hygiene. It is not intended as a conclusive document on the subject.

This is the fourth Dgroup discussion on rural sanitation and hygiene. The first discussed "Performance Monitoring of Sanitation and Hygiene Behaviour Change" and the second discussion was about "Rural Sanitation Supply Chains and Finance", and the third about "Governance for Rural Sanitation and Hygiene". The discussions are linked to the learning component of the Sustainable Sanitation and Hygiene for All programme in Nepal, Bhutan, Laos, Vietnam and Cambodia. This summary will be an input for the regional workshop on "Scaling up Rural Sanitation and Hygiene" in Vietnam at the end of November 2012.

TOPIC 1: UNDERSTANDING SCALING UP OF RURAL SANITATION AND HYGIENE IN YOUR COUNTRY

SCALING UP OF RURAL SANITATION AND HYGIENE IN YOUR COUNTRIES

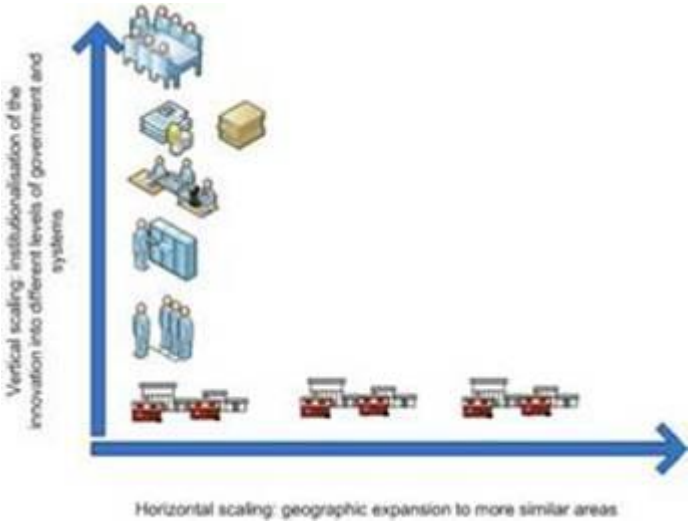
A first question, which Ms. Hilda Winartasaputra from Plan touched upon, is to what extent an innovation or a programme is **ready for scaling**. Whether there is actually proof of concept and whether this is sufficiently documented and agreed upon. I did not explicitly ask you about that, but there are **check-lists** to help reflect whether their intervention is ready for scaling (see www.ExpandNet.net and (www.msiworldwide.com). Besides documentation and testing, agreement is important. From some contributions it does not become clear whether **sufficient consensus** about the innovation or programmatic approach exists in the countries. Some people have been talking about the scaling up of their particular project, rather than a rural sanitation and hygiene programme in the province, region or country led by local or national government.

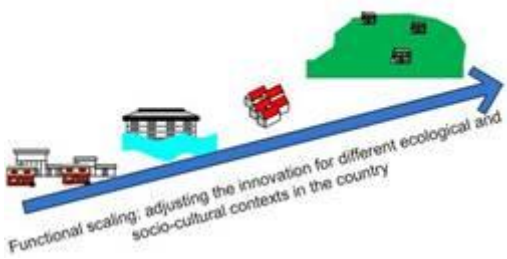
In the introduction of the first topic, I made a distinction between **horizontal** (geographic expansion), **vertical** (institutionalisation) and **functional** (adjusting to different context) scaling. When we mention "scaling up", we usually think about rapid geographic expansion of the rural sanitation activities, and/or rapid increase in coverage (this is also called "horizontal scaling"). A first question is whether we expect this to happen spontaneously, or whether we feel this requires a planned guided effort. The WHO ExpandNet argues that **spontaneously spread rarely happens**, or spreads only partially. They even argue that while spontaneous take up from one area to another may occur, it may lead to situations where the programme innovation is incompletely replicated and does not yield the same results. That may threaten the credibility of the idea. They also mention though that it is important to promote this spontaneous take up. Of course you will never want to stop people with the enthusiasm for sanitation… but guide it properly. It is said that we can learn from spontaneous scale ups to make guided scaling up in other areas more effective.

There is a view that rapid large scale geographic expansion of rural sanitation and hygiene activities **cannot happen without institutional changes**, such as policies, norms, budgetary changes. This idea is that changes need to happen not only at national level, but in all levels of a decentralised system, mainstreaming the programme innovation. This is also called "vertical scaling".

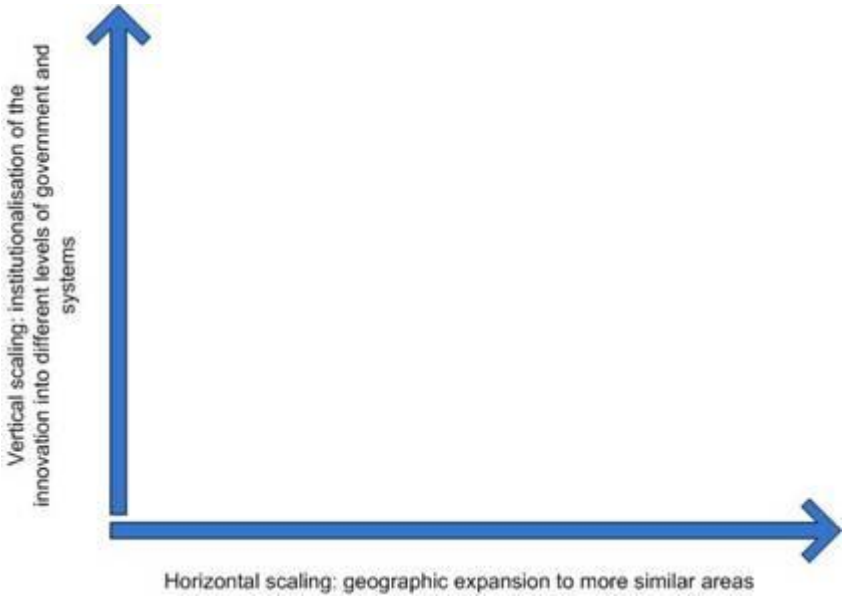
Finally we recognise that countries are diverse in terms of social cultural groups, local economies and ecological regions among other things. Rigidly applying a programme methodology that has been developed in one region, to all other regions, will create problems and might not be effective. For example if we try to

spread technology options from mountainous areas to coastal/ low lying areas, or if we are trying to promote behaviour change with ethnically very different groups. It is clear that **scaling up will need to include testing and adaptation of the methodology for new areas**. This is also called "Functional scaling". I've tried to visualise these 3 dimensions of scaling below.





Across the 7 countries, the emphasis is on horizontal scaling and to a certain extent institutionalisation. Systematically adjusting the approach to different geographical contexts is in the mind, but in most countries it is not yet firmly on the agenda. It is impossible to characterise where the different countries are, and there is not necessarily a consensus between the different contributors, but let me give you the opportunity here below, if only to provoke our thinking about that.



CAMBODIA

The contributions from Cambodia mentioned that the government agency and development partners at national level have been working on scaling of rural sanitation for several years, but that it is not happening fully because of some challenges in translating this onto the ground more broadly. Dr. Samnang Director, Department of Rural Health Care mentioned that the **coordination mechanism is working well at national level, but not always at provincial and district level.** There is no clear policy or guideline for scaling up for sub-national staff and it does not help that there are many unaligned initiatives in the country. So there are a lot of building blocks, and different things happening on the ground. There is a degree of institutionalisation, but not yet at all levels, and the spread of a harmonised approach is also just

starting. As Ms. Lyn McLennan from WaterSHED says the national coordination between CLTS, subsidy and sanitation marketing, has not yet translated in effective coordination in each geographical area.

NEPAL

In Nepal, **two processes** are taking place:

(1) **Spontaneous geographic expansion**: all 75 districts are almost starting at once Mr. Suman Sharma, ex-Director general of DWSS says. Others add to this, to explain how coordination and dissemination has helped that expansion, and that this has a very broad: multi-sectoral and multi-level involvement.

(2) **Institutionalisation** has come relatively recent, in 2011 the **National Sanitation and Hygiene Master Plan** was endorsed aiming at streamlining fragmented efforts in the country under government leadership. Now there is a mandated coordination structure at all levels, a national steering committee, a separate budget line item for sanitation nationally, a direction that local governments should spent at least 15% of their block grants on sanitation, hubs at national level (sector improvement unit and recently the TA unit), and an emerging trend of celebrating ODF declarations. **This has all helped to localise sanitation and integrate it into local government plans.** Mr. Nanda Khanal from the Sector Efficiency Improvement unit (SEIU) mentions that 55 out of 75 districts have prepared their district sanitation plan. However, contributors recognise that those would be dead plans without the enthusiasm at local level. As Mr. Nam Raj Khatri from WHO and SacoSan says, it should not become the sole responsibility of government agencies without a bottom-up drive from communities and local governments. Nepal thus combines a level of institutionalisation (vertical scaling) as well as geographic expansion (horizontal scaling), and the **needs to start working on functional scaling to adapt approaches to other areas in the country**. An important new area is the low-lying Terai, as underlined by all contributors, among others Gunaraj Shresthra director of CODEF.

KENYA AND RWANDA

In Kenya the focus is on scaling of CLTS, but there is a two-pronged approach with another group of people working on the supply side. The latter is just progressing. For the scaling of CLTS there is a **high level of institutionalisation** it seems, with an institutional mechanism, materials, a road map, and a designed process for scaling up and learning. Scaling up is done in-house through the health structure itself and their community health workers.

The contribution from Rwanda emphasises that in this country, institutionalisation (vertical scaling) has to precede horizontal scaling and expansion. It is therefore wise to invest first in guidelines and policies. Sector coordination is seen as key for both horizontal and vertical scaling, which is why at this moment a lot of attention is given to strengthening local WASH platforms. Thus showing a high level of vertical scaling, but as appears little expansion at this moment.

VIETNAM

In Vietnam there is coordination at national level, but in this large country **there are several programmatic approaches for rural sanitation**. At this moment the government is exploring how to scale an approach to 20 provinces. There is some spontaneous uptake by different organisations, but **not yet a wide-spread or institutionalised approach in the different levels of government**. There are however examples of district wide and provincial level work. Local partnerships and collaboration have been instrumental in district wide achievements and provincial work, notably between the Health department, Women's union, district authorities, Provincial People's Committees and so on. Like Cambodia, the institutionalisation has not yet reached local levels, and in Vietnam this involves 62 provinces. Functional scaling, adjusting to different cultural and ecological contexts, is also mentioned as a priority in the Vietnamese contribution.

BHUTAN

Bhutan has followed a different process than the other countries in developing a scalable rural sanitation approach and taking it to scale. Recognising its diversity, Bhutan started in 2008 to pilot the approach for 4 distinct contexts: high mountain nomadic tribes, hill communities, mountain communities and low land communities. Only after this **functional scaling**, Bhutan started to work on the institutional aspects, working district wide and working on policy issues. More recently it is entering the phase of broader horizontal expansion.

INDONESIA

Indonesia's challenge is of course its mere size (230 million people) and diversity. For some years an innovative approach has been field tested and expanded in one province, and in 2008 a national strategy was developed to take this country wide. Besides work on open defecation, improved sanitation and hand washing with soap, the national strategy includes 3 more behaviours: household water treatment and safe storage, solid waste and waste water (this is called "STBM" community based total sanitation). As explained by Ms. Kirstin Darundiyah from the Water and sanitation sub directorate, Ministry of Health of Indonesia, the work on demand creation seems to be the most costly, as it is done in-house within the health structure and health volunteers. Budget for demand creation comes from the national level to districts, whereas the provincial levels receive budget for advocacy, but as yet budgets are insufficient. There are 500 districts in Indonesia and the expectation is to move forward gradually in all. Therefore more work needs to be done on the supply side as well. **Challenge is the adjustment of the approach** for different cultures, beliefs and geographic conditions, **while at the same time standardizing the approach**.

Mr. Martin Keijzer, who is working for Simavi with the SHAW programme implemented through 6 NGO's in Eastern Indonesia, considers that scaling up is happening when others replicate SHAW's approach. He describes a high level of local institutionalisation in the areas where the programme works. This could be a strength to build upon.

CONSTRAINTS AND ENABLING FACTORS FOR SCALING UP

Successful scaling of any programme has a lot to do with the context. Recently WSP launched the results of its work on "**Enabling Environment Assessment**" for scaling of rural sanitation and hygiene, assessing 8 components of the enabling environment at national level: Policy, strategy, direction; institutional arrangements; (agreement on) programme methodology; implementation capacity; availability of products and tools; financing; cost-effective implementation and monitoring& evaluation.

A USAID/ Health Policy Project working paper points to the fact that while macro level policies may be adjusted, there are **often still a number of operational policies that have a huge influence on implementation on the ground**. We all know the examples of well-intended rules or procedures which are just not practical on the ground.

Finally it is important to reflect on the (possible) constraints and enabling factors resulting from other programmes. There are **many priority (health) programmes, for example HIV-AIDS, TB, often using social mobilisation, participation and advocacy techniques**. Rural sanitation and hygiene is just one of those programmes. All these programmes are trying to work through the same "voluntary community health workers", motivate the same district authorities, provincial authorities and village leaders, and all create "community groups"…

You have mentioned in total **36 constraints and enabling factors**. I'm grouping these, because a constraint is presented as the absence of an enabling factor… An issue which is clearly mentioned is the need for both **national** coordination, alignment and clarity, as well as **local** coordination, alignment and clarity. The first does

not always translate in the latter. Overall the following aspects were most mentioned (in this order of importance):

1. Local coordination
2. Commitment of local HR
3. High cost of sanitation hardware
4. Local clarity about the use of subsidies
5. National programmatic alignment (on approach)

At this moment, across all countries, the following factors are most frequently mentioned as **enablers** (in order of importance):

1. Local coordination
2. National policy, master plan or roadmap
3. Local leadership
4. Having master training in the area
5. Strong national leadership by lead ministry

Whereas the following factors were the most frequently mentioned as **constraints**:

1. Lack of commitment of local HR
2. High cost of sanitation hardware
3. Lack of local clarity about the use of subsidies
4. Lack of national programmatic alignment (on approach)
5. Low priority of local authorities

There were many interesting points and it's impossible to do justice to everything you said. You also mentioned some risks, I want to highlight some:

- Several contributions pointed to the problem of concentrating on the "easy areas", and the lack of interest of government and development partners alike to include the **more remote and difficult areas**.
- Mr. Suman Sharma pointed out that the current spread of sanitation in Nepal **depends very strongly on the enthusiasm of individual people and local leadership**. This is great, but the concern is how to sustain this.
- Almost everybody pointed to the **issue of sustainability**. Some also said that the competition for ODF or ODF awards, can lead to an erosion of the behavioural change motivation, low quality and lack of sustainability.
- Both Henk Veerdig from SNV Nepal and Kirstin Darundiyah mentioned the **tension** between standardisation of the approach and the need to accommodate and allow for local diversity and solutions.
- Kabir Rajbhandari from SNV Nepal mentioned the issue of **lack of quality control** over the ODF declaration process and how this can potentially undermine credibility.
- Lyn McLennan from WaterSHED Cambodia mentioned that once demand from consumers surges, some small businesses struggle to keep up with the demand. There are seasonal and structural labour shortages as well which affect the **capacity for response**.

WHO OR WHAT SHOULD BE DRIVING SCALING UP IN RURAL SANITATION AND HYGIENE?

This question referred to the dilemma whether scaling up of rural sanitation and hygiene should be **bottom-up demand driven**, implemented as a **compulsory programme** from national level, or maybe you feel that **market forces could be a driver**. If scaling is only demand driven, support would only be given to those districts that have prioritised rural sanitation and hygiene, or even only with those communities that prioritise it.

Very few among you expect that rural sanitation and hygiene will achieve scale automatically, even if the above mentioned enabling conditions would be in place. Almost all point to the need for government leadership and drive to accelerate progress in sanitation. Government has to take the leadership because they are the **duty bearers** and have the obligation, and they are also because they are the only ones who are able to align all stakeholders in the country. Some mention also that **private sector** can come in, once the government has taken this leadership.

Specific suggestions on what the government can do to drive scaling up are, among other things:

- Providing incentives and recognition to well performing institutions and individuals
- Disseminate success stories in collaboration with the media
- Making all levels accountable, and assuring monitoring, common data management and reporting

Some people also point to the need to have a **good mix** of intervention and attention to different levels.

Furthermore two people suggest demand from society for a **product or service that works**, should be the main driver. This can also be consumer demand, for good quality products that respond to their aspirations.

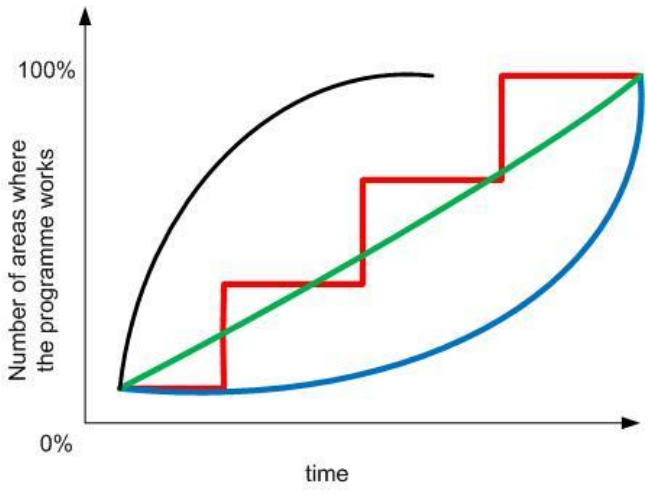
Finally someone says a **change in social norms**, when the majority of people are saying that open defecation is no longer acceptable, should be the main driver. I think that is a beautiful aspiration to end the summary of this first topic with.

TOPIC 2: THE HR CHALLENGE

HOW DOES THE PROCESS OF EXPANSION LOOK LIKE? HOW FAST ARE YOU PLANNING TO SCALE UP?

This was how fast your scale up is planned and how it is phased. Obviously you will have more time to build up HR capacity is the scaling up process itself is slower. In the introduction of this topic, I mentioned 4 possible paths:

a. Working as a planned roll-out, in batches (red line)
b. Start in practically all areas at once (black line)
c. Increase areas gradually over time (green line)
d. Start slowly with a few areas and then make a great final leap once all issues are tackled (blue line).



Interestingly, most people in the second half of discussion think that the scaling process in their countries is **most similar to the blue line**. First of all, Ms. Kirstin Darundiyah from Indonesia says, we improve readiness at province and local level. Then we can achieve good (quality) and fast scaling. Also in Ghana, Mr. Bimal Tandukar tells, the HR capacity development starts slowly with a few areas and after successful demonstration then the idea is to make a big leap. Mr. Nanda Khanal from Nepal says, our model is very near the blue line, with multi-dimensional interventions for some time now. We are now somewhere in the middle of the blue curve, so rapidly scaling up. This must be why Mr. Suman Sharma from Nepal says that at the moment

scaling up in Nepal feels like a balloon expanding on all sides. There may be some areas that are less active, but overall it is now a self-propelling social movement. It does need close monitoring and support though, to avoid it gets stuck in a specific area.

WHERE WILL BE THE BIGGEST HR GAP? FOR WHAT TYPE OF WORK PROCESSES AND SKILLS?

In relation to this question, Mr. Sonam Gyaltshen from the MoH of Bhutan pointed to the importance of building **both local capacity and national capacity**. Without that support from national level becomes difficult. Mr. Chea Samnang from the MoH in Cambodia agrees that human resources at national and sub-national levels are a pre-condition for scaling. Other contributions, from Nepal, Ghana and Indonesia emphasised the **capacity gap at the "middle level"**.

For Nepal, this is **not so much about social mobilisation capacities**, though important, but also **about capacities of district authorities and line agencies to steer and coordinate scaling up**. In districts that show good progress, Nanda and Suman argue, there are joint plans, monitoring and verification. This minimizes duplication and double counting at local level. This echoes the point made by Mr. Henk van Norden of UNICEF South Asia Region, that it is essential that governments are in the lead because they are the only ones who can take an approach to scale. External agencies, he says, can never hope to reach everyone. Besides the fact of course, that governments are the duty bearers.

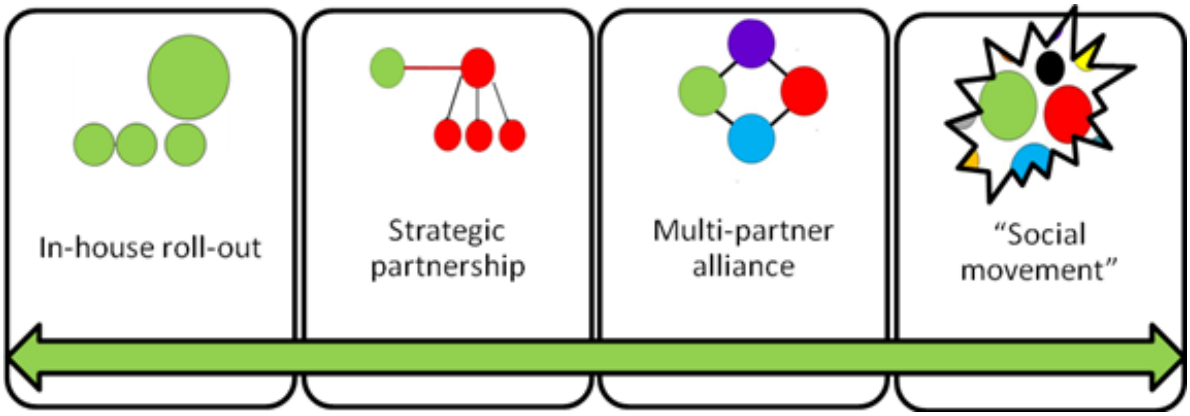
The contribution from Cambodia further adds that at national level a **strong and close collaboration** with other agencies and ministries is needed. Therefore, when we talk about the capacity building for the staff, we should look at the **staff from various concerned agencies/ministries**, not only the lead line agency. These different ministries should then make sure there is commitment from their agency at local level as well.

Sonam mentioned the difficulty of transferring some aspects of a sanitation programme, especially the behavioural change and market aspect, to staff with engineering background. This is also mentioned by the Nepali contribution. A similar issue, that **new skills are not always very compatible with staff's back ground**, is mentioned by Mr. Phurpa Thinley from LNW consulting in Bhutan. In Bhutan, the number of staff for carrying out the expansion is not so much a problem: there is health staff in each basic health unit (sub-district level). The challenge is to teach people with a clinical background, now new facilitation and data management skills. Besides the facilitation and community mobilisation skills, Phurpa says that staff from the basic health unit should be able to summarise and present data to planners and decision makers at local level in order to keep them engages. Suman from Nepal agrees with him, and mentions the weakness in monitoring for the process and post-ODF support.

A specific issues mentioned about Ghana is the need to have a clear common understanding of the approach among all and how that contributes to the sanitation targets. The Government of Ghana banned bucket latrines in 2010, and for some people, the introduction of CLTS is promoting technologies which are inferior to that, thus going backwards on standards.

WHAT IS YOUR OUTREACH STRATEGY?

Here the question is whether you are thinking of scaling up through **one single organisation**, such as the ministry of health, or whether you are thinking to **involve one or more partners**. The two contributions from Bhutan clearly talked about **in-house roll-out** in the structure of Ministry of Health. Ms. Hilda Winartasaputra from Plan international said, however, that it's important to **"go beyond borders" of the organisation or section, involving other people.** One reason can be for example because there is not enough personnel or mainly consists of men as technical staff. She explains that this has worked well in some countries where women who previously "only" worked as admin staff became capable trainers and facilitators for hygiene promotion and others.



Bhutan:
Through the health workers at the basic health units and supported by community leaders and other natural leaders. Engagement of local authorities.

Indonesia:
in-house roll-out in MoH involving all staff at primary health centres, plus all village cadres

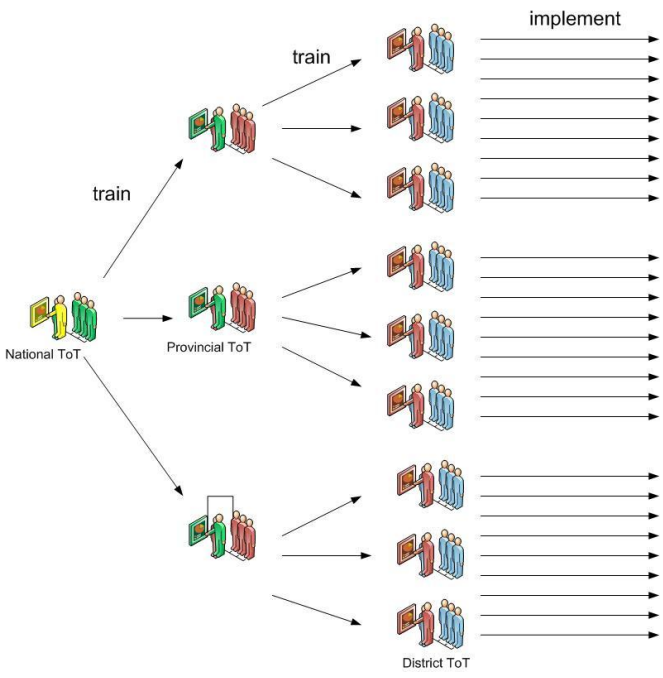
Vietnam:
Ministry works with the Womens' Union as the main partner for outreach to communities.

Cambodia:
Close collaboration with several ministries at national level. And locally also all concerned agencies at provincial and district levels, as well as local authorities, village leaders, Village Health Volunteer (VHV) and Village Development Committee (VDC)

Nepal:
Work with local bodies in the lead and with anyone who has a huge network or penetration in remote communities.

The above is a tentative classification of the different outreach strategies, of course it is never completely black and white. Some countries though have a stronger multi-sectoral approach than others. As can be seen, **several outreach strategies rely heavily on the mobilisation of voluntary leaders at community level**. In some countries this is working better than others. As Nanda rightly said at this end of his contribution, one of the issues is whether and how to keep the motivation for all the volunteers at local level.

How do you build capacity of people? How to ensure quality and motivation?



Cascade type training is probably the most common form of capacity building for scaling of rural sanitation and hygiene. Cascade training creates Master ToT's, who then transfer those skills to ToT's who then train facilitators (see figure). Sometimes more layers are necessary because of the size of districts. So at district level ToT's might be trained to again train others at sub district level.

There are **three issues** associated with this capacity building model, especially if it's a one-off training:

- The risk of **loss of quality** of the training in each step of the way

- The fact that facilitators when they go to the field encounter a **myriad of situations**, and will need to adjust their methodology. With their limited experience, they sometimes cut out key aspects.

- Sometimes the nature of programme does not only require people to learn new skills, but also change **their mindset**. That is difficult to achieve in this type of setting.

You made many interesting points about capacity building. First of all, Mr. Alfred Lambertus, senior consultant from Indonesia points out that **capacity itself does not necessarily lead scaling** because the enabling environment in mainstream government practice is so different for externally supported programmes. Alfred is not referring to the high level policies and enabling environment, these are also important, but to the fact that the devil also lies within the detail. There are usually many **operational policies** and regulations at local level that affect the space the programme has. So while programmes can produce (motivate) champions within the government and communities, very often this leadership doesn't reach **sufficient critical mass to sustain scaling up** and the champions fade away due to rotation, promotion or new projects. Sonam also pointed to the difficulties of creating incentives in programmes that cannot be replicated in a scaling up, whereas Bimal mentions that capacity investments may go to waste unless combined with activities to improve the enabling environment for implementation (and performance). Also Mr. Chea Samnang from Cambodia emphasis that human resource development is only one of several conditions for sustainable scaling and by itself does not work.

Both Nepal and Cambodia have a **national unit within the government** from where training and support is provided, and Nepal also trains people to be **master trainers at district level**. However, the contributions from Nepal and Indonesia mention the need to work still on **greater standardisation of training modules, materials and guidelines**.

Hilda and Phurpa gave some practical views about capacity building:

- The quality of training activities depends a lot of **how** it's done and **who** is selected to participate.
- Learning needs through **practice** rather than through class-room style settings.

Both agreed that **post-training support and follow-up is essential**. This can consist of constant and timely observation by the experienced programme facilitators to the trained staffs while they are conducting the triggering workshops. Feedback sessions after every workshop will further sharpen the skills development. Henk van Norden also points to learning alliances as a strategy to ensure further capacity building during implementation. Other means are of course exchange visits to **facilitate peer-to-peer learning**, and the **use of outstanding people as co-facilitators in training**. Both serve to strengthen capacity, but also as motivating factor and incentive to staff. **Logistic support** to staff in remote areas will also help motivation.

Sometimes capacity development can become **very CLTS centred**, which is **a risk** because CLTS alone does not result in sustainable access to sanitation. Thus one of the conditions is to provide equal attention to market skills, technology options and post-ODF work for example on hygiene. For these subjects more should be done to share lessons and recognise the efforts of well performers.

Finally Hilda mentions the importance of **integrating sanitation in curricula of formal training** to achieve sustainable long term solutions. For example Plan Indonesia has been working with a **vocational school** in Grobogan District of Central Java promoting inclusion of sanitation business into the curriculum. This point of working together with academic and vocational institutes is also mentioned by Kirstin as a strategy to sustain capacity in a context of frequent staff rotation at local level.

TOPIC 3: ACHIEVING AND MAINTAINING MOMENTUM IN SCALING

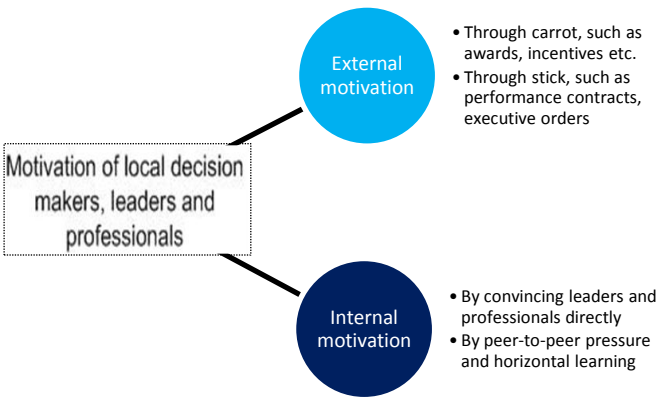
WHICH MOTIVATIONAL STRATEGIES DO YOU USE OR ARE MOST APPROPRIATE FOR YOUR CONTEXT?

In the first topic, we already spoke about drivers. Most of you indicated that **government leadership**, at different levels, is essential to create momentum and accelerate progress in rural sanitation and hygiene. Though we would like to see **people's demand for sanitation** drive (bottom-up drive), this is unlikely to happen in early stages or without an intervention to create such demand. Several people have suggested that there may be a **tipping point**. A point at which there will be sufficient critical mass among leadership, local professionals as well as sufficient demand among people, sufficient so that sanitation activities do start to expand spontaneously.

Knowing that leadership at different levels and commitment of professionals for sanitation is essential but usually does not emerge automatically, the question for governments is of course how to create such leadership and maintain the momentum? Note that I am not referring here to the leadership at community level to become ODF, but to leadership in local organisations and commitment of local professionals to start working on sanitation in their area. Several strategies have been tried in different countries mentioning a few:

- Pushing scaling by **executive mandate** (top down), setting targets and holding everybody accountable for it. Earmarking a percentage of local block grants for sanitation can also be imposed from national level and push activities .
- Providing **incentives and awards** for local governments or communities that have achieved ODF or 100% improved sanitation. These can be communal incentives or awards, or personal incentives for the involved officials.
- Trying to convince through a **large scale media campaign**.
- Trying to convince different stakeholders in different organisations and levels of government to work on sanitation, through **large groups of "facilitators" or "trainers" spreading the message at those levels**.
- Trying to convince through **showcasing ("ODF celebrations")**
- **Benchmarking** exercises which show that some districts or communes are performing better than others.
- Facilitating peer-to-peer pressure and learning around sanitation through **collaborative groups**, such as the association of mayors committed to sanitation in Indonesia.
- Facilitating peer-to-peer pressure and learning around sanitation through **several collaborative groups of key people**, e.g. decision makers, engineers, facilitators.

The first question about your **motivational strategies** asked about ways to motivate local governments and professionals to scale up rural sanitation promotion activities. It did not refer to the behaviour change of households or communities. The assumption is that capacities and motivation of local authorities and professionals is essential for good quality work with communities. There are several ways to motivate local authorities (decision makers, leaders) and local professionals, which can be grouped into two broad tactics: providing **external motivators** or promoting the emergence of **internal motivators**. It is generally believed that internal motivation will be more sustainable and necessary to keep momentum



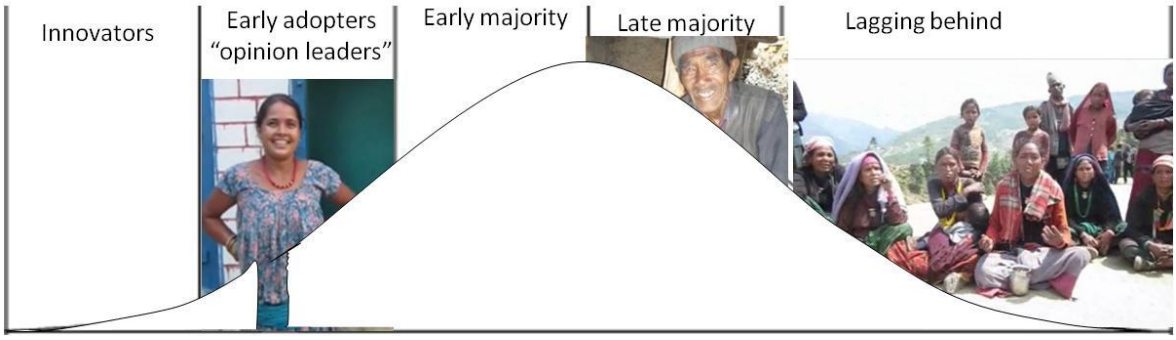
going.

Most examples on motivational strategies are about "carrot" strategies, communities, districts, leaders, professionals will obtain awards, incentives and recognition for achievement. Very few mention "stick" strategies (see below). Most people feel that "stick" strategies in their context will not be effective because:

- It is too early in the process to start using stick strategies, coverage is still too low, more critical mass is needed (Suman Sharma)
- There are over a 100 ways that local authorities or representatives can justify their non-cooperation if they are not convinced. There is very little that a national government officials can do to take action, and if they do, it may impact their career (Bimal Tandukar from Ghana)
- The conditions for enforcement such as clarity about mandate, the necessary legal framework and mechanisms, do not (yet) exist for sanitation (Nanda Khanal from Nepal and Thea Bongertman from Laos)

WHAT DO YOU FEEL ARE THE ADVANTAGES, DISADVANTAGES AND RISKS FOR THOSE STRATEGIES CONSIDERING DIFFERENT PHASES?

All of these strategies for creating momentum have advantages and disadvantages of course. In earlier messages, some of you have asked for example how effective awards and celebrations will be in the long run. Sure for the front runners this is motivational, but what if your district is just one of many? There is obviously more thinking needed of what works in which phase. Perhaps we need to develop something like the technology adoption curve, a sort of **adoption curve for sanitation**. The different between early adopters and those lagging behind may not only apply within communities but also among local bodies.



"Carrot" motivational strategies

Carrot motivational strategies are considered especially useful for early phases of the scaling process, to engage and win over leadership until results become clearly visible to all says Bimal. Sonam Gyaltshen from Bhutan, Eka Setiawan from Plan Indonesia, Suman Sharma from Nepal and Selamawit Tamiru from SNV Ethiopia and several others point to the risk that awards or competition over reaching ODF can cease to be a motivational tool over time. One strategy shared by Eka is to improve the quality of ODF verification, include a post-ODF budget and plan as a condition for declaring ODF and also to make clear that ODF status can be withdrawn in future if the community/ district (?) returns to OD. The latter is of course a form of "stick".

"Stick" motivational strategies

Besides the idea of withdrawal of ODF status, there are two other examples of the use of "stick" motivational strategies with local governments:

- In Bhutan, mainstreaming of sanitation and hygiene in planning and targets, has now led to it becoming a "Key Result Area" with which districts and sub-districts are required to align shares Gabrielle Halcrow.
- In Ethiopia, writes Selamawit Tamiru, local leaders (districts cabinets and administrators) are evaluated against performance on sanitation and hygiene.

It seems that scaling sanitation through executive mandate, setting targets and holding local governments accountable to those, is not an option for most countries.

Promoting internal motivation of leaders and professionals for sanitation

Though it is not explicitly mentioned in most contributions, many of you talk about creating internal motivation of key leaders, local authorities and professionals. This is all about convincing these people that rural sanitation and hygiene is a priority. Examples that are given are advocacy with political leaders, media campaigns, meetings, personal interaction. Data are also important to show the linkages between sanitation, disease burden, child morbidity, stunting and even economic growth.

A special way of promoting internal motivation for sanitation with leaders and professionals is through peer groups and learning. This strategy does not only aim to convince, but also to create a shared professional standard: it becomes the norm. Sharing between peers further helps to overcome obstacles that can be encountered in implementation and supports adjustment of the approach to new situations with less risk of losing quality. Deviariandi Setiawan from WSP Indonesia gives a number of examples:

- Various active mailing lists; set up informally and used by STBM practitioners to communicate and sharing ideas/concerns.
- Active STBM website that contains all relevant information on STBM; regulation, project guideline, best practice, lesson learnt, study/workshop reports, etc.
- Electronic newsletter (distributed monthly to relevant stakeholders and mail lists) that featuring: hot news of STBM progress from regions, emerging innovations, champions profile, review publication, etc.

Nanda Khanal suggests peer learning activities such as exchange visits as well, but he also mentions the importance of selecting right people (with the right attitude). Bimal also mentions that in the absence of a strong authority, peer pressure can be a better motivational tool. Mr. Loknath Regmi from the Ministry of Local Development in Nepal and several others suggest that district and village committees are a key engine for local motivation in Nepal. The hope is that so much critical mass is created among professionals and leadership, that prioritising rural sanitation becomes the norm rather than the exception.

HOW DO YOU AVOID LOSS OF MOMENTUM DUE TO LOSS OF QUALITY IN IMPLEMENTATION?

A lot has been mentioned above already about ways to avoid loss of momentum due to loss of quality in implementation. Some additional remarks worth mentioning at this point is the importance of clear operational guidelines (mentioned by Deviariandi), but also to provide support to non-performing clusters or districts, understanding bottlenecks and guiding them to small steps of improvement (mentioned by Bimal). Another aspect is to make sure that implementation actually takes place. As Gabrielle says, making sure that budget lines for sanitation are used for the right things, that time allocation by implementing staff is actually given. This part of institutionalisation, integration of sanitation within existing roles of the government requires a longer term view of the sector and a professionalisation of the role of local governments in public health. Institutionalisation of new sanitation approaches into national curricula, as mentioned by Devi, is also part of that professionalization.

Everybody agrees that information is essential for ensuring quality and often momentum is lost because of **a loss of credibility due to implementation issues**. As was said in the one of the first contributions: "Sometimes competition for ODF can result in haste and unhealthy practices …, that can lower quality and functionality of facilities and create a loss of credibility of the whole campaign." In other situations, local professionals are simply not motivated any more to deliver good quality work, due to a range of issues. Or the context is so different and local professionals have insufficient support to adjust the approach.

Again there are **different strategies to obtain information and ensure quality**. Most well-known is probably the **centrally managed database**, for example internet based, where progress on all targets is checked. Alternatively there can be **local monitoring**, or **monitoring and learning through peer-to-peer groups** as mentioned above. A relative new approach is to **monitor only results, not activities**, which leaves space for local creativity to adjust activities if it doesn't work. And then there is of the strategy to use **learning alliances** to ensure quality as well as continuous improvement. We have not spoken a lot about these different approaches to information and quality control. Suman Sharma suggested caution in using M&E data regulating, rather it should be used for learning.