GIZ Sanitation for Millions (S4M) Programme

Behaviour Change Campaign (BCC) and Training Action Plan

Photo Credit: GIZ S4M Project – Pupils of Anaka P.7 Primary School, Anaka Town Council, Nwoya District.

PART 1: S4M's BCC APPROACH FOR SMALL TOWNS

1.0 INTRODUCTION

Behaviour Change Communication (BCC) is the strategic use of communications to positively influence people's knowledge, attitudes, and practices[1]. It is about the strategic use of communications to encourage individuals and communities make informed decisions to adopt healthier and more sustainable practices. BCC has been successfully deployed to change behavioural practices especially in the WASH space. It borrows from both behavior and social change. On the other hand, Social Behavior Change (SBC) can broadly be defined as a structured process of persuading and empowering groups or individuals with the aim to influence and ultimately change their behaviors in order to positively impact the community. In this document, BCC and SBC will be used interchangeably.

Within the Water, Sanitation and Hygiene (WASH) sector, BCC has been promoted for a long time with mixed, although often disappointing results. Consequently, the BCC paradigm has shifted: whereas its focus used to be on instructing people on the adequate behaviors (that is, telling them what to do, nowadays it is broadly accepted that effective BCC starts with understanding the behavioral determinants (beliefs, taboos, implicit social norms) that constrain or enable change. This evidence is then used to design strategies, which include comprehensive approaches addressing people's motivation, ability and their environment, recognizing that multi-faceted interventions are needed to enable behavior and social change.

1.1 ABOUT GIZ SANITATION FOR MILLIONS (S4M) PROGRAMME

GIZ Sanitation for Millions (S4M) Programme is currently supporting the Anaka Cluster of small towns (Anaka, Amuru, Koch-Goma, Purongo and Olwiyo) in Northern Uganda to improve access to adequate and equitable sanitation and hygiene (S&H) services. In the effort to improve the S&H situation for the vulnerable population, including identifying future opportunities for sustainable interventions, S4M works primarily with the Ministry of Water and Environment (MWE), Ministry of Education and Sports (MoES), and Ministry of Health (MoH) at national as well as communities, schools, Health Care Facilities (HCFs), religious institutions and town councils in the Anaka Cluster. GIZ S4M programme works with Implementing Partners (IPs) to be able to reach out to communities and institutions including CARITAS and Makerere School of Public Health (MUSPH). GIZ S4M also works closely and collaborates with the regional structures of government/MWE especially in addressing Faecal sludge Management gaps including the Northern Umbrella for Water & Sanitation and the Water and Sanitation Development Facility North (WSDF-North). All these partners are involved in the implementation of the programme and will use this BCC approach.

1.2 SOCIAL PRACTICES ASSESSMENT BY S4M PROGRAMME

In July-August 2023, GIZ S4M programme conducted an assessment on Water, Sanitation and Hygiene (WASH) Social Behaviours and Practices in Anaka Cluster of Towns. The overall purpose was to ascertain the existing WASH knowledge, attitude, behaviours, and practices at institutional and households' level to inform implementation of awareness and mobilisation measures of the project. One of the key deliverables of the social practices assessment was ***to draft a BCC and trainings action plan aligned to the project indicators and implementation structure (Technical officers and Implementation partners operational***

[1] https://iwrmactionhub.org/learn/iwrm-tools/behaviour-communication-change

frameworks). The assessment was conducted in communities (households), in institutions (schools and healthcare facilities-HCFs), and in public spaces (e.g., markets, and churches). The results and recommendations of the social assessment have formed the drafting of this BCC action plan.

The key recommendations from the social practices assessment that relate to BCC at each level are summarized in Table 1 below[2]:

Table 1: Key Recommendations from the Social Practices Assessment conducted by GIZ S4M Programme

Level	Recommendations
Household (HH) sanitation	• Develop a clear BCC approach to address the different barriers and challenges why HHs do not have access to improved toilets (to address demand and the supply chain). • Develop or adopt existing IEC materials *(e.g., "Living Freshi" by MoH)* to counter the negative myths and beliefs; and conduct training for GIZ team and partners on SBC. • Use BCC to market and convince HHs to adopt and use basic toilets/latrines; • Consider selection and training of local folk groups to perform in communities as part of the BCC strategy.
Household (HH) hygiene	• One priority behaviour for the BCC campaign should be on ***"hand washing with soap and water in HHs and communities"***. • Develop clear and consistent messages on HWWS to include critical times when to WASH hands with water and soap. • Develop BCC materials on hand washing with soap and water, to be informed by the above messages.
Institutions (Schools & HCFs)	• Develop and/or print BCC campaign materials, with messages aligned to the behaviours under bullet #1 above, to help support learners to change behaviours; and train teachers on BCC. • Paint nudges (as part of BCC) in strategic places/locations (such as toilet walls in schools, HCFs and churches) with key hygiene messages to promote behaviours but also to reinforce or keep users reminded of hygiene messages
Sanitation and hygiene in public spaces (e.g., markets & churches)	• Develop and share with them the BCC materials on the "dos" and "don'ts" of public toilets (in local language), to: o *Encourage proper use of toilets/latrines in the markets and churches.* o *End practices such as throwing of used pads in toilets/latrines* o *Encourage handwashing after toilet/latrine use*
Menstrual Health & Hygiene Management (MHHM)	• Develop or adopt BCC materials with messages such as; o *"Don't throw pads into pits";* o *"Menstruation is normal", for promotion targeting both boys & girls; and men and women* o *Use incinerators for disposal/burning of used menstrual pads"*
Faecal Sludge Management (FSM)	• Develop or adopt BCC materials with messages: o *to end the practice of manual pit emptying in households and institutions.*

[2] There were some beliefs established in Anaka cluster of towns during the social practices assessment surrounding the use of piped/treated water that will need attention as well by the GIZ S4M partners. However, the GIZ S4M is a purely sanitation project and hence issues of water are not included in this framework.

1.3 GIZ S4M INDICATORS FOR WASH SOFTWARE MEASURES IN THE ANAKA CLUSTER

The GIZ S4M programme developed an indicators framework to guide the implementation of software measures (*please see Annex 2*). The indicators framework highlights various objectives, indicators and related activities. Specifically, under the "awareness and BCC measures" sub-section are the following planned activities:

- Development and dissemination of new (non-existing) and revise existing IEC materials on WASH/Hygienic practices (consider all institutional types: Religious/Schools/HCFs & Households)
- Conduct hygiene and MHH awareness and BCC campaigns at **HCFs** (target OPD, antenatal classes, food and nutrition days, immunisation, ART clinic days and vaccination days). (*Please refer to the HCF Concept and Measures for more information).*
- Conduct hygiene and MHH awareness and BCC campaigns in **Schools** through Health Parades, Class-Health checks, Incorporation in schools MDD-themes, school sanitation and hygiene competitions -TMG, IEC materials, sports events, WASH clubs. (*Please refer to the Schools Concept and Measures for more information*)
- Conduct **hygiene** and MHH awareness and BCC campaigns at **faith-based organisations** (target religious leaders, workers, associations/structures, congregation at specific theme sermons). *Please refer to this BCC action plan*.

It is against the above background that the GIZ S4M programme has drafted this BCC training and action plan, based on the outcomes and results of the social practices assessment and the S4M indicator framework. The BCC training and action plan will support the GIZ S4M technical team and partners to address the bad behaviours and practices identified during the assessment both in HHs, institutions (schools and HCFs) and in the public spaces (such as markets and religious centres).

PART 2: THE BCC FRAMEWORK FOR SMALL TOWNS

2.0 BRIEF INTRODUCTION

The proposed BCC action plan is based on the Elephant-Rider-Path (ERP) model or framework. The ERP is a straightforward, visual model that speaks to the importance of aligning emotional drivers (the Elephant) with rational arguments (the Rider) and necessary enabling conditions (the Path) so that sustainable behavior change can take place. Through this SBC framework, the GIZ S4M team and implementing partners (IPs) will have guidance for implementation of WASH activities.

2.1 PURPOSE OF THE BCC APPROACH (FRAMEWORK & ACTION PLAN)

1. To motivate communities/HHs by making them feel they ought to change
2. To support the sanitation promoters and sales agents at community and institutional level to focus on the positives (e.g., prestige, convenience, durability) as opposed to the negatives (shame and disgust)
3. To make the desired sanitation and hygiene (S&H) behaviour change seem doable
4. To encourage a positive mindset (change is possible).

2.2 TARGET AUDIENCE

The BCC framework is intended to coherently define an approach to design both GIZ S4M and other partners' SBC promotional activities to achieve sustainable behavior change results in line with the GIZ S4M sanitation and hygiene targets. Therefore, the intended target audience for the BCC framework is:

1. Primarily, GIZ S4M team and Implementing Partner (IPs) staff to effectively implement SBC at the different levels.
2. Secondly all national, regional and district or small-town level collaborative partners who oversee projects that aim to positively influence behaviour.
3. Men and women living in households and in communities; teachers and children / learners in schools; staff, patients & caregivers in HCFs; vendors and visitors in markets); Muslims in mosques and Christians in churches.

2.3 SCOPE

This BCC framework may be applied at the individual, family, community, and institutional levels. It acknowledges that the interplay of behavior changes at the individual and family level feeds into wider community social norm transformations and vice versa, so that the related health benefits can ultimately and sustainably be achieved. While BCC interventions are more focused and outputs expected at the individual, family and community level, there are crucial complementary interventions such as establishment of an enabling environment that must also be achieved, at the district and national level.

2.4 EXPECTED OUTPUTS

The application of the BCC framework to enhance the adoption and sustenance of behaviors is critical for GIZ S4M programme. Therefore, this action plan will ensure that all GIZ S4M team and Implementing and Collaborative Partners are knowledgeable and aware of the SBC principles. This will enable the programme to achieve the following outputs as specified in the software measures indictor framework:

- **Module objective indicator 2:** 75% of 100,000 additional people (of whom 60% are women) reached through hygiene and/or menstrual health and hygiene awareness interventions have confirmed the use of these practices in their daily lives.
- **Module objective indicator 3:** After one year in operation, 80% (32) of the 40 sanitary facilities rehabilitated or newly built-in public institutions comply with the minimum quality standards, including standards for menstrual hygiene management.
- **Output indicator 2.1:** 800 additional professionals (including 40% from the private sector) have confirmed that they were able to use the contents of training measures in the implementation of the service offers.
- **Output indicator 2.2:** 40,000 girls participated in measures to improve menstrual health and hygiene in public institutions.

3.0 BEHAVIOUR CHANGE MODEL: THE ELEPHANT-RIDER-PATH (ERP)

This BCC action plan is rooted in an evidence-based, behavior change model - the Elephant-Rider-Path (ERP) - to design a high-level behavior change strategy and action plan. The ERP is described below.

The Behavior Change Model: The Elephant-Rider-Path (ERP)

Developed by Chip and Dan Heath in 2010, the Elephant-Rider-Path (ERP) model is based on the well- established fact that people's rational decision-making systems are not always aligned with their emotional drivers. For clarity, the model uses the analogy of an elephant and its rider. The key principle underlying the model is that for behavior change to take place, it is necessary that both the emotional drivers (the Elephant) and the rational mind (the Rider) are aligned towards the same direction, while an enabling environment (the Path) is cleared and shortened for them. In short, in order for behavior change to occur, the Elephant must be motivated to change, the Rider must know how to arrive at the change, and the Path must be clear to facilitate the change – all three are required.

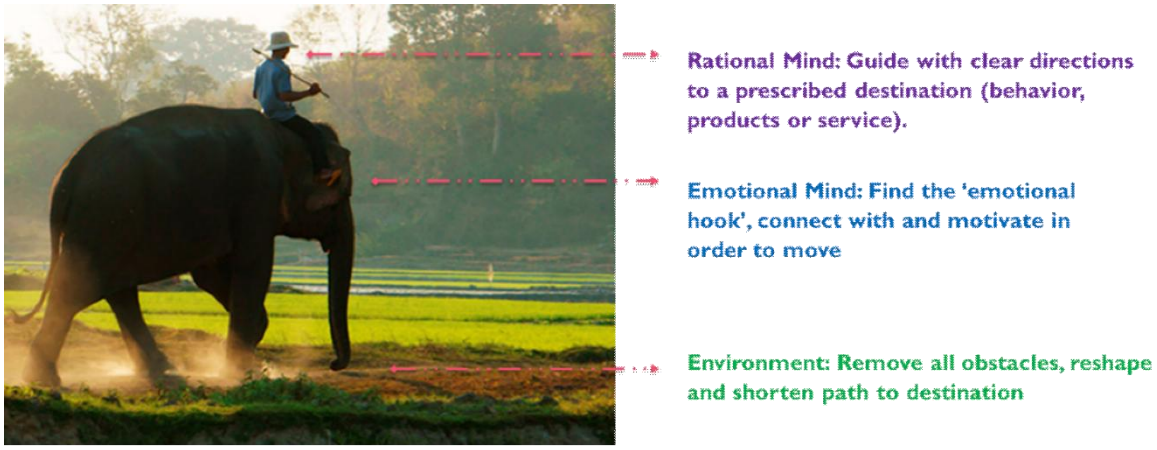


Figure 1: Illustration of the Elephant- Rider-Path Model

Elephant (Emotional mind) – are the factors that affect an individual's motivation to carry out a behavior, such as beliefs, attitudes, taboos, values, willingness to pay, ability to pay, competing priorities, etc. Emotional drivers tend to be underestimated in behavior change processes. Often people are very much aware of the importance of a certain behavior (take the 64% of HHs in the Anaka cluster that had knowledge that it is important to practice hand washing with soap after defecation, but whose actual practice was very low), hence their current behavior mindset does not support the practice.

Emotions get people to act or fail to act, even when their head may say no or yes, respectively. Therefore, the analogy of the Elephant is particularly insightful: the sheer size and strength of the Elephant will always overpower the Rider when there is a disagreement on which direction to take. The "Elephant" are mainly the HHs that are targeted for behaviour change. It is important, therefore, to appeal to the emotions and feelings of HH heads through value propositions such as convenience, prestige and respect among community members that come along with owning an improved latrine.

Rider – are the factors that affect an individual's ability to carry out the desired behavior, such as knowledge and skills. The Rider (GIZ, IPs) must be clear on the targeted behaviours to change and be consistent with the messaging, so as to give clear direction to the HHs (the "Elephant") on where to go and what to achieve. The Rider must also be clear on the available sanitation products and services offered by the program to motivate the "Elephant" or HHs to move in the right direction.

Path – are the external factors such as access, social norms, product features, etc. The direction (path) to take should be shaped in a way to enable the desired behavior to be practiced with ease. The path is often the "situation problem", such as lack of visually appealing and affordable hand washing stations (e.g., unattractive, and low-quality tippy taps) that can act as nudges for the desired behavior. Therefore, it is critical to influence the path through interventions that create the enabling environment so that the path is clear for the intended behavior to happen. An Elephant will very easily go back to "business as usual" if the conditions required for the change to take place are not available, regardless of the direction the Rider tries to take. Examples of interventions that make it easy for HHS to adopt the desired behaviour of construction of improved toilets/latrines include:

a. Providing viable options of improved latrine (use of catalogues)
b. Taking products and services closer into communities (hardware shops in villages)
c. Improving access to financing to help acquire funds to construct latrines (connection to SACCOs, etc)
d. Linking HHs to trained masons to correctly install/construct improved latrines.

PART 4: APPLICATION OF THE BCC FRAMEWORK

4.0 PRIORITY WASH BEHAVIORS

As documented in the social practices assessment that was conducted by GIZ, there are key behavior challenges that significantly constrain progress towards sanitation and hygiene (SH) targets in the Anaka cluster. These range from low use of improved, individual household basic toilet facilities to low rates of hand washing with soap. Similar challenges were recorded in the institutions and open public spaces such as markets. Given the slow progress in increasing access to basic SH service levels, the proposed GIZ S4M's BCC framework will prioritize specific behaviours and corresponding target groups, alongside handwashing with soap, as detailed in the table below.

Table 2: Prioritized WASH Behaviors and Target Groups

CATEGORY	TARGETED GROUP	PRIORITIZED BEHAVIOURS FOR PROMOTION
Households	• HHs with no toilets	• Build new/upgrade to an improved, individual household toilet facility • End the practice of open defecation / use of "flying toilets" • Consistent and proper use of toilets/latrines • Children faeces management
	• HHs with unimproved toilets	
	• Households sharing toilets	
	• Landlords	

	• Pregnant women	• Hand washing with water and soap at critical junctures
Schools	• School Health Clubs • All learners in a school • School Administrators	• Consistent and proper use of toilets • Hand washing with water and soap at critical junctures • Proper menstrual hygiene management • Stop manual pit emptying • Proper menstrual hygiene management (Don't throw pads in toilets; don't laugh at girls during menstruation; use incinerators)
HCFs	• Patients, staff, caregivers, pregnant women during antenatal clinics • Hospital Administrators	
Markets and Churches	• Market vendors • Visitors to markets • Market masters	• Consistent and proper use of toilets • Hand washing with water and soap at critical junctures • Proper menstrual hygiene management (Don't throw pads in toilets; don't laugh at girls during menstruation; use incinerators)
	• All Christians	

4.1 BEHAVIOUR DETERMINANT ANALYSIS

The primary objective of a BCC strategy or action plan is to compel the intended audience to *act*– to support uptake of an available service (in this case construction of improved sanitary toilets), to talk to households (HHs), communities, school children, etc. about the benefits of using improved sanitation services, and to adopt or maintain a behavior such as handwashing with soap. In most cases, just sharing information (for example using Information, Education, Communication-IEC approach) is not enough to get people to go for services or to adopt a certain behaviour. This is why it is so important to understand why people act the way they do. Identifying those determinants needs to happen before designing a BCC strategy and communication activities or materials.

4.1.1 Determinants of household behaviour change in Anaka cluster (Sanitation)

The following were the behaviour determinants and factors limiting HHs from constructing and using improved latrine options:

1. **Low levels of education**, coupled with limited knowledge of the benefits of improved sanitation hence sanitation is not a priority for investment at household level.
2. **Cultural myths**, beliefs and practices as highlighted in sub-section 3.3.6 above.
3. **Poor attitude**, as majority of town residents (including leaders such as Councillors) do not value having toilets and were reported to be hard-hearted, with strong beliefs and mind-set.
4. **Lack of knowledge and information** about other available or alternative toilet/latrine options, and that latrines can be cheap in the long-run, hence high prevalence of unlined pit latrines which cannot easily be emptied.

5. **Lack of experts such as trained masons** to provide information and guide households to construct better quality toilets, hence poor-quality toilets which do not motivate people to use them.
6. **Inadequate water** to facilitate adoption of waterborne (WBTs) or pour-flash toilets.
7. **Inadequate capacity** of town council authorities including:
    - weak enforcement of the Public Health Act (PHA) and other laws, because of fear since some people in the communities were reported to own guns.
    - inadequate understanding of many town council teams (both technical & political) on the innovative approaches for S&H promotion such as sanitation marketing.
    - the political leadership that are not adequately enlightened to support sanitation.
    - lack of town council byelaws and when technical personnel use the Public Health Act (PHA) to enforce good sanitation, the politicians were reported to turn against them
8. **Lack of or inadequate exemplary leadership** particularly from the elected political leaders such as LC Is, LC IIs and LC IIIs/Mayors of town councils because quite often these do not have toilets in their own homes.
9. **Problem of collapsing soils** in some parts of Anaka town council, as pits of up to 12-20 ft were reported to collapse and **water-logged soils** in places such as Purongo town council.
10. **Very limited on-going sanitation and hygiene sensitisation programmes**, as no one is currently talking to communities about the importance of having toilets.
11. **Limited allocations, in terms of funding, by town councils** to support sanitation improvements in the towns, as S&H majorly uses local revenue. The Primary Health Care (PHC) grant, where a HCF III receives UGX 2-4 million a quarter, was reported to go mainly to immunization and addressing S&H within the HCFs
12. **Low incomes of majority of small towns' residents**, coupled with high costs of construction of latrines which makes affordability a challenge.
    - A fairly good 2-stance latrine was reported to cost between 1-2 million (digging pit – Ugx 100,000; Putting the slab – Ugx 70,000: labor, cement and bricks – 500,000; roofing with 2 iron sheets – Ugx 120,000); while construction of a septic tank alone was estimated to cost 1-4 million Uganda shillings.
    - Towns such as Anaka, for example, are former Internally Displaced Peoples' (IDP) camps, where some people failed to go back to their respective rural villages and yet they lack funds to survive in the town

4.1.2 Determinants of household behaviour change in small towns (Hand Hygiene)

From the social assessment and other previous studies, the main reasons for the disconnection between the knowledge and the behavior on hand washing were self-reported (MWE, 2012) as being: forgetfulness, complacency, limited availability of water, no hand washing facility available and the cost of soap. However, almost every HH (at 95%) has soap that is primarily used for clothes and dish washing, as well as for bathing. The majority of the HHs in Anaka cluster towns had a movable container also known as "jerry-can" as the handwashing device (58.3%). Limited availability of facilities, water, or soap

seemed to be the factors derailing the practice of the behavior. Among parents/caretakers of children under 5 in HHs, due to ignorance and the belief that children's faeces are safe, it was common practice to feed children without washing hands and not to wash hands after cleaning a babies' bottoms.

The assessment in schools and HCFs (Anaka GH inclusive) established that these were flooded with hand washing stations during the Covid-19 pandemic but since the pandemic ended, the facilities were either broken down or non-existent (read stolen), and hence there is no effective hand washing with soap and water particularly by learners and by patients and their caregivers. The biggest barriers included lack of hand washing infrastructure, inadequate funds to procure soap and lack of motivation for teachers to promote positive WASH behaviors.

4.1.3 Determinants of behaviour change in institutions and public spaces.

The social practices study also established the determinants or factors that constrain adoption of improved WASH behaviours in institutions (schools and HCFs) as well as public spaces (such as markets and religious centres). For example, the assessment in schools and HCFs (Anaka GH inclusive) established that these were flooded with hand washing stations during the Covid-19 pandemic but since the pandemic ended, the facilities were either broken down or non-existent (read stolen), and hence there is no effective hand washing with soap and water particularly by learners and by patients and their caregivers. The biggest barriers included lack of hand washing infrastructure, inadequate funds to procure soap and lack of motivation for teachers to promote positive WASH behaviors. (*please refer to detailed social practices assessment report*).

In conclusion, the determinants summarised in the sub-section above can be categorized into three main groups related to the **environment** (e.g., availability of a service such as a handwashing station, or even its location), **skills and knowledge** (level of awareness of the service and/or the resulting health benefit; or level of awareness of the skills or steps required to access the service or maintain the behaviors); **and ideation** (e.g., what are the prevailing beliefs about the behavior or intended audience? Are they positive or negative? How much social support does the audience have to pursue services or maintain required behaviours)?

5.0 BCC INTERVENTIONS AND TRAINING ACTION PLAN

Considering the factors outlined above and the behaviour determinants for the different behaviours, the following key interventions are proposed for implementation in households, institutions (schools and HCFs) and open/public spaces. To note is that the specific timing for each of the proposed actions and interventions will be determined by GIZ S4M programme team and the IPs.

TABLE 3: BCC INTERVENTIONS AND TRAINING ACTION PLAN

Behaviour challenge	Target Group /Audience	Application of the ERP Model			Behaviour objective / Outcome	Actions/Activities
		Rider (Rational Guidance)	Elephant (Emotional drivers)	Path (Enabling conditions)		
Household BCC ACTION PLAN						
End the practice of open defecation / use of "flying toilets"	HHs with no toilets; pregnant women	Knowing the dangers of OD such as contamination of drinking water (end up "eating" faeces); knowing the impact of OD on health and hygiene standards; demystifying myths about pregnant women and use of toilets; and that improved toilet products are readily available and affordable (cost of not having toilets)	Associating having toilets with feelings of safety (for children, women, and elderly) and convenience; improved health for family and community.	1. Ensure availability of sanitation supply chains that provide diverse, durable and pleasing improved toilet products in targeted communities. 2. Ensure availability of masons to quality services and respond to demand. 3. Provide information in easy-to-use formats through channels that are credible by the target group.	Eliminate Open Defecation (OD)	1. Develop and facilitate easy access to a variety/diverse, durable, pleasing, easy to maintain and relatively affordable products (of different prices) for promotion. 2. Train masons to provide professional and affordable products and services to HHs and landlords; and link HHs and Landlords to trained masons. 3. Train and use Sanitation Promoters/VHTs as Sales Agents to promote the different toilet products and services. 4. Develop appropriate information products and materials for use by Masons and VHTs (e.g., catalogue with different toilet options; OD chart Sets, and Teaser & Instructional Posters; improved & unimproved toilets, etc.). 5. Liaise with MFIs, SACCOs and VSLAs to develop appropriate sanitation loan products – for both HHs and Landlords; and link HHs and landlords to
Build new/upgrade to an improved HH toilet facility	HHs using unimproved sanitation facilities in the towns	Knowing that improved toilets: Improve health and hygiene standards; Are safer and easier to use and clean; that improved toilet products are readily available, affordable and easy to build, with long-lasting features; and that suitable financial products and services for toilet purchase are also readily available and affordable.	Associating improved toilets with feelings of safety (for women, children and elderly), family nurture; feelings of pride, prestige and increased social standing; feelings of conformity with relevant social and religious norms.		HHs move from use of unimproved to improved toilets. Increased access to individual household toilets	
Build new improved individual household toilet facility	Landlords and HHs using shared latrine facilities (improved or unimproved) in the towns.	Knowing that improved individual toilets for tenants are initially expensive but have high returns in future; are more convenient and easier to manage by tenants in order to maintain proper sanitation and hygiene at premises	Associating rental units with improved individual toilets with increased income from increased property market value (hence higher rental charges).	Sanitation supply chains that provide diverse, durable and aesthetically pleasing improved toilet products. Rapid response to demand and professional product	Increased access to improved, individual tenant toilet/ latrine facilities	

	HHs using shared latrine facilities (improved or unimproved) in the towns.	Knowing that improved individual HH toilets are initially expensive but are more convenient and easier to manage/clean by HHs that shared toilets.	Associating HHs with improved individual toilets with improved cleanliness; convenience and reduced quarrels and dissatisfaction between HHs.	and service delivery (by masons & pit emptiers). Incentive mechanisms to reward landlords for individual HH toilet construction (E.g., recognition as "Super Landlords"). Suitable credit mechanisms by financing institutions.	Increased access to improved, individual HH toilet/latrine facilities	financing institutions for facilitate access to financing for sanitation. 6. Conduct training for GIZ S4M team, IPs, and Town Council Authorities for harmonised understanding on SBC. 7. Identify and interest Hardware shops to stock materials for construction of latrines/toilets (e.g., iron bars and cement in smaller quantities). 8. Identify and train local Folk Groups on SBC (e.g, use of Role Plays to promote proper use of toilets and ending OD). 9. Organise Folk Group performances in selected communities, and in schools and HCFs. 10. Conduct radio talk-shows targeting HHs
Consistent and proper use of toilets/latrines	HHs and tenants	Knowing the dangers of using dirty toilets such as increased infections; and its impact on health (increased costs of treatment, etc.).	Associating clean toilets with increased desire by HH members and tenants to often use toilets/latrines	Ensure HHs and Tenants are trained on proper Operation and maintenance of toilets/ latrines; and have access to detergents for cleaning.	Reduction in flies' infestation and reduction in the spread of sanitation related diseases (such as diarrhoea).	1. Conduct sensitisation campaigns to: • provide information on keeping toilets/latrines clean and in hygienic conditions for the next user; • eexplain/define what is meant by "proper & consistent use" of a toilet/ latrine. For example:

						○ Use of toilet for disposal of faeces only; not for garbage disposal ○ Do not drop solid non-biodegradable materials (such as stones) ○ Put a basket or bucket for anal cleansing materials ○ Place a broom and bucket of water or ash for immediate cleaning of soiled floor, Etc. 2. Develop and/or adopt SBC materials on O&M e.g. • Proper O&M of improved toilets. • Misuse of toilet 3. Facilitate access to durable and easy to maintain sanitation options.
Children faeces management	Mothers/Caregivers of under-fives.	Demystifying the myths about babys' faeces being safe. knowing the dangers of using dirty toilets such as increased infections; and its impact on health (increased costs of treatment, etc.).	Invoke feelings of purity, freshness and comfort of clean hands before and before eating or feeding a child/baby.	HHs heads ensure family has a toilet; mothers and caregivers receive adequate information and training on how to manage babies' faeces.	Childrens' faeces are properly disposed off and managed (since it is a source of OD).	1. Development and/or adoption of SBC materials depicting negative and positive behaviours of disposal of babies' faeces 2. Conduct sensitization drives of mother and caregivers about: • Positive disposal mechanisms for babies' faeces (e.g., directly into a pit latrine or bury with a hoe) • Negative disposal mechanisms for babies' faeces (e.g., with grey water into the garden). • Proper disposal of babies' diapers • Teach a child how to use a toilet.

Limited or no practice of hand washing with soap after toilet use and/or before eating.	HHs, especially those without any hand washing facilities	Knowing that HWWS: - is critical for the wellbeing and health of the family and especially of young children; - easy enough to perform and necessary resources are for the most part already available.	Associating clean hands with purity, freshness, attractiveness and comfort (e.g., clean hands are hands to be proud of); and help improve family and community health.	Emphasize the already existing availability of most of the resources needed (jerricans, soap) in the HH; - ensure hygiene supply chains with sufficient outreach, by: ○ training local masons in the production of affordable, desirable hand washing stations; ○ training HHs how to make their own HWFs; and/or ○ linking HHs to private sector providers who sell HH handwashing stations.	Increased HWWS practice in HHs (particularly after defecation, cleaning babies' bottoms and before eating).	1. Demonstrate handwashing facilities in households (e.g., during campaign days such as Global Handwashing Day (GHWD) or during Sanitation Week). 2. Develop and/or adopt SBC materials on HWWS. 3. Conduct training for SPs/VHTs/Sales Agents and local masons in the production of affordable and desirable hand washing stations. 4. Link HHs to private sector suppliers of HWWS facilities.
BCC ACTION PLAN FOR SCHOOLS						
Misuse of toilets/ latrines; dirty and stinking toilet/latrines. Limited or no handwashing with water and soap. Poor menstrual hygiene	School Health Clubs (SHC) All learners in a school School Administrators School Management Committees (SMC)	Knowing that improved WASH in Schools leads to improvements in educational outcomes (enrolment rates, retention, completion rates, and performance)	Association of clean toilets/latrines with freshness and good health. Association of clean toilets/latrines with improved grades in schools. Association of improved MHM with high enrolment and	Ensuring availability of: visually appealing toilets/latrines, which encourage and motivate learners to use them. Ensure availability of hand washing stations closer to toilets or eating areas within a school, that can act	Increased use of clean toilets in schools. Reduced infections due to poor WASH practices in Schools.	1. Develop and/or adopt existing SBC materials on WASH for schools (including MHM). 2. Training of Teachers & learners in Schools on SBC and the targeted behaviours, for effective promotion of S&H in Schools. 3. Training of School Health Clubs (SHC) on WASH and specific SBC such as Jingles; and how to

management practices Rampant practice of manual pit emptying Inadequate toilet facilities evidenced by high Pupil: stance ratio in schools.	Parents Teachers Associations (PTAs)		completion rates, especially of girls.	as nudges for the desired behavior.	Increased practice of HWWS at critical junctures, in Schools. Improved MHM in schools. Schools stop/end the bad practice of manual pit emptying	engage peers e.g., during assembly or during health parades. 4. Training of SMC and PTAs on S&H and planning & budgeting for WASH in schools. 5. Paint nudges on the latrine/toilet blocks in schools, HCFs and markets, to reinforce messages. 6. Organise BCC campaigns e.g., through competitions between schools, Health Parades, and MDD, and reward winners. 7. Participate in national and international campaign days e.g. Global handwashing Day (GHWD) and World Toilet Day (WTD) and show-case the BCC approach and materials used by the S4M program.
BCC ACTION PLAN FOR HEALTH CARE FACILITIES (HCFs)						
Poor S&H conditions in HCFs due to improper cleaning of toilets and patient areas. Limited or no handwashing with water and soap in HCFs.	Patients Caregivers Healthcare staff IPC members Members of Health Unit Management Committee (HUMC)	Knowing that poor WASH conditions and improper cleaning in HCFs reinfects people who are already sick. According to the Hippocratic oath, doctors and nurses are obligated to ensure that sick people are treated properly and as quickly as possible to relieve their pain. Although hand washing reduces infection rates by 45%, some	Testimonies of patients who were re-infected in hospitals. Recognition of Health Unit as 'top notch practitioners' who are valued and held in high esteem by their patients. Patients attest to and believe in their	National Medical Stores (NMS) providing a fully stocked supplies (including gloves, detergents, and sanitizers) to HCFs (esp. treatment rooms) for use by the Health Unit staff. Providing hand sanitizers at the entrance of each	Health Unit staff wash regularly their hands with soap and water before attending to each patient. Pregnant women visiting HCFs stop the bad practice of OD.	1. Develop and/or adopt existing SBC materials on WASH for schools; and WASH in HCFs (including MHM). 2. Training of members of Infection Prevention Control (IPC) committees on SBC and targeted behaviours, for effective promotion of S&H in HCFs. 3. Training Health Unit Management Committees

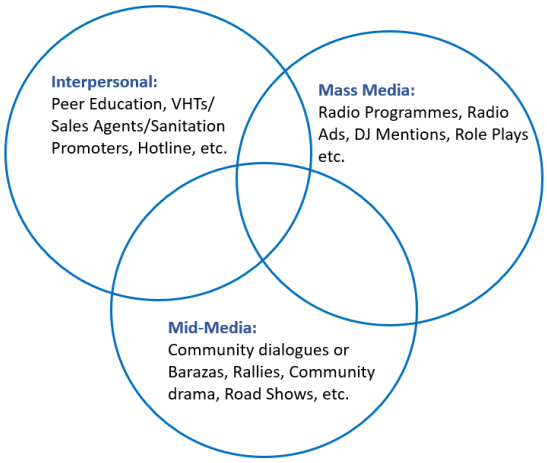
Poor MHM practices in HCFs. Rampant practice of manual pit emptying in HCFs. OD practiced by pregnant women. Potential high rate of reinfection of patients due to poor WASH in HCFs.		Health unit staff see this as time wasted when they have many patients waiting for their attention.	Health Unit staffs' abilities to heal them. 'Cleaning staff in HCFs are professional enough and clean with pride and provide patient care, as frontline soldiers".	Ward as an alternative to cut down on the time spent hand washing with soap and water. Motivated attendants are trained on WASH and given "Ambassador of Cleanliness" tags to wear. HCFs budget and provide adequate cleaning supplies.	More patients talking positively about Health Unit personnel. Reduced reinfection rates and increased enrolment of patients. Patients experience a clean, inviting environment at HCFs and do not hesitate to visit if need be.	(HUMC) on S&H and planning & budgeting for WASH in the HCF & to develop O&M plans. 4. Paint nudges on the latrine/toilet blocks in the HCFs to reinforce messages. 5. Organise sessions on WASH during Clinic days e.g., Antenatal clinics, and HIV/AIDS, TB Clinics and Immunization days. 6. Organise S&H campaigns and competitions between HCFs and reward winners. 7. Participate in national Campaign days such as the National Cleaning Days by MoH and the Global handwashing Day (GHWD). 8. Hold radio talk shows targeting HCFs (HCF staff and patients).
BCC ACTION PLAN FOR MARKETS & CHURCHES						
Lack of access to water services in the markets. Inadequate sanitary & handwashing facilities in the markets and at churches.	Market vendors Caretakers / cleaners of toilets in markets Tenderers Members of market Management Committees	Knowing that poor WASH conditions and improper cleaning of toilets/latrines in the markets and/or churches is a source of infection for both market vendors and customers who visit such places.	Associating clean markets and churches with purity, freshness, attractiveness and comfort, especially that markets not only sell fresh food stuffs for cooking but also have small restaurants that sell cooked and ready to	Provision of adequate sex-segregated sanitary facilities to markets and churches with washrooms and incinerators for managing used menstrual pads. Provision of adequate hand washing facilities at strategic locations inside the	Toilets/latrines in the markets and at churches are kept clean at all times. Vendors and visitors to markets alike use public	1. Develop and/or adopt existing SBC materials on WASH for public spaces such as markets and churches (including on MHM). 2. Training of members of the market management committees (and/or private sector) on SBC and the targeted behaviours, for effective S&H promotion in markets.

Poor O&M of the few existing latrines/toilets. Low practice of handwashing with water and soap. Poor MHM practices in Market toilets.			eat food to customers.	markets and closer to latrine/toilet facilities. Motivated attendants are trained on O&M of public toilets/latrines and given adequate cleaning equipment including Personal Protective Equipment (PPE).	latrines/toilets correctly. Vendors and visitors to markets alike regularly wash their hands with soap and water after using the toilets.	3. Train Toilet/latrine attendants on proper O&M of public toilets. 4. Paint nudges on the latrine/toilet blocks in the markets and churches, to reinforce messages. 5. Organise Folk Group performances in the markets and at churches. 6. Conduct radio talks-shows targeting market vendors and churches/ Christians. 7. Hold Barazas targeting markets, together with local leaders.

6.0 CHANNELS OF COMMUNICATION

There will be a need for BCC to have multiple, mutually reinforcing communication channels in order to optimize change. These will include three (3) basic channels: interpersonal (e.g., use of VHTs/Sanitation Promoters/Sales Agents), mid-media (e.g., Community dialogues) and mass media (radio programmes and ads). A summary is shown Figure 2 below.

Figure 2: Three Basic Channel Types



Audiences will have to be carefully segmented (E.g., HHs, Schools, HCFs, Markets), messages and materials pre-tested, and mass media (including radio), interpersonal channels (such as dialogues or Barazas) and community mobilisation are used to achieve defined behavioral objectives.

The greatest impact will be achieved by combining communication channels and using reinforcing messages, repeating messages, and using common creative elements among channels to help facilitate change. To note, therefore, is that the three basic channels support and reinforce each other.

Mid-media are community-based activities and include community dialogues or Barazas as well as entertaining activities (e.g., local drama) that also educate and reach large (more then 20-30) groups of people at one time. These activities will have audience participation or question time. Often there are diverse audiences participating and the activity can be repeated in many different locations.

Some of the factors to consider when selecting a communication channel include:

- **desired reach**: if the S4M programme desires to reach all the five (5) towns at once, it may consider use of mass media as one of the channels. Note that the social practices assessment established that radio was the most frequently used source of information on WASH (30.2%), with over 61.7% of the HHs in Anaka's cluster of towns listening to radio.
- **listenership or preferences of intended audiences**: in terms of listenership to radio, it was established that Mega FM (42%), Rupiny (34.7%) and Voice of Nwoya FM (31.8) were the most listened to radios. It was also noted that these radios appeal to different audiences as Favour FM was said to appeal to Born Again Christians;

Rupiny, is listened to majorly by young people; Mega FM appeals to older people; while Voice of Nwoya is listened to by everyone.

- **Literacy level**s – with 62.7% of residents in the Anaka cluster of towns being of primary school level rules out use of print media and mobile/social media technologies.
- **Budget availability**: including funding for development of the products, production costs, duplication and airing as well as resources for production and distribution of the communication products and materials.

7.0 MONITORING AND EVALUATION

As indicated earlier, the BCC training and action plan will enable the S4M programme to achieve outputs as specified in the software measures indictor framework including Module objective indicators 2&3 and related output indicators 2.1 and 2.2. Therefore, these indicators will guide monitoring. The programme will focus on learning and adapting with the goal of capturing program progress, results, and impact in line with the output and outcome indicators. The GIZ S4M team and partners will collect data that is useful for program adaptation; and contributes to global knowledge on behavior change for the WASH sub-sector. Based on the selected behaviors, other customized indicators could also include: % of women/girls who were able to wash and/or change their menstrual materials when they wanted to while at (home/school/market); and % of people (sex disaggregated) who report disposing their child's feces into a latrine.

8.0 CONCLUSION:

As seen from the sub-sections above, effective BCC starts with understanding of the behavioral determinants (beliefs, taboos, implicit social norms) that constrain or enable change. The evidence from the social practices assessment was used to draft this BCC training and action plan; the plan recognizes the need for multi-faceted interventions to achieve behavior change. The Elephant-Rider-Path (ERP) model is a powerful tool for BCC campaigns and messages.

It is anticipated that this BCC approach (training and action plan) will support the WASH sector and partners to address the bad behaviours and practices that were identified during the social assessment in the households, institutions (schools and HCFs) and in the public spaces (such as markets and religious centres). It is recommended that a mix of communication channels is considered to be able to reach out to different audiences. Additionally, the GIZ S4M team and partners will benefit from a specific and detailed tailor-made SBC training in order to facilitate implementation of this BCC action plan.

To note is that although social behaviour change approach is widely used, there is need for interventions that address the environmental (i.e., physical or structural) barriers to support correct, consistent use of the desired behaviors. For example, households cannot empty their overflowing latrines or septic tanks without sufficient access to desludging services. Thus, communication-only approaches (IEC, BCC, and SBC) should not be used in WASH programming.