Winrock International's Behavior Change Communication (BCC) Strategy for the Ghana WASH Project

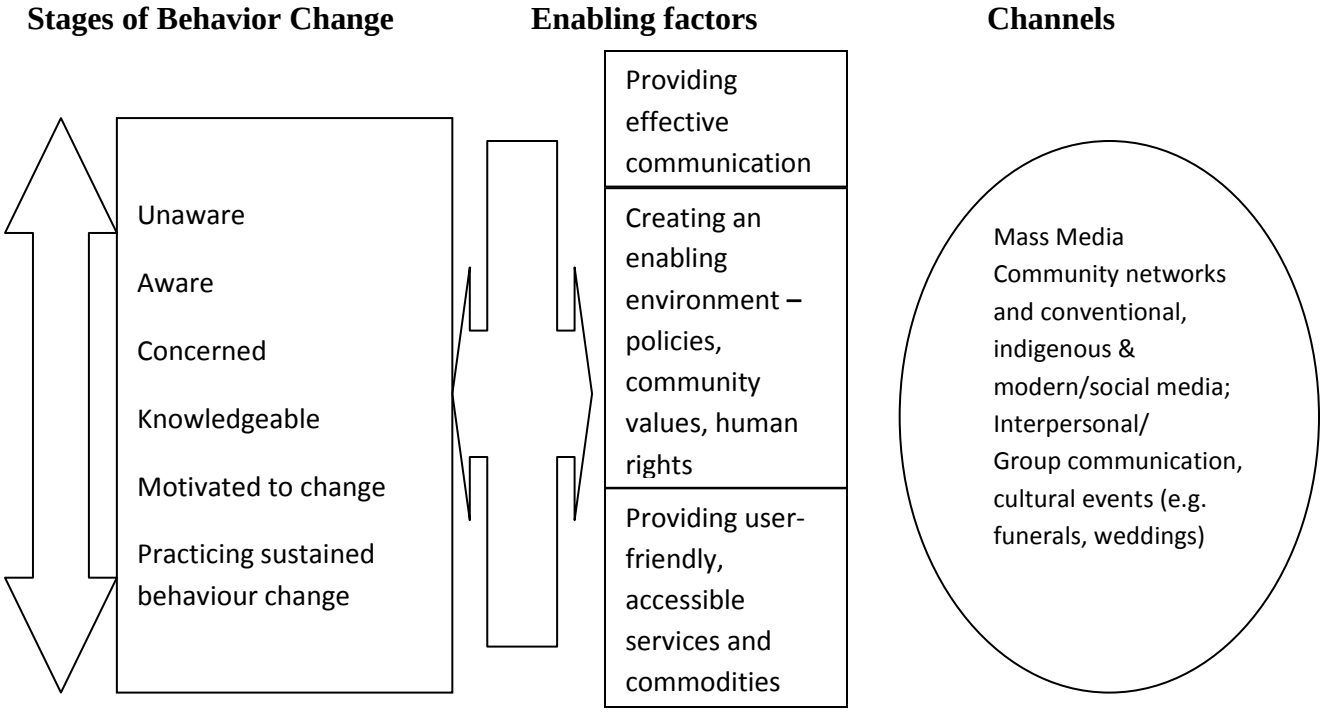
Background

Water, Sanitation and Hygiene (WASH) are powerful drivers of human development, as they affect quality of life through improved health and rising wealth. Behavior change interventions are crucial to not only improving hygienic health, but also generating multiplier social impacts. Awareness is growing amongst public health practitioners that until hygiene is properly practiced both at home and in the community as a whole, the desired impact of improved water and sanitation service in terms of community health benefits cannot be realized. In line with this approach, Winrock International (WI), through Relief International (RI) under the G-WASH project, is promoting hygienic behaviors in schools, communities, and clinics.

Behavior Change Communication Methodology

Behavior-change methodologies applied in health-related areas show a strategic departure from the old methods of simply providing knowledge, i.e. 'telling' people what to do, to emphasizing that the knowledge gained is put into practice. To ensure this, one needs to listen, understand, and then negotiate with individuals and communities for positive behaviors to become a part of the way people live. A popular framework based on the combination of the theories/models used by BCC practitioners is presented in the figure below.

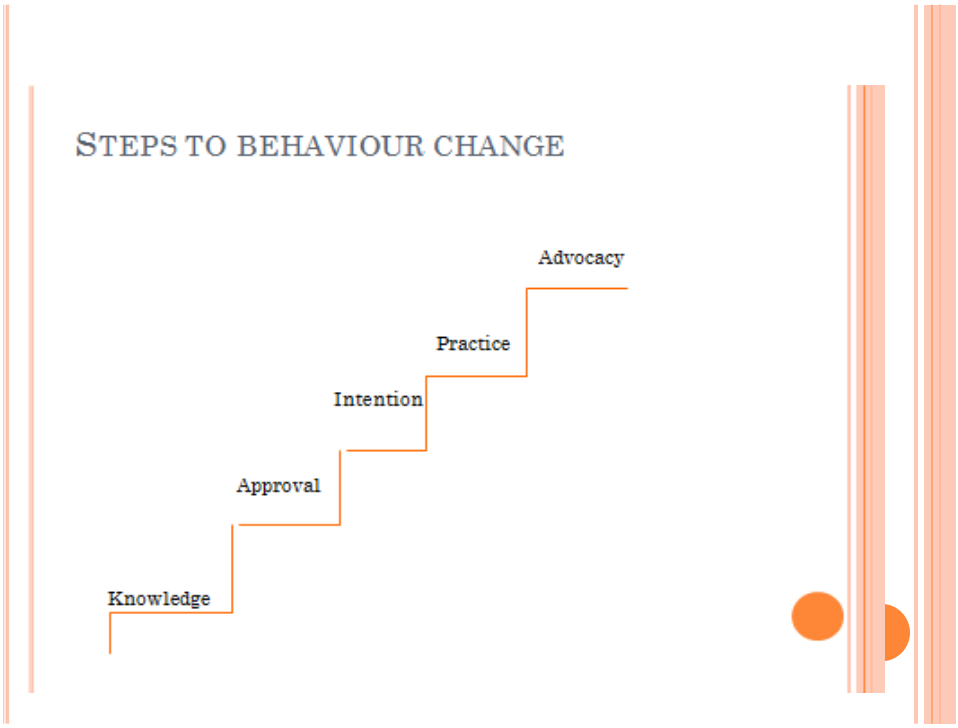
Figure 1: Framework for BCC Design



When changing behavior, the individual or the target community goes through a series of steps (as indicated in the stages of behavior change in the figure above) — sometimes moving forward, sometimes moving backward and sometimes skipping steps. Even when individuals or communities adopt new behaviors, there may be times when individuals or communities revert to old behaviors, at least under certain circumstances such as fear of the unknown, ignorance, poverty, lack of facilities, comfort with the current situations in which they find themselves, superstition, apathy, and illiteracy.

Understanding where the majority of a group is in the change process is crucial in designing this BCC strategy. Strategies to enable behavior change are based on a comprehensive understanding of issues: how people think and behave; that different people think and act differently; resources people have or don't have could be a hindrance to adoption of hygienic behaviors; constraints and limitations encountered in adopting new behavior; the reasons people may resist change – and of course, the ways and means through which people are most influenced or motivated to change existing behavior practices. The figure below shows the various steps that one has to go through for complete behavior change.

Figure 2: Steps to Behavior Change



To promote healthy behaviors it is necessary to reflect on the causes of the existing behaviors, who the targets are, and how or through which means can they be targeted for a positive change. To address this depends largely on which unhealthy behavior exists.

Behavior Change Communication Framework

To ensure sustained access to and use of services, behavior change becomes a central core guiding framework and not a peripheral add-on. It is important to note that this guiding framework will be applied to develop site-, location- and agency- or partner-specific interventions to be promoted and implemented at various levels, i.e. individual, household, school, community, and district.

Indirect communication is a powerful strategy in changing behavior. When safe sanitation practices are provided and positive behaviors demonstrated at strategic locations in the community—such as clinics—and popularized by key change agents—such as teachers, community volunteers, religious or community leaders or individuals of importance in the community—the value of the message is better accepted. Similarly, when safe sanitation is provided and positive behaviors encouraged and motivated in schools, children become effective change agents. Similarly, private companies selling and promoting soap and other sanitation services and goods enable change in ways that reach out to a wide audience.

In summary, behavior change is best achieved when the messages promoted:

- relate to people's beliefs, perceptions and practices;
- are communicated through multiple and popular information channels and networks;
- are practiced and popularized by potential change agents in the community; and
- are feasible to adopt according to available infrastructure and services.

Multiple mechanisms and agents lead to message reinforcement and incremental adoption and demand for safe sanitation and positive behaviors. Supported by appropriate infrastructure, WI's BCC approach will adopt a multi-pronged approach to incrementally improve access to, use of and demand for safe sanitation and adoption of positive behaviors.

Development of G-WASH BCC Strategy

Development of the BCC strategy began with a situational and behavioral analysis of health practices in relation to water sanitation and hygiene behaviors. The analysis, which was accomplished through baseline survey, community profiling analysis, consultative discussion and meetings, field visits, and review of existing literature, took place in 35 communities in 5 regions of the G-Wash project. It provided information on the current status of access to water and sanitation, hygiene behaviors and practices, school hygiene and sanitation as well as socio-economic characteristics that influence the water, sanitation and hygiene of target populations in

Western, Central, Volta, Greater Accra and Eastern Regions of Ghana. Information from the baseline and community profiles assisted in identification of the risky undesirable hygiene and sanitation practices in the project catchment areas. The baseline information and community profiling also provided information on current communities' capacities to manage water and sanitation infrastructure at the community level, as well as socio-cultural beliefs, norms and practices that affect communities' access to water and sanitation. Following the administration of the baseline survey, the G-WASH project began working closely with District Steering Teams to provide additional technical advice on the project. See Annex 1 for baseline report and recommendations.

Developed through a consultative and participatory process, the G-WASH Project BCC strategy is intended to guide the execution of all communication efforts on the project's operational areas: in community mobilization, community and government advocacy, interpersonal communication, media advocacy, and capacity building. The G-WASH BCC conceptual framework focuses on influencing different audiences through multiple interventions to facilitate community and individual health behavior change, with capacity building as a cross-cutting component.

The key areas of high risk behaviors to be targeted by the G-Wash project are:

- Open defecation practice both by adults and children
- Hand washing without soap/cleansing agent
- Water contamination through unhygienic water collection, transportation and storage practices
- Poor disposal of household solid and liquid waste
- Use of untreated water for household and domestic purposes
- Weak capacity to manage and repair water and sanitation facilities at the community level for sustainability

In order to move from current undesirable behaviors to ideal or desired behaviors, the project must overcome several barriers and engage a broad number of stakeholders. Among the barriers are: difficulty scheduling meetings around communities' schedules, unavailability of facilities, lack of education surrounding the importance of good hygiene practices, fear of the unknown, financial constraints, beliefs, customs, and traditions, forgetfulness, and the unavailability of space to construct hardware facilities. To ensure project sustainability, the G-WASH BCC strategy includes working closely with key stakeholders such as the Metropolitan and District Assemblies/Metropolitan and District Water and Sanitation Teams (DWSTs), Community Water and Sanitation Agency (CWSA), Ghana Health Services, Ghana Education Services, Water and Sanitation Committees, Water and Sanitation Development Boards, Unit Committees, Assembly members, chiefs and opinion leaders, religious leaders, and private operators including other local and international non-governmental organizations.

Below is a summary of the steps to be taken in the BCC strategy.

1. Community selection and entry

The G-WASH program targets rural communities, primary schools, and clinics. These schools, clinics, and communities were identified based on past and planned water and sanitation interventions, prevalence of water and sanitation related diseases, potential for successful and sustainable implementation through: (a) consultation with CWSA, Ghana Water Company Limited (GWCL), and District Assemblies (DAs); (b) consultation with other donors and organizations working in water and sanitation in the target regions, including Danish International Development Agency (DANIDA), UNICEF, and international NGOs; (c) USAID's current and planned health and education programming; (d) innovative program development; and (e) potential for engagement with local stakeholders. BCC activities will be carried out in communities in which water and sanitation provision has proved possible.

2. Community Mobilization & Training

BCC activity at the community level is led by LNGOs. Community opinion leaders such as chiefs, queen mothers, religious leaders and Assembly members are involved in all community activities. Audience segmentation at the community level is one key strategy for engagement in all community activities. Through a sectional planning approach, communities are divided and engaged to work in sections based on existing divisions in the community. Community members are grouped into men, women and children to ensure effective participation. Other identified social and religious groups play key roles in community mobilization.

BCC messages and trainings are developed for different segments of the local communities and take into account use of local languages, cultural sensitivities, gender and the stages of behavior change the intended audience is in and the role that they are expected to play. The design of a BCC message is different for different intended audiences. The message seek to be informational, persuasive, encouraging, educational, gender sensitive, action oriented, etc. (See Annex 2 for list of stakeholders and their expected roles within the BCC strategy.)

3. BCC Activities

Building on this basic knowledge and reflecting on the specific challenges and opportunities in Ghana, Winrock's strategy focuses on influencing the planning and implementation of water and sanitation services and ensuring sustained access to and use of available services and infrastructure. WI employs a systematic approach for understanding behaviors and their context, developing comprehensive behavior change strategies using participatory methodologies such as BCC messaging, role plays, and drama to create awareness on the water and sanitation and hygienic issues, and then converting those strategies into specific program activities that can be monitored, adjusted and evaluated over time. The BCC component of the Ghana WASH project

focuses on identifying, facilitating and encouraging the most critical health-promoting behaviors in a specific context. It uses behaviors as the lens not just to ensure use of and demand for improved services, but also to plan and design infrastructure and services in collaboration with its implementing partners, RI, ADRA and LNGOs. Finally, WI's BCC approach calls for coordinated and consistent interventions at various levels, from an individual's behavior, to practices at the household, school, community and agency levels. Promoting key behaviors through messages targeted towards specific target groups reinforces communication across groups, which is particularly important in influencing change. These coordinated interventions are essential to maximize immediate health impacts and achieve long term social development outcomes.

Winrock has designed a comprehensive package of activities for target groups to motivate families and communities to demand, access, use and sustain available water and sanitation services.

WatSan Committees – WatSan Committees are key to the sustainability of the G-WASH project. The LNGO will train the committee in the overall purpose of the project, on the importance of good hygiene and sanitation, development of behavior change messages, good practices, etc. Additionally, for those communities receiving water and latrines, the committee will be trained in maintenance of systems. If a WatSan committee does not exist, the LNGO will work with community chiefs and other natural leaders to establish one. WatSan committees will receive bi- monthly support from LNGOs and BCC agents.

District Activities - G-WASH will continue to liaise with District Assemblies, District Steering Teams, District Water and Sanitation Teams, Environmental Health Officers, and local health clinics to promote a united approach to Water and Sanitation, Behavior Change, and Community Led Total Sanitation in project communities. District officials will meet with the BCC team and LNGOs on a quarterly basis, and play an active role in the G-WASH project in all communities.

CLTS – WI's new focus in Year 3 of the G-WASH project will be on Community Led Total Sanitation (CLTS) and School Led Total Sanitation (SLTS). Integral to the strategy will be the identification of specific change agents within communities, with support from CLTS Specialists, traditional leaders and opinion leaders, to stimulate and motivate total sanitation coverage and practice for the community. The CLTS and SLTS approach promotes self-investment in sanitation services as the need for improved services is built through demand, brought about by adoption and practice of improved sanitation and hygiene behavior.

SHEP/CLTS – Our principal method to reach children is through the SHEP program. BCC specialists will train teachers in all communities in School-Led Total Sanitation, basic hygiene, sanitation, and maintenance of latrines. The training will also include training on interactive and child centered teaching approaches. The SHEP teacher training will take place over 3 days and

will be monitored over the life the project. The teachers will be given a set of activities that they are expected to conduct with child health clubs on a monthly basis. Activities will include organization of health awareness days in the community, development of posters, drama presentations to the community on health issues, and community clean-up campaigns.

Development of Behavior Change Messages – Behavior change communication messages are targeted at specific audiences aimed at affecting a change in their behavior(s) or to have them maintain their current positive behavior(s). LNGOs will work with community Water and Sanitation Committees to develop behavior change messages focusing on mothers or principal caregivers of young children as the primary G-WASH audience, with secondary targets being husbands, friends/peers/relatives, and other community members. See Annex 3 for a detailed analysis of risky behaviors identified and targeted ideal behaviors.

Winrock BCC Strategic Plan – July to December 2011[1]

ACTIVITY	TIMEFRAME (July 1, 2011 – December 31, 2011)						RESPONSIBLE PERSON	Expected Outcomes / Outputs
	Jul	Aug	Sep	Oct	Nov	Dec		
Receive list of communities, schools and clinics from RI							BCC Specialist	List of target communities, schools and clinics available to BCC Team
Validate list with the District Assemblies (GES, MOH,CWSA In the focus areas)							BCC Agents	List of target communities, schools and clinics confirmed by DA, GES, MOH, CWSA, etc.
Introduce BCC Team Members and LNGO staff to communities, Schools and clinics							BCC Agents	Cordial working relationship between BCC team and beneficiaries
Meet with Community Leaders (Chiefs) in newly added communities							BCC Agents & LNGO Field staff	Date agreed upon for community meeting
Organize community meetings to introduce project to members of newly added communities							Field Officers and BCC Agents	Overview of G-WASH Project explained to community members
Identify Key Stakeholders in new target areas							Field Officers and BCC Agents	Stakeholders in the project areas known
Develop rules and procedures with Stakeholders participating in the programme							COP, BCC Specialist, BCC Agents	Roles of partners outlined
Organize and hold quarterly meeting with DSTs							BCC Agent	Challenges, lessons and success shared
Conduct gender training for partner LNGOs							BCC Team	Knowledge and skills of LNGOs staff enhanced to mainstream gender into BCC activities
Conduct capacity needs assessment of LNGOs to determine strengths and weaknesses							Field Coord. & BCC Specialist	General strengths and weaknesses of LNGOs identified and documented
Follow-up internalization of project objectives by new LNGOs							BCC Specialist	LNGOs implementing activities according to project design and strategy

[1] Strategic Plan to be reevaluated mid-FY 2012

Follow-up internalization of effective communication strategy covered during training							BCC Specialist & BCC Agent	LNGOs delivering (using) effective communication for G-WASH BCC
Organize and conduct training for new LNGOs on leadership, advocacy and civic engagement							BCC Specialist & BCC Agent	LNGO staff acquire the needed skills and knowledge on leadership, advocacy and civic engagement to implement BCC activities
Follow-up internalization of advocacy, leadership concepts covered and ensure that the LNGOs designs and implement an advocacy strategy.							BCC Specialist & BCC Agent	LNGOs have designed and are implementing project activities according to leadership and advocacy concepts with proper civic engagement
Meet M/DWST to identify support needs.							BCC Specialist and BCC Agents	Support needs for M/DWST known and documented
Agree with M/DWST on the mode of support to District Assemblies							BCC Specialist and BCC Agents	
Facilitate support to District Assemblies							BCC Specialist and BCC Agents	M/DWSTs given the needed support to enable them support field activities
Meet with EHAs to identify support needs to EHAs							BCC Agents	Support needs for EHAs known and documented
Agree with EHAs on the mode of support							BCC Agents	
Facilitate support to EHAs							COP & BCC Specialist	EHAs given the needed support to enable them support BCC activities
Sensitize communities to assist in identifying potential WatSan entrepreneurs							BCC Agents & LNGOs	Community members are able to assist in identification of watsan entrepreneurs
Assess training needs of potential WatSan entrepreneurs							BCC Agents & LNGOs	Strengths and weaknesses of potential watsan entrepreneurs known and documented
Review existing training materials							BCC Specialist and Field Co-ord.	Existing training materials reviewed and available for use
Organize training on business management skills and proposal writing							LNGOs and BCC Agents	Selected watsan entrepreneurs able to write proposals and managing their businesses effectively
Conduct community profile analysis using participatory methods such as community mapping, transect walks, institutional analysis							BCC Specialist, BCC Agents and LNGOs	Existing WASH situation in project target communities known and documented.

Hold a community forum to discuss findings and develop community action plans based on the profile analysis.							BCC Specialist, BCC Agents and LNGOs	All project beneficiary communities have developed action plans to improve upon existing watsan situation
Utilize results of community profile analysis to sensitize community around water, sanitation, and hygiene issues							BCC Specialist, BCC Agents and LNGOs	Water, sanitation and hygiene situation in communities improve
Organize and conduct experience sharing workshops at district level for all stakeholders							BCC Agents and LNGOs	Lessons, challenges and success shared among stakeholders
Sensitize communities on WatSan committee formation and roles and responsibilities of WatSans							Field Officer & LNGOs	Communities know the responsibilities of a watsanc and qualities of people to select
Facilitate / Assist the formation of new watsancs and review of old/existing watsancs							BCC Agents & LNGOs	Membership of existing watsancs reviewed and new ones formed
Facilitate the conduct training needs assessment for both new and existing WatsanCs							BCC Agents & LNGOs	Strengths and weaknesses of various watsancs known and documented
Follow-up internalization of effective communication strategy covered during training (for WatSan Committees)							BCC Agents & LNGOs	WatSanCs effectively leading watsan activities in their respective communities
Follow-up internalization of advocacy, leadership concepts covered and ensure that the LNGOs designs and implements an advocacy strategy.							BCC Agents & LNGOs	
Organize and run training programs for LNGOs on user fees collection and financial management							BCC Agents & LNGOs	Capacity of LNGO staff enhanced to supervise and monitor facility user fees collection and finance management
Monitor to ensure facility user fees and finance management principles are followed.							BCC Agents & LNGOs	Facility user fee collection and finance management practices documented
Train LNGOs, DA staff (DST members) and Project Staff on CLTS approach							BCC Specialist, BCC Agents	LNGO staff, DA staff (DST members) and Project Staff acquire the necessary skills on CLTS approach
Provide technical support for LNGOs, Project Staff and DA staff to implement CLTS in their respective Districts and Regions							BCC Specialist, BCC Agents	LNGOs and DAs promoting behavior change in communities using the CLTS approach

Support regions and districts to carry out post-triggering activities (follow-up) in communities							BCC Specialist, BCC Agents	LNGOs and DAs promoting behavior change in communities using the CLTS approach
Network with other institutions who are working in BCC in these communities' schools and clinics in targeted communities							LNGOs and BCC Agents	Institutions working in project schools and clinics and their activities identified and areas of collaboration agreed upon.
Conduct needs assessment on hygiene promotion for schools and clinics							BCC Specialist, BCC Agents & LNGOs	Knowledge and skills gaps for hygiene promotion identified
Develop plans based on identified needs							BCC Agents & LNGOs	All schools and clinics have hygiene promotion and facility management plans
Follow-up to assess if hygiene promotion activities are undertaken							BCC Agents	All schools and clinics implementing action plans
Train district level stakeholders on SHEP							BCC Specialist and BCC Agents	Enhanced knowledge and skills of stakeholders on SHEP
Monitor the implementation of developed action plans in schools							BCC Specialist and BCC Agents	Adoption and practice of healthy behaviors
Meeting with stakeholders and health teams to review materials							BCC Specialist, BCC Agents and LNGOs	Reviewed materials available
Develop, package and print BCC materials (and messages) for use by LNGOs for hygiene promotion in communities							BCC Specialist, BCC Agents	BCC materials available for distribution to LNGOs and DAs
Organize ToT for LNGO and DA staff on the use of BCC materials to promote behavior change							BCC Specialist, BCC Agents	LNGO staff and DA staff (DST members) acquire the needed skills to train health promoters on the use of BCC materials
Support LNGO staff to train hygiene promoters (behavior change groups) and conduct hygiene promotion using BCC materials and participatory approaches							BCC Specialist, BCC Agents	LNGOs using agreed BCC materials and participatory approaches to promote hygiene in communities
Identify Behavior Change groups in the target communities.							BCC Agents & LNGOs	Behavior change groups in target communities known and documented
Train groups on behavior change message delivery and use of participatory methods							BCC Agents & LNGOs	Community based behavior change groups acquire the relevant skills and knowledge
Organize reflection meetings with community groups							BCC Agents & LNGOs	Community groups exchange lessons and best

Conduct refresher training for Community Groups							BCC Agents & LNGOs	practices
Organize review meetings at community level							BCC Agents & LNGOs	Challenges, lessons, best practices discussed to ensure sustainability
Conduct community visits to monitor progress							M&E and BCC Agents	Changes in behaviors related to water, sanitation and hygiene documented.

Annex 1: Baseline Findings and Recommendations

As described above, existing WASH behavior, access, and capacity in Western, Central, Volta, Greater Accra and Eastern Regions of Ghana were determined through baseline survey, community profiling analysis, consultative discussion and meetings, field visits, and review of existing literature. The main findings are outlined below.

Existing WASH Behaviors and Practices Identified in the Project Areas

Findings on access to water

The baseline analysis showed that only 32% of people have access to potable water year-round. Of those without year-round access, 52% have access to potable water only for 3 months of the year. Access to water is hindered by frequent interruptions in water supply resulting from breakdown of water facilities; drying up of boreholes and hand-dug wells towards the dry season; a lack of access to potable water sources; and/or the lack of technical expertise at the community level to identify and repair water facilities. Apart from households with direct connection to pipe systems (21%), all other households carry water from the source using open pans, buckets, or jerry cans.

The level of water contamination during transportation was said to have decreased as a result of public education on safe water transportation between the source and the house. However, the practice placing leaves in open pans to prevent the water from spilling during transportation is still practiced. About 97.5% of households stored drinking water in multiple containers, including plastic and metal drums (71%), earthen-ware pots (24%), jerry cans (23%) and buckets (15%). About three quarters (73.5%) of households appropriately covered water meant for drinking.

Most households (82%) in the project districts did not practice water treatment. In some cases, water from streams, rivers and dams is perceived to be natural and therefore safe for drinking without treatment. The 18% that did treat water before drinking did so by boiling or using decantation, filtration, and/or chlorination.

The “pay-as-you-fetch” system was the most dominant (95%) water fee collection system, while payments of levies by adult individuals accounted for the other 5%. Household expenditure on water and sanitation constitute only 5% of households’ estimated monthly expenditure.

Women performed close to 95% of the tasks associated with ensuring that water is available in the right quantities for the entire household. Women are traditionally responsible for sweeping, scrubbing, raising platforms and draining stagnant water, among other activities, to ensure that the water collection point is clean. Women are also now playing new roles as water fee collectors, as they have been found to be more responsible handling money than men. Men’s

traditional gender roles were limited to digging of pits for wells. There is, however, increased recognition by men and women of the need for balancing gender roles at home to reduce the burden on women and girls.

Access to Water in Institutions

Only about 36% of schools in the study area had water storage facilities. Facilities used for water storage include rain water harvesting systems, poly tanks and plastic containers of varying sizes. None of the schools had access to improved water facilities. Most schools in the urban areas relied on water tanker services for water (for drinking and other uses).

Access to Improved Sanitation and Hygiene Practices

Access to improved sanitation was found to be generally low (about 21%). Although the survey showed 26% of respondents using no type of sanitation facilities, this was most prevalent in the Central Region (66.7%). About 41% of respondents used public-owned shared toilets, and 12% shared household-owned toilets. The survey revealed that only 41.2% of households properly disposed of children's waste. Some 49% disposed of it into the bush, 17% in refuse dumps, while 3% left was not disposed of.

Few households had physically challenged members at the time of the survey. About 45% of households with physically challenged relatives did not use any sanitation facilities, 17% used traditional pit latrines, 14% chamber pots, and 9% household toilets. Walking long distances and the lack of physical support to access public shared latrines were the main causes mentioned as limiting access for the physically challenged.

Knowledge of appropriate hand washing techniques was found to be satisfactory. However, only about 53% of people interviewed demonstrated good hand washing behavior. 34.8% of households with children under 5 reported their children experienced diarrhea in the two weeks preceding the survey. Only 20% of all 600 households interviewed were found to have good knowledge of the causes and prevention of diseases such as malaria, diarrhea, cholera, bilharzia, typhoid fever and Guinea worm.

Key findings from the community profiling were the indiscriminate dumping of refuse and improper handling of household liquids. For instance, a general observation was lack of good drainage systems to collect running water from the bathhouses. Women complained of low walls for bath houses, which do not provide adequate privacy.

The survey indicated that 12 (36%) of the schools visited did not have any toilet facilities. When they needed to use the facilities, students in these schools either went back home or did so in the open. The average pupil squat-hole ratio was 67:1 for boys and 64:1 for girls, exceeding the Community Water and Sanitation Agency (CWSA) permissible ratio of 50:1 for both boys and girls. None of

the schools had changing rooms for girls. The survey revealed that 33% of the schools visited had School Health Education Program (SHEP) Coordinators and offered hygiene and sanitation-related education. Topics taught include: latrine use and maintenance; safe drinking water; water storage; hand washing behaviors and practices; personal hygiene and its related water issues; environmental cleanliness, water-borne and excreta-related diseases; and HIV/AIDS.

Institutional arrangement for managing water and sanitation facilities existed but they are not fully resourced or functional. Their functions have been reduced to the collection of user fees at the community level, without the capacity to perform other crucial functions required of water and sanitation management.

The use of mass media such as radio, TVs and posters was found to be an acceptable means of information dissemination at the community level. The target population had also indicated preference for the use of Government Information Service Department's communication strategy as a means of information dissemination.

Private players in water delivery were found to be water tankers, water vendors and domestic vendors who transported water from mostly unimproved sources to the underserved population. The people of Teshie, Manhean, Nsakina, Kpobiman and Abensu depend heavily on the private sector for their water service delivery.

Some customary laws were found to affect positively and negatively access to water at the community level. Customary laws such as "no washing near a stream, river and dam" positively protected water sources. Others such as "women who are menstruating are not allowed to go close to natural water sources" limited some households' access to water since women are the primary collectors.

Recommendations

1. The project should facilitate access to water using sustainable (all-year round) water facilities for communities, schools and clinics.

2. Even though access to sanitation facilities is low, the project should work on incremental access by encouraging those with access to shared latrines to graduate to obtaining sanitation facilities that will meet the WHO definition of improved sanitation facilities. This can be done with the promotion of latrines which come at a minimal cost and meet the WHO standard.

3. The project should create behavior change messages to directly address some of the key weaknesses in behavior/practice around hand-washing and water treatment identified during the survey.

4. Lack of effective operation and maintenance regimes at the community level was found to hinder access to improved water facilities and as well sanitation facilities. The project should institute business-oriented operation and maintenance structures at the community level to ensure rapid response to communities that need repair services.

5. It is important to mainstream disability issues in WASH program implementation. People with disability need specific design adaptations for sanitation facilities, hand washing and water access. There is the need for PWDs to use facilities which include features such as rails for maximum support.

6. The provision of sanitation facilities for schools should take into account the CWSA pupil squat-hole requirement to reduce the waiting time for pupils to use sanitation facilities at the school level. Ghana WASH-promoted school sanitation facilities should make structural arrangement for changing rooms for girls to address their needs at the school level.

7. It is necessary to build the capacity of teachers to provide hygiene education as part of the regular school curriculum. Positive hygiene behaviors, including correct use and maintenance of facilities, should be systematically promoted among staff and schoolchildren. It is crucial to develop a training program that targets children (school-going age) and run workshops to impart water and sanitation knowledge and practice.

8. It is important that correct use and maintenance of water and sanitation facilities is ensured through sustained hygiene promotion. Health promotion interventions should be consistent with active participation of the targeted communities. In addition, Health Education & Communication (HE&C) materials should be carefully selected for size, pictorial accuracy, durability, portability, simplicity and subject specificity. Materials should be well-designed and pre-tested.

9. Women as the primary collectors of water should be given special roles in the management of water facilities in their communities. Community participation through the bottom-up approach should be encouraged and existing women's groups like religious, trade and professional associations should be involved to enable them discuss how to use water with care.

10. Communities should lead the change process and use their own capacities to obtain their objectives. Successful implementation of WatSan projects requires community commitment. Communities should participate in project identification, implementation, and evaluation to ensure project sustainability. This should take account of the needs of diverse community members including vulnerable groups, people with disabilities, women and girls.

11. It is important to build local capacities to enable sustainability. This should include the training of community facilitators and the private sector, including local artisans. There is also the need to encourage local focal persons for community-led programs.

Annex 2: Stakeholder Identification and Analysis

Name of stakeholder	Role expected to play
Communities	• Adopt and practice ideal behaviours • Contribute to massage development
Traditional rulers	• Create the enabling environment for the adoptions of desirable behaviours • Encourage & support the Watsan Committees in the implementation of community Action Plans • Ensure the enactment & enforcement of rules and regulations(sanctions)
Religious Groups/Faith Based Organizations	• Assist in the dissemination of massages on hygienic practices and behaviours
District Water & Sanitation Teams	• Advice & assist in the implementation of the BCC activities • Monitor the implementation of BCC activities • Report on BCC activities in the municipality/ district
Municipal, Metropolitan & District Assemblies	• Support with resources in the implementation of BCC activities
Community Water and Sanitation Agency	• Provide guidance and technical support on the BCC activity implementation
Water and Sanitation Committees	• Facilitate the development & implementation of community action plans for improved hygiene behaviour and practices • Development & dissemination of BCC messages on hygiene behaviours • Monitor the functionality and repair of the facility • Encourage the adoption and practice of desirable hygiene behaviours • Monitor the adoption and practices of household hygiene behaviours
Unit Committees	• Create the enabling environment for the adoptions of desirable behaviours • Encourage & support the Watsan Committees in the implementation of community Action Plans • Ensure the enactment & enforcement of rules and regulations (sanctions)
LNGOs /CBOs	• Ensure that community structures are in place and functioning (through training & coaching) • Help/support in the dissemination of BCC messages at the community level • Undertake community mobilization & sensitization at the community
International Non-Governmental organizations	• Facilitate experience sharing among partners • Provide funding for workshops • Build capacity of project staff and other partners • Monitoring of BCC activities and results
Ghana Education Service	• Provide frame work for BCC activities in schools (SHEP) • Support implementation of SHEP activities • Coordinate and monitor SHEP activities
Community Health Volunteers/Community Health Personnel	• Support Dissemination in the BCC Messages

	• Support in implementation & monitoring of Behaviours
Ghana Health Services	• Support dissemination of BCC messages through community outreach • Monitor the adoption and impact of desired hygiene behaviors
Department of Community Development	• Support development & dissemination of BCC messages through community mobilization and animation • Support implementation of BCC activities at district and community levels
Environmental Health & Sanitation Unit	• Supervise the hygiene and sanitation promotion in project district • Support development and dissemination of BCC messages • Support and supervise capacity building of community level structures in BCC activities • Monitor and report on BCC activities in the municipality/district
Ghana Water & Sewage Company	• Provide framework and guidance for management of water service delivery in urban areas
Ministry of Water Resources Works and Housing	• Provide guidance and technical support
Ministry of Local Government and Rural Development	• Provide guidance and technical support • Knowledge management (through documentation, learning and experience sharing)
CLTS Natural Leaders	• Encourage the achievement of ODF status by communities • Support scaling up of CLTS in neighboring communities • Monitor and report the progress of communities towards achievement of ODF and other improved behaviors
Community Water and Sanitation Agency (CWSA)	• Provide guidance and technical support • Knowledge management (through documentation, learning and experience sharing)

Annex 3: Behavior Analysis

		Audience Analysis			
Risky Behaviours Identified	**Ideal Behaviors**	**Primary targeted Audience**	**Secondary targeted Audience**		
			For immediate support	**Social mobilization**	**For Advocacy**
Hand washing without soap or cleansing agent	Hand washing with soap at critical times	Children, women, & men	Husbands, wives, grand- mothers, mother-in-laws	Watsan committees, hygiene promoters, community health volunteers/personnel, chiefs, SHCs	Teachers, chiefs, DSTs, EHAs, M/District Assemblies, Faith based organizations/Religious leaders
Open Defecation practices	Safe disposal of both adult and children excreta	Men, women and children	Husbands, wives, grand- mothers, mother-in-laws, LNGOs, Watsan Committees,	Watsan committees, hygiene promoters, community health volunteers/personnel, chiefs, Landlords SHCs	Teachers, chiefs, DSTs, EHAs, M/District Assemblies, Faith based organizations/Religious leaders
Water contamination through unhygienic water collection, transportation and storage practices	Safe water collection, transportation, storage and use practices	Women & children	Men, women, Husbands, mother-in-laws, grandparents, Wives	Watsan committees, hygiene promoters, community health volunteers/personnel, chiefs, Landlords/landladies	Teachers, chiefs, DSTs, EHAs, M/District Assemblies, Faith based organizations/Religious leaders
Poor disposal of household water, refuse, and liquid waste	• Proper refuse disposal by households • Safe disposal of domestic waste water	Women & children	Husbands, wives, grand- mothers, mother-in-laws, house heads	LNGOs, M/DWST, watsanc, EHAs	Assembly men, Chiefs, DSTs, EHAs, M/District Assemblies, Faith based organizations/Religious leaders, LNGOs
Use of unsafe water for household and domestic purposes	• Water from unsafe sources treated before use	Children, women	Husbands, men, mother in-laws, household heads	LNGOs, M/DWST, watsanc, EHAs	Assembly men, Chiefs, DSTs, EHAs, religious leaders, Faith based organizations/Religious leaders, LNGOs
Weak capacity to manage and repair water and sanitation facilities at the community level for sustainability	Communities are able to effectively manage watsan facilities without external support	Men, youth leaders, women	Chiefs, Assembly men, religious leaders, queen mothers.	Assembly men, Chiefs, DSTs, EHAs, religious leaders, Faith based organizations/Religious leaders, LNGOs	Chiefs, queen mothers, M/DCEs, MPs