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Lao People's Democratic Republic

Sanitation Marketing in Lao PDR

Synthesis Report on Technical Assistance: Sanitation Marketing in Lao PDR (P132368) and Supporting Scaling Up Rural Sanitation Through the Community-Led Total Sanitation (P132453)

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GWASE

EAST ASIA AND PACIFIC

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List of Abbreviations

ADB	Asian Development Bank
BCC	Behavior Change Communications
CDD	Community Driven Development
CLTS	Community Led Total Sanitation
DHHP	Department of Hygiene and Health Promotion
DHMIS	Demographic Health management Information System
ESI	Economics of Sanitation Initiative
JMP	Joint Monitoring Program of WHO/UNICEF
HCD	Human Centered Design Approach
HGNDP	Health Governance and Nutrition Development Project
HHWTS	Household Water Treatment and Storage
IDA	International Development Association
IEC	Information Education and Communication
KBF	Kumban Facilitators
KAP	Knowledge Attitudes Practices
LO	Latrine Owners
LSIS	Lao Social Indicator Survey
MDG	Millennium Development Goals
MFI	Micro Finance Institution
M&E	Monitoring and Evaluation
MPWT	Ministry of Public Works and Transport
MoH	Ministry of Health
MoNRE	Ministry of National Resources and Environment
MoPI	Ministry of Planning and Investment
MoF	Ministry of Finance
Nam Saat	National Centre for Environmental Health and Water Supply
NSEDP	National Social and Economic Development Plan
OD	Open Defecators
ODF	Open Defecation Free
PRF	Poverty Reduction Fund
PSI	Population Services International
RWSS	Rural Water Supply and Sanitation
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures
SME	Small and Medium Enterprise
SMEDPO	Small and Medium Enterprise Development and Promotion Office
SNV	Netherlands Development Organization
TVET	Technical Vocational Education and Training
TWG	Technical Working Group
VIT	Village Implementation Team
WB	World Bank
WSP	Water and Sanitation Program (World Bank)
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

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Acknowledgements

This report is a synthesis of the two Technical Assistance (TA) 'Supporting Demand Creation for Rural Sanitation through the Community-Led Total Sanitation (P132453) and 'Sanitation Marketing in Lao PDR' (P132368) carried out by the World Bank's Water and Sanitation Program. These TAs have been implemented in close collaboration with the National Center for Environmental Health and Water Supply (Nam Saat) and the Department of Hygiene and Health Promotion, the Ministry of Health. The Task Team Leader for this TA is Viengsamay Vongkhamsao. The following World Bank staff have provided valuable contributions: Bounthavong Sourisak, Community Development Specialist, Viengsompasong Inthavong, Water and Sanitation Specialist, Susanna Smets, Senior Water and Sanitation Specialist, and Almud Weitz, Principal Regional Team Leader. The peer reviewers were Satoshi Ishihara, Senior Social Development Specialist, Somil Nagpal, Senior Health Specialist, and Jozef Verhagen, Senior Water and Sanitation Specialist.

Executive Summary

Background and Rationale

1. This report summarizes the results, lessons and recommendations to the Government of Lao PDR from two Technical Assistance projects (TA) "Supporting Demand Creation for Sanitation through Community Led Total Sanitation" (P132453), and "Sanitation Marketing in Lao PDR" (P132249), carried out by the World Bank's Water and Sanitation Program between October 2012 and December 2015.

2. Access to improved sanitation facilities in Lao PDR has increased considerably over recent years, from 28% in 2000 to 71% in 2015. In 2015, 94% of the urban population has access to an improved latrine, while only 56% of the rural population does. Among the rural population, stark inequalities exist across regions and among ethnic and socio-economic groups. Only 13% of the poorest quintile has access to an improved toilet, compared to 100% of the richest quintile. Poor sanitation is associated with high levels of malnutrition, especially with stunting (49% of rural children were stunted in 2011).

Objective and Outcomes

3. The development objective of the TAs was to increase improved sanitation and hygiene practices and change community behavior to achieve Open Defecation Free (ODF) status at the village level. This was achieved through three key interventions achieving below outcomes.

a) <u>Developing scalable models for demand creation through Community-Led Total Sanitation (CLTS)</u>

- Capacity building for CLTS was strengthened at all levels; a pool of 25 national CLTS master trainers was set-up and now deliver training of trainers across the country; 469 provincial and district level officials were trained in CLTS related topics.
- National CLTS capacity building packages were developed and adopted; based on operational guidelines[1], a national CLTS toolkit was issued and is being used by 10 NGOs across 31 districts in 10 provinces, and a CLTS curriculum was developed for the University of Health and Science, to start in academic year 2017/2018.
- CLTS process was piloted within Poverty Reduction Fund (PRF) project; partnership agreement signed for 40 villages; roles and responsibilities articulated in PRF's standard operating procedures.
- CLTS took place in 266 villages[2] in the 2 provinces, resulting in a 32 percent increase in sanitation access in triggered villages from Jul 2014 to Feb 2016, an annual rate of change 8 times as fast as the national rural average (2.6 percent/year). Out of the 266 villages at least 53 percent (or 141 villages) were ethnic minority villages in remote areas (Annex A). A total of 113 villages (43 per cent) were declared ODF and almost 40,000 people gained access.

b) <u>Strengthening supply chain for affordable and aspirational sanitation products and services</u>

[1] Operational Guideline for Rural Sanitation issued in April 2014 by DHHP
[2] An additional 126 villages are still undergoing the process at the time of writing.

- Aspirational and affordable latrine products were developed including an easy-to-clean pour-flush toilet costing LAK 500,000- 650,000 (USD 60-80)[3].
- 12 enterprises were trained in latrine manufacturing and business skills in the two provinces, 10 remain active; 'one-stop-shop' model was introduced to simplify latrine purchasing for households; 102 sales agents trained, with 10 percent remaining active. A total of 1,465 toilets were sold to date by 10 enterprises.
- A sanitation marketing toolkit was produced to align sanitation marketing approaches and facilitate future replication in other regions.

Developing and supporting implementation of behavior change communication (BCC) strategies

- BCC tools are under development (ready by June 2016); the process was led as a sector-wide effort led by Nam Saat[4] to facilitate wide uptake.

Key Lessons Learned

A rich set of lessons resulted from the technical assistance, of which the following are highlighted:

Institutional Strengthening	**Operational Aspects**
Forging a partnership with different agencies that have a strong presence on the ground, such as PRF and Lao Women Union will enable district-wide implementation at scale. Crucial is to maintain Nam Saat's mandate and accountability for delivery of sanitation services in such partnerships.	Leadership from district and village authorities for rural sanitation is critical; a clear understanding of their respective roles in planning, monitoring, demand creation/CLTS, behavior change and market facilitation is essential; capacity building efforts should match these roles.
Supporting provinces and districts with practical planning and budgeting tools has helped to develop realistic implementation plans and mobilize a minimum level of operational budget on sanitation activities. However, a better articulation of rural sanitation budget-line is required.	Given the lack of microcredit for rural households, saving preferences for sanitation, and difficulties to motivate villagers with previous random supply-led subsidies, a harmonized policy for pro-poor support is urgently needed. This should be well targeted and delivered without undermining the nascent market.
Advocacy and pro-active engagement of provincial and district senior decision makers and administrators is critical to harness support for resource allocation for sanitation activities at a local level. National top-level dialogue is required to support sub-national allocation mechanisms.	Sanitation entrepreneurs have benefited from close collaboration with districts and village chiefs, while sales agents are best recruited among village volunteers to avoid conflict of interest with public roles. Due to the nascent market, external support to businesses remains needed in the short term and can best be delivered through efficient sector-wide NGO market facilitation.

[3] Excluding transport costs and shelter
[4] WSP major supporter, but also technical and financial contributions from UNICEF, Plan, SNV were leveraged

Recommendations and Way Forward

i. Development of a national rural sanitation sub-program with dedicated budget line under MoH

Rather than as a sparsely funded sub-activity under MoH's national program on Health and Hygiene Promotion, a program on rural sanitation and hygiene would need to be established.[5] The program budget – in addition to salaries - would have to cover expenditures for basic operational costs, CLTS and BCC activities, pro-poor incentives, monitoring and other indirect sector coordination cost. The development of a harmonized financing guideline will need to be part of such program, articulating a policy for pro-poor support and incentives for village ODF achievement in the context of the existing inequalities in access. To meet the national sanitation access target of 80 per cent by 2020, over 200,000 people would need to gain access annually (2017-2020). This translates into a minimum budget requirement of USD2.3-2.8 million annually, or USD10.8 million over the 2017-2020 period (an annual investment of USD 14 per capita). It assumes that USD3.8 million is allocated over this period for targeted subsidies to the poor[6], USD1 million for ODF-awards, and the remaining 55 percent for software expenditures.[7]

ii. Integration of the rural sanitation program within multi-sectoral nutrition programs and the government's nutrition Social and Behavior Change Communications Strategy

With increased funding for nutrition, including the World Bank-funded Health Governance and Nutrition Development (HGNDP) project, as well as USAID and EU/UNICEF support, there is a huge opportunity to integrate rural sanitation activities in these programs. Such integration can help maximize the use of the national toolkits, e.g. the CLTS and BCC materials and training manuals developed under these TAs, and deliver important efficiencies in scaling-up.

iii. Tailoring gender and ethnic minority issues into Behavior Change Communications Strategy

To further supporting the government's efforts on improving rural sanitation among ethnic minorities living in poor and remote areas, sanitation interventions such as behavior change communications strategy should be supporting them to overcome physical, social and cultural barriers. Motivators for stopping open defecation and perceived benefits of latrine usages were found to be similar among different ethnic groups. The ongoing BCC tools production has incorporated motivators addressed to both men and women among different ethnic groups, to ensure identification and comprehension is good. Because literacy especially among ethnic groups is low, the BCC material package is mostly visual so that it can be widely used among various ethnic groups. It is expected that the government will apply the BCC package into their future programs across the sector such as nutrition, Model Healthy Village and education.

iv. Mobilization of high-level support and funding commitment to scale-up sanitation service delivery through Poverty Reduction Fund

[5] This could also include rural water supply, however, the government is currently considering the transfer of the rural water supply mandate to the newly created Department of Water Supply under Ministry of Public Works and Transport.

[6] This assumes a subsidy of USD 40 per households, to be used by 24,000 households annually.

[7] This budget estimate does not include the recurrent administration and salary costs of government at different levels nor external TA for market development.

Informed by the lessons of the pilot partnership between Nam Saat and PRF, a realistic scale-up plan needs to be developed, reflecting allocations for minimum operational budgets for Nam Saat in a selected number of districts. Through working in partnership with PRF, the Ministry of Health will be able to more cost-effectively deliver rural sanitations services in the 44 districts where PRF is operating, some of the most remote and poor ones.

v. Alignment of Water Global Practice technical assistance strategically with HGNDP Operation

To ensure optimal effectiveness of future TA, a geographic focus on the 12 districts in four provinces of HGNDP's community-interventions is recommended, directing assistance to sanitation marketing and implementation support, and expanding behavioral focus of sanitation BCC to so-called "baby-WASH" (child feces disposal, separation of children from animal feces) for greater nutrition impacts.

vi. Scaling-up and deepening the scope of collaboration between Nam Saat and PRF (under PRF3)[8]

Informed by an evaluation of the pilot partnership, a detailed scale-up strategy will be developed, with a multi-pronged approach for horizontal scaling: i) expanding to a district-wide approach in the 6 pilot districts, and ii) expansion of partnership in HGNDP districts. Other development partners may also be brought on board, supporting the strategic collaboration of Nam Saat with PRF in other districts. Depending on the outcomes of the pilot, future TA could be used to test out potential financing mechanisms under PRF3[9] for more poor-inclusive service delivery, such as a) the use of Self Help Groups or formal saving and loan schemes that allow households to invest in sanitation; and b) the use of infrastructure and/or livelihood grants for pro-poor support; upon prioritization of sanitation by the community, the development of a village ODF-plan, such grants could be used to transparently support eligible poor households.

vii. Policy and programmatic assistance and advocacy for rural sanitation

High-level advocacy for resource mobilization would be the basis for the development of a joint work program to addressing institutional weaknesses, for example in the areas of: i) development of a pro-poor financing policy, ii) national monitoring for sanitation iii) human resource development in partnership with the University of Health and Science.

[8] While not covered this report, additional Bank executed TA is also planned to help improve the sustainability of rural water schemes under PRF3, through piloting a number of management and post construction support models

[9] This is especially relevant since HGNDP does not provide any partial support or financing mechanism to poor households

1. Introduction

1. This report synthesizes the activities, outputs and achievements of the following complementary Technical Assistance, carried out by the World Bank's Water and Sanitation Program in support of strengthening rural sanitation service delivery by the Government of Lao PDR:

- 'Supporting Demand Creation for Sanitation through CLTS' (P132453) and;
- 'Sanitation Marketing in Lao PDR' (P132249)

2. The TA program has been implemented over a multi-year period from November 2012 until March 2016, and has also benefited from dedicated policy and sector coordination efforts[10]. The suite of TAs was developed in response to three challenges in the sanitation sector in Lao PDR:

- *The sanitation access agenda was far from being finished.* Access to improved sanitation facilities in Lao PDR has increased considerably over recent years, from 28% in 2000 to 71% in 2015, achieving the MDG target. In 2015, 94% of the urban population has access to an improved latrine, while only 56% of the rural population does[11]. Among the rural population, stark inequalities exist across regions and among ethnic and socio-economic groups. Only 13% of the poorest quintile has access to an improved toilet, while among the richest quintile this is 100%[12]. The SDG targets aim to reach universal access 2030.
- *Lack of integrated program methodology* addressed both demand for supply of affordable latrine. Prior to the TA program, rural water and sanitation projects in Lao PDR, as in many other countries, were characterized by a supply-led approach through hardware subsidies with little behavioral focus. The TA program builds on earlier lessons learnt from piloting CLTS and developing low-cost aspirational sanitation products for rural consumers that matched their preferences for durability[13]. Hence the TA was able to immediately work at scale within 10 districts in two provinces as well as at the national level.
- *Poor sanitation was impacting on health and economic development of the* country. Poor sanitation and hygiene caused at least three million disease episodes and 6,000 premature deaths annually while stunting rates among children in rural areas were very high at 49% in 2011. National economic losses due to poor sanitation totaled USD 193 million per year, equivalent to 5.6% of GDP.[14]

3. This report documents the results and lessons learned from the TA program that includes experiences both from government-led rural sanitation service delivery within two provinces in Southern Lao PDR (Champasak and Sekong) , as well as from national-level engagement to strengthen systems, tools and capacity building approaches for scaling-up rural sanitation

[10] The budget for the combined TA (P132453 and P132368) for this period was USD 2,216,801 (including fixed staff costs). A third TA "Supporting Sector Coordination for Scaling Up Rural Sanitation (P132249) has been concluded in April 2015, which focused predominantly on sector coordination and policy support.
[11] Joint Monitoring Program of WHO and UNICEF. Progress on sanitation and drinking water – 2015 update and MDG assessment, 2015.
[12] Based on World Bank analysis of Lao Social Indicator Survey (2011/12), (2006) and (2000)
[13] This was done in 2011-2012 using a Human Centered Design approach.
See also https://www.ideo.com/work/human-centered-design-toolkit
[14] Hutton, G. et al. (2009) Economics of Sanitation Initiative Lao PDR Country Report. World Bank.

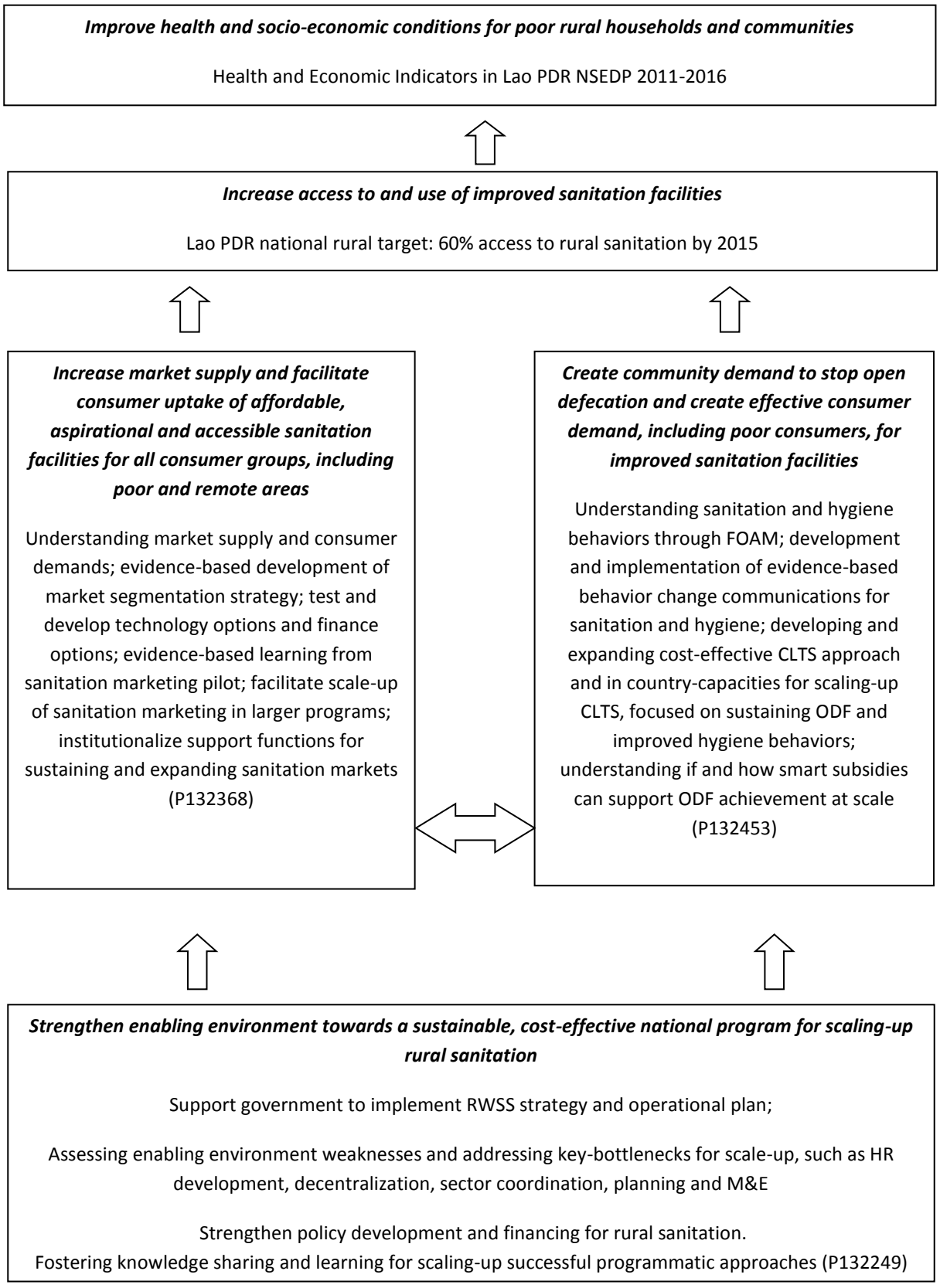
service delivery. The report makes recommendations to government on how - with the support of development partners – the effectiveness and scale of rural sanitation services can be increased to achieve sustainable sanitation outcomes for the rural population of Lao PDR. It also proposes recommendations for the engagement of the World Bank Water Practice in the sector in support of rural sanitation service delivery, aligned with lending operations, notably the Poverty Reduction Fund (PRF3) and the Health Governance and Nutrition Development Project (HGNDP).

4. The approach under this TA is based on the theory of change that connects strengthening local supply chains with behavior change and demand creation for sanitation, while improving the enabling environment to allow for a programmatic approach at-scale. WSP's global experience under its 'Scaling Up Rural Sanitation Program'[15] has been used to inform and strengthen government-led and market-based delivery mechanisms under this TA. The approach has built on earlier initiatives in the period 2011-2012 in Lao PDR, specifically for Community-Led Total Sanitation (CLTS)[16], as well as the development of affordable and aspirational toilet products, based on rural consumer preferences[17].

Figure 1 illustrates the theory of change for Lao PDR.

[15] This global TA program has been implemented in 16 countries globally over the period 2011-2016.
[16] World Bank Water and Sanitation Program. Piloting CLTS in Lao PDR: Lessons and Prospects, 2012.
[17] World Bank Water and Sanitation Program. Development and Marketing of Affordable Technology Options for Sanitation in Lao PDR, Feb 2012

Figure 1 Theory of change for rural sanitation service delivery for Lao PDR



2. Country Context and Rationale

2.1. Country and Sector Context

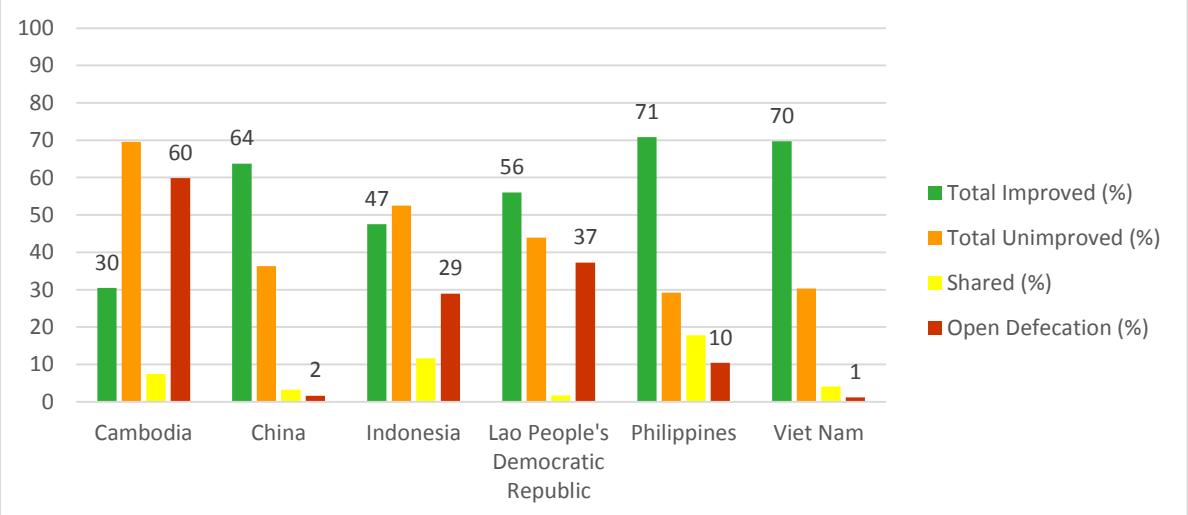
Country background

5. With a GDP per capita at USD 1,793.5 in 2014, Lao PDR is classified as a lower-middle income economy. Albeit from a very low base, Lao PDR has achieved impressive growth rates over the last two decades, averaging 6.9% per annum. During the decade starting from 2005, with an average growth rate of 7.8% per annum, Lao PDR was the fastest growing economy in the East Asia and Pacific (EAP) region, mostly driven by the natural resource sector. However, Lao PDR's growth has not been inclusive, and the gains for the bottom 40% were significantly lower than for the rest of the population. In parallel, poverty reduction was also less responsive to growth, and inequality widened over the decade. The poverty rate fell from 46 percent in 1992/93 to 23.2 percent in 2012/13, leaving most of the country's poor in rural areas, where the depth and severity of poverty are much higher. Lao PDR, with an estimated population of seven million, has seen rapid urbanization over the last few years – in 2015, there were 4.3 million citizens (61%) living in rural areas and 1.8 million (39%) in urban areas.

6. Natural resources - forestry, agricultural land, water, and minerals - comprise more than half of Lao PDR's total wealth and the country's key development challenge will be to ensure that this wealth is sustainably managed and transformed into investments in public infrastructure and better health and educational outcomes, especially the poor. Lao PDR is likely to meet the criteria for graduation from 'Least Developed Country' status by 2020, which has been set forth as a vision in the recently approved 8th National Socio Economic Development Plan (NSEDP) 2016-2020. Although good progress has been made on a number of Millennium Development Goals (MDGs), a critical off-track MDG is nutrition, with an estimated 44% of under-five children being stunted and 27% severely underweight in 2011. The Sustainable Development Goals (SDGs) will set a new framework against which the government will monitor and evaluate its progress.

Rural Sanitation coverage in Lao PDR and in the region

Figure 2 Rural sanitation coverage in Lao PDR and regional peers

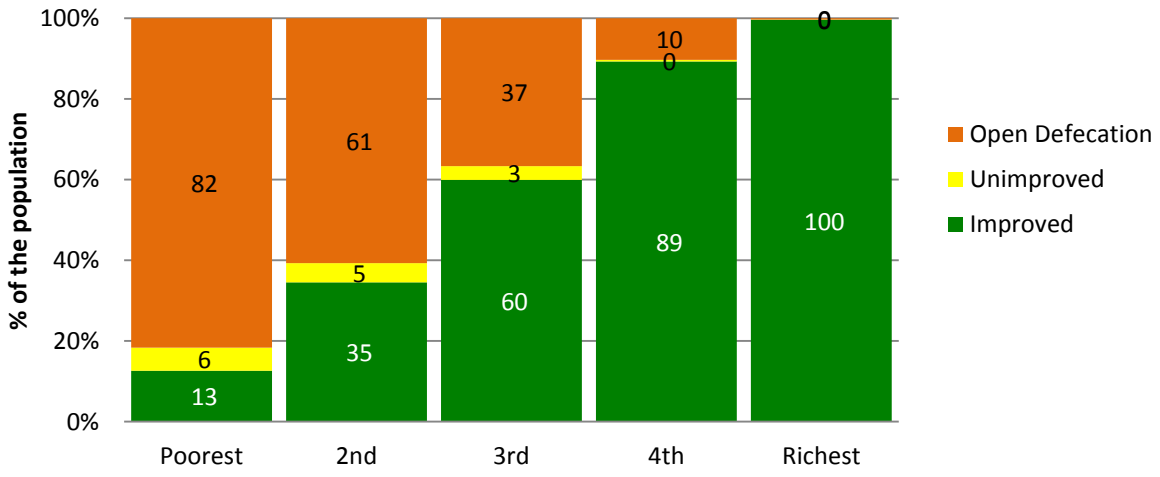


Source: WHO and UNICEF JMP Report, 2015 (Unimproved combines "open defecation", "shared" and "other unimproved)"

7. As can be seen in Figure 2, Lao PDR has one of the highest levels of open defecation in the region, with the exception of neighboring Cambodia. While urban access to improved sanitation facilities in Lao PDR has increased from 66% in 2000 to 94% in 2015, rural sanitation access is catching up and has increased from 17% to 56% in the same period[18]. While a 2.6% annual increase in access in rural areas over the last decade is commendable, stark inequalities remain across regions, wealth brackets and ethnicity. Residents of the Southern region are much less likely than others to have access to improved facilities: 35% have sanitation coverage, compared to 61% in the Northern region, and 68% in the Central region.

8. Figure 3 shows that in 2011, only 13% of the poorest quintile had access to an improved toilet and 82% practiced open defecation, while among the richest quintile access was 100%. Progress in the bottom 40% has been slow, increasing from 12% in 2000 to 35% in 2011, while the top 60% has seen an increase from 33% to 89% in the same period[19]. In households where the head of the household speaks Lao, 74% have access to improved facilities, compared with 30% of those where the head speaks Khmou, 46% of those where the head speaks Hmong, and 72% of those where the head speaks "other" languages[20].

Figure 3 Sanitation access across wealth quintiles in Lao PDR (LSIS, 2011/2012)



Source: MICS/DHS (2011-12); tabulation by World Bank

National targets and the persistent lack of domestic resources for rural sanitation

9. While the National Socio-Economic Development Plan (NSEDP) 2016-20 includes national targets of 90% of the population using clean water and 80% using a latrine by 2020, there is no specific national target for rural sanitation in the NSEDP. The National Action Plan for Rural Water and Sanitation, issued by the Ministry of Health in 2012, promoted a target that 60% of the rural population should have access to improved sanitation by 2015. Based on the recent JMP assessment of 56%, this has been missed. During the 2014 High-Level Meeting on Water and Sanitation, convened by the Sanitation and Water for All

[18] Joint Monitoring Program of WHO and UNICEF. Progress on sanitation and drinking water – 2015 update and MDG assessment, 2015.
[19] Based on World Bank analysis of Lao Social Indicator Survey (2011/12), (2006) and (2000)
[20] Special tabulation of Lao Social Indicator Survey, 2011/2012

(SWA) partnership[21], the Minister of Health announced the goal to reduce open defecation to 35% in rural areas by 2016 (currently estimated at 37%) and increase access to sanitation in rural areas to 70% by 2015 (estimated at 56%). This humbling situation means that the 2020 vision to graduate from Least Developed Country[22] status as well as universal sanitation targets under the Sustainable Development Goals[23] will be stretching and will require an acceleration from the 'business as usual' scenario.

10. A recent World Bank Service Delivery Assessment for Water Supply and Sanitation[24] concluded that to reach an interim target of 80% rural sanitation access by 2020, over 200,000 people would need to gain access annually. This is almost double the number of rural households that gained access between 1995 and 2012. The assessment found that much of the investment in domestic facilities has been initiated and funded by householders themselves, especially as (until recently) most projects by government and development agencies were short-term and tended to be fairly small scale[25].

11. Table 1 illustrates a minimum domestic budget indication required to achieve 80% access in 2020, through 200,000 additional people every year gaining access. A total annual minimum estimate of around USD 2.3-2.8 million will be needed, excluding administration and salary costs at different government levels. This estimate assumes that no compensation is given to village CLTS committees, and assumes that external technical assistance will be made available to support the adoption of the sanitation marketing approach and other critical areas where in-house government capacity needs further research and development, such as M&E system development and BCC campaign development.

12. The table below is based on the assumption that a government-led national program will be implemented in the period 2017-2020, across 16 provinces, 100 districts and 4000 villages, aiming to exposure 80,000 households of 400,000 people annually[26]. The assumption is that 200,000 people, or 40,000 households, or 50% of those living in targeted villages, will be gaining access as a result of the rural sanitation program.

13. Annually it is expected that 24,000 poor households, or 30% of all households living in the 4000 villages, will be able to make use of a partial subsidy of USD 40 per household. In addition, over a 4 year period, it is expected that 50% of villages will become ODF and will receive a cash ODF-award of USD 500. The total four-year program budget would equal USD 10.8 million, of which USD 3.8 million allocated for pro-poor subsidies, USD 1 million for village level ODF-awards and 55 per cent for so-called 'software' costs. Assuming 0.8

[21] See http://sanitationandwaterforall.org/

[22] http://www.unohrlls.org/UserFiles/File/LATEST%20IPoA.pdf which mentions universal access to water and sanitation

[23] SDGs target 6.2 is defined as **"**by 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations".

[24] World Bank (2015) Service Delivery Assessments for Water Supply and Sanitation Lao PDR. Turning Finances into Services for the Future

[25] A 2009 Sanitation Financing study (Giltner., et. al.) estimated that better-off households are willing to pay for good quality toilets. Household financing has been driving coverage increase, although slowly, as only 18% of household latrine construction in 2008/09 was subsidized, with the vast majority funded from households' own resources.

[26] The district wide approach is based on realistic expectation that existing human resources can implement rural sanitation in 10 villages per district per year, hence covering 40 villages in the district in the planning period 2017-2020. This national program is assumed to be present in all 16 provinces (excluding Vientiane), and two-thirds of all districts, and half of all Lao PODR's 8000 village sin the first planning period.

million people, gain access, the total program expenditure represent only USD 14 per capita (including subsidies/incentives). Based on the above assumptions, at least 64,000 households will self-invest over the program period, leveraging an amount of over USD 6 million directly from households[27].

Table 1 Minimum budget estimate required for 2017-2020 to reach 80% sanitation access

Budget item	year 1	year 2	year 3	year 4	Total
Goods and Services					***800,000***
Production of BCC tools (1 set per village) and other collateral	100,000	100,000	100,000	100,000	400,000
Other production costs (for new spots) and airing time	100,000	100,000	100,000	100,000	400,000
Subsidies and incentives (pro-poor support / ODF awards[28]					***4,840,000***
Partial subsidies for poor households (USD 40 per poor household)	960,000	960,000	960,000	960,000	3,840,000
Incentives for ODF villages (USD 500 per ODF village)	100,000	300,000	300,000	300,000	1,000,000
Operational costs					***984,464***
Operational costs for CLTS + BCC at district level	156,000	234,000	234,000	234,000	858,000
Operational costs supervision and ODF verification for province	9,920	13,888	25,792	41,664	91,264
Operational costs for national level (roadshow, training, ODF declaration)	8,800	8,800	8,800	8,800	35,200
National level indirect sector costs					300,000
Monitoring system development and regular hosting	100,000	40,000	40,000	40,000	220,000
Sector coordination, annual review and policy development	20,000	20,000	20,000	20,000	80,000
Capacity Development/training cost					***3,858,384***
Training and refresher for village facilitators/committees	699,000	959,400	959,400	959,400	3,577,200
Training of trainers for central/province and district staff	47,680	26,752	26,752	-	101,184
Annual review workshops / learning visits and workshop at provincial level	45,000	45,000	45,000	45,000	180,000
TOTAL	**2,346,400**	**2,807,840**	**2,819,744**	**2,808,864**	**10,782,848**

14. As households will continue to be the predominant source of capital financing for rural toilets, perhaps with the exception of targeted partial subsidies for the poorest households, a drastic scale-up of government financial and human resources is required, as

[27] Assuming USD 100 per toilet (excluding shelter)

[28] At this moment, an impact evaluation is being conducted that is testing the effectiveness of a modest partial poor subsidy of USD 20 on the uptake of sanitation by poor households. It is expected that higher subsidies will lead to higher uptake, assuming that demand creation is well executed and the rules of the game for subsidy eligibility are clear. Hence a higher value of USD 40 is used in the budget (price without transport and shelter is around USD 80). The impact evaluation also tests whether a village level cash incentive will lead to faster achievement of ODF or higher sanitation uptake rates, or whether such incentives are not necessary to motivate communities.

compared to the minimum allocations now provided. Government-led demand creation for sanitation and capacity building will be critical to enable and motivate households to make such investments in their own sanitation facilities.

15. Current domestic government resources for so-called "soft" program spending, such as for rural sanitation promotion, CLTS, behavior change communications, capacity building and important functions such as monitoring are virtually negligible, and mostly reliant on financial support of development partners and NGOs. This is partly due to absence of a dedicated budget line for rural sanitation program spending in the overall budget plan of the Ministry of Health[29]. Announcements made during the SWA meeting in 2014 in support of increased budget allocation and the set-up of a dedicated budget line have thus far not yet materialized.

16. Box 1 lists the SWA commitments, with progress made thus far on the development of an overarching WASH policy (in development and slated for approval by May 2016) , and on the first Joint Annual Sector Review (conducted in May 2015), while other commitments remain underfunded.

17. The extremely resource constrained environment means that the National Centre for Environmental Health and Water Supply (Nam Saat), under the Ministry of Health, mandated for rural sanitation, has targets to meet, but almost no resources for meeting them.

Box 1 Commitments of Lao Government during the 2014 Sanitation and Water for All - High-Level Meeting

Announcements made by Minister of Health:

1. The Ministry of Health (MoH) and the Ministry of Public Works and Transport (MPWT) in collaboration with Ministry of Natural Resources and Environment (MONRE) will develop an overarching policy on WASH for both urban and rural areas by 2016
2. The Ministry of Health and the Ministry of Public Work and Transport to continue to strengthen WASH Sector coordination and to take the lead on organizing Annual Joint Sector Review (Urban and Rural) and tracking agreed Sector indicators in close collaboration with all WASH stakeholders.
3. By 2016, access to sustainable, equitable and safe water supply to 70% in rural communities including schools and health centers
4. By 2016, open defecation will be reduced to 35% in rural areas including schools and health centers through Community Led Total Sanitation (CLTS) and sanitation marketing promotion to contribute to reduce the rate of malnutrition
5. The Ministry of Finance and the Ministry of Planning and Investment will increase the annual budget allocation to 30% for rural WASH including creating separate budget line in national budget for rural WASH
6. The MOH and MPWT will strengthen their institutional capacity of both urban and rural WASH agencies (Nam Saat and Nam Papa) to deliver sustainable WASH services by 2016.

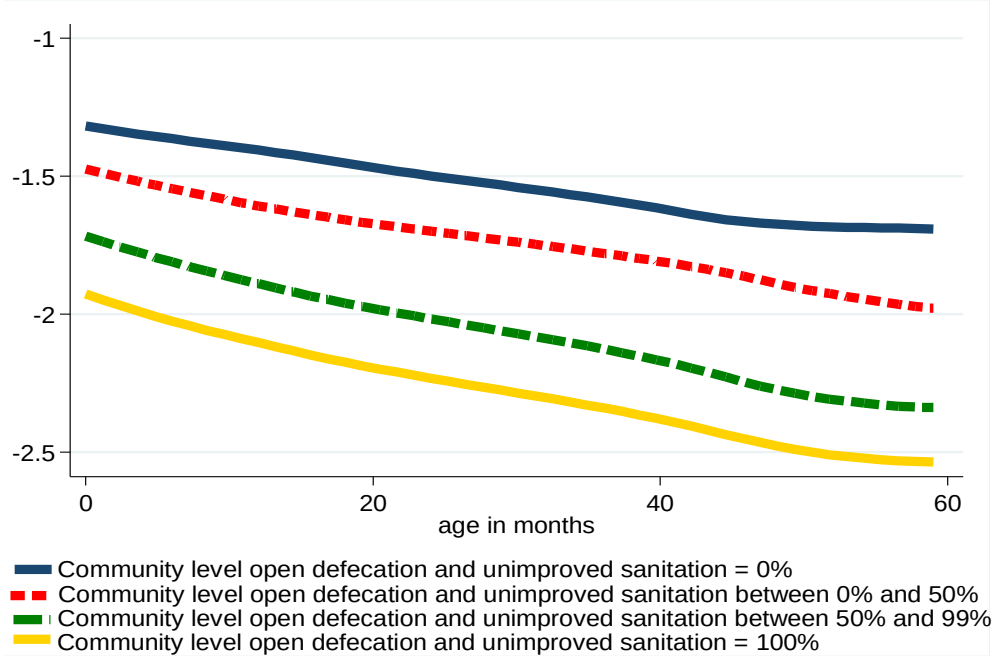
[29] Rural sanitation program spending hence is often "hidden" under general headings such as supervision and monitoring as part of Nam Saat rural water and sanitation budgets, that tend to be reserved for hardware investments (new rural water schemes, rehabilitation of wells, etc.). This leaves the only resources available to be the basic salaries of Nam Saat staff, with limited operational budget to carry out rural sanitation promotion.

2.2 Rationale for investing in rural sanitation

18. The Government of Lao PDR has made important steps in recognizing the vital role of water, sanitation and hygiene for addressing the burden of disease and persistent undernutrition in the country[30]. Poor sanitation and hygiene causes at least three million disease episodes and 6,000 premature deaths in Lao PDR every year. Diarrheal disease is tied with pneumonia as the second largest killer of children under five. In Lao PDR, 44% of children under five years of age (around 417,000 children) are stunted (low height for age), 27% are underweight and 6% are wasted (low weight for height)[31].

19. The recently approved National Nutrition Strategy to 2025 and Plan of Action 2016-2020 (Jan 2016) includes sanitation and hygiene under its priority interventions. Research has indicated that when any members of a community practice open defecation, there are negative implications for the health of all community members. The relationship between open defecation and stunting in rural communities of Lao PDR is shown in Figure 4. As the percentage of community members who practice open defecation and/or use unimproved latrines moves from 0% to 100%, children are on average shorter. Children grow shorter even when less than 50% of all community members practice open defecation or use unimproved facilities. Once a child's height becomes shorter than average, it remains shorter than average at every age and even falls below the critical measure of stunting (Z score of -2).

Figure 4 Relationship between open defecation and height-for-age score of children under five



20. The research also revealed that – controlling for other relevant variables - children living in rural villages where community members defecate in the open and/or use unimproved latrines are 1.1 cm shorter than healthy children living in rural villages where everybody uses improved sanitation. This small difference in height is irreversible, and matters a great deal for a child's cognitive development and future productive potential.

[30] Hutton et al. (2009) Economics of Sanitation Initiative: The Economic Cost of Poor Sanitation in Lao PDR. World Bank 2009

[31] Research Brief "Investing in the Next Generation". Water and Sanitation Program. August 2014

Universal usage of improved sanitation is needed to adequately address stunting. Therefore future policy, targets and incentives need to be aligned to promote community-wide behavior change, going beyond individual household interventions.

2.3 Rationale for the TA program and partnerships

21. Prior to the start of the World Bank's TA program, a number of government and donor-assisted projects were implemented which promoted latrine use and basic hygiene in rural areas. They tended to promote relatively expensive toilet designs, and relied heavily on providing direct and often full subsidies for toilets. These projects, though patchy in nature, largely failed to stimulate real demand for toilets, and therefore had limited impact on the level of latrine use nationally[32].

22. Through intense consultation with the Department of Hygiene and Health Promotion (DHHP) and Nam Saat, as well as with strategic development partners and NGOs active in the rural sanitation space, a comprehensive TA program was initiated. The program focused on policy development and sector coordination, as well as on the development of a new programmatic approach for rural sanitation service delivery. This programmatic approach aimed to stimulate collective behavior change at the village level to stop open defecation, while ensuring that once the demand is generated, rural households are able to easily access and afford toilet options that meet their aspirations and preferences through local suppliers. Unlike previous small-scale projects in few scattered villages, such a programmatic approach would be strongly anchored with the mandated government institutions and implemented at district level. This would allow scale-up and replication through a national rural sanitation program, assuming that human and financial resources would gradually become available over time, with the prioritization of the rural sanitation agenda. Hence, the TA aimed to develop nationally applicable guidelines, tools, materials and capacity building packages that could be scaled up through government with development partner support.

23. Partnerships with UNICEF, SNV and Plan international were sought in the joint development process of such programmatic approach. The joint development of national guidelines and toolkits would avoid fragmentation and ensure a more efficient use of scarce resources (often persistent in sectors where most resources are channeled off-budget through multiple NGOs). It is important to note that by 2012, as a result of sector consensus building, these agencies had stopped the use of upfront full hardware subsidies (i.e. a supply-led approach) and were focusing on behavior change and demand generation for improved latrines through the Community-Led Total Sanitation (CLTS) approach.

3. Technical Assistance objectives and summary results

Project Development Objective

24. The overall development objective of the TA was to increase improved sanitation and hygiene practices and change community behavior to achieve Open Defecation Free (ODF) status at the village level, through:

- supporting the government in developing sustainable and scalable models for demand creation in rural areas through CLTS, (for P132245),

[32] See sanitation financing study (Giltner. et al., 2012)

- strengthening the supply chain for affordable and aspirational sanitation products and services (P132368),
- developing and supporting local implementation of evidence-based behavior change strategies (P132368).

25. A comprehensive TA program was implemented from November 2012 to March 2016 with the aim of laying the groundwork for a national program to scale up rural sanitation and hygiene promotion[33]. This was to be done by a combination of both provincial level support to implement a new service delivery approach at meaningful scale, combined with national level system strengthening. The provinces of Champasak and Sekong in the south functioned as a 'learning laboratory' and provincial authorities received support to implement Community-led Total Sanitation (CLTS)[34] combined with sanitation marketing. This implementation experience was then used to consolidate lessons learned, develop guidance documents and capacity building manuals and toolkits that would help scale up nation-wide implementation with the support of other development partners. The Ministry of Health (MoH) specifically the Department of Hygiene and Health Promotion (DHHP), and the National Center for Environmental Health and Water Supply (or 'Nam Saat') under this department are the nodal agencies responsible for rural sanitation. These agencies, including their provincial and district units, were thus the principal audience of the TA.

Table 2 provides a summary overview of the achievements as compared to the intended intermediate outcomes and indicators set out in the project concept notes.

[33] The budget for the combined TA (P132453 and P132368) for this period was USD 2,216,801 (including fixed staff costs). A third TA "Supporting Sector Coordination for Scaling Up Rural Sanitation (P132249) has been concluded in April 2015, which focused predominantly on sector coordination and policy support.

[34] Community-Led Total Sanitation is a facilitated community empowerment process that motivates community members to collectively stop open defecation and start building and using improved latrines with the aim of reaching and sustaining Open Defecation Free (ODF) status. See also www.communityledtotalsanitation.org

Table 2 Summary table of achievements and results of the TA

Intermediate Outcome	Indicators	Achievement of results
1. <u>Clients capacity increased</u>: 1.1. Local private sector and local government capacity strengthened to implement sanitation marketing and behavior change strategies to increase adoption of toilets by poor rural households.	• Sanitation businesses in 8 districts (in Champasak and Sekong) are trained, and are producing and marketing affordable and desirable sanitation facilities to poor households. • Sanitation finance models have been identified and tested to support sanitation businesses and poor households to access micro-finance loans for sanitation (Sekong and Champasak) • Provincial and local governments are actively involved in facilitating market development and are leading implementation of behavior change communication efforts, and coordinate sanitation marketing with CLTS	**Partially achieved** • 12 enterprises enrolled in the sanitation marketing network and trained; 11 are still selling toilets. A total of 1,465 latrines were sold to date and expected to continue • Existing micro finance institutions were surveyed but none were suitable due to lack of rural penetration. Village bank sanitation loans were piloted in one district (in partnership with GiZ), but uptake of sanitation loans was limited • Province and district health officers in 10 districts have understanding of sanitation marketing, facilitate contacts with suppliers during CLTS; implementation of BCC activities has not yet started due to delay in campaign development
1.2. Government capacity strengthened to coordinate, implement, and monitor at-scale rural sanitation programs, using CLTS for demand creation	• Local government at provincial and district level trained and effectively coordinating, facilitating and monitoring implementation of CLTS interventions • Local resources agencies / NGOs trained in CLTS programmatic approaches to support implementation • CLTS successfully implemented in 143 villages in at least 4 districts in 2 provinces (Champasak and Sekong) by Dec 2014 (and in 400 villages by mid-2016[35])	**Partially achieved** • 469 members of provincial and district CLTS team members trained, enabling them to conduct the CLTS process by themselves; 3-6 capable officers per district • Annual national learning events/training on CLTS conducted with participation of various NGOs; rather than focusing on local NGOs, TA invested in developing partnership with PRF and trained 122 PRF district officers, district Nam Saat and Kumban facilitators for a pilot partnership • CLTS triggering took place in 266 villages, resulting in 32% increase in sanitation access in triggered villages. Total of 113 (43%) of villages declared Open Defecation Free and around 39,000 people gained access. Due to government budget constraints, CLTS process could not be completed in time and in all villages planned for the scale-up after 2014

[35] As part of a collaboration with East Meets West Foundation for a Randomized Controlled Impact Evaluation for rural sanitation incentives, the CLTS implementation plan was expanded to include a total of 400 villages over a longer period till mid-2016. (Impact Evaluation under P151311)

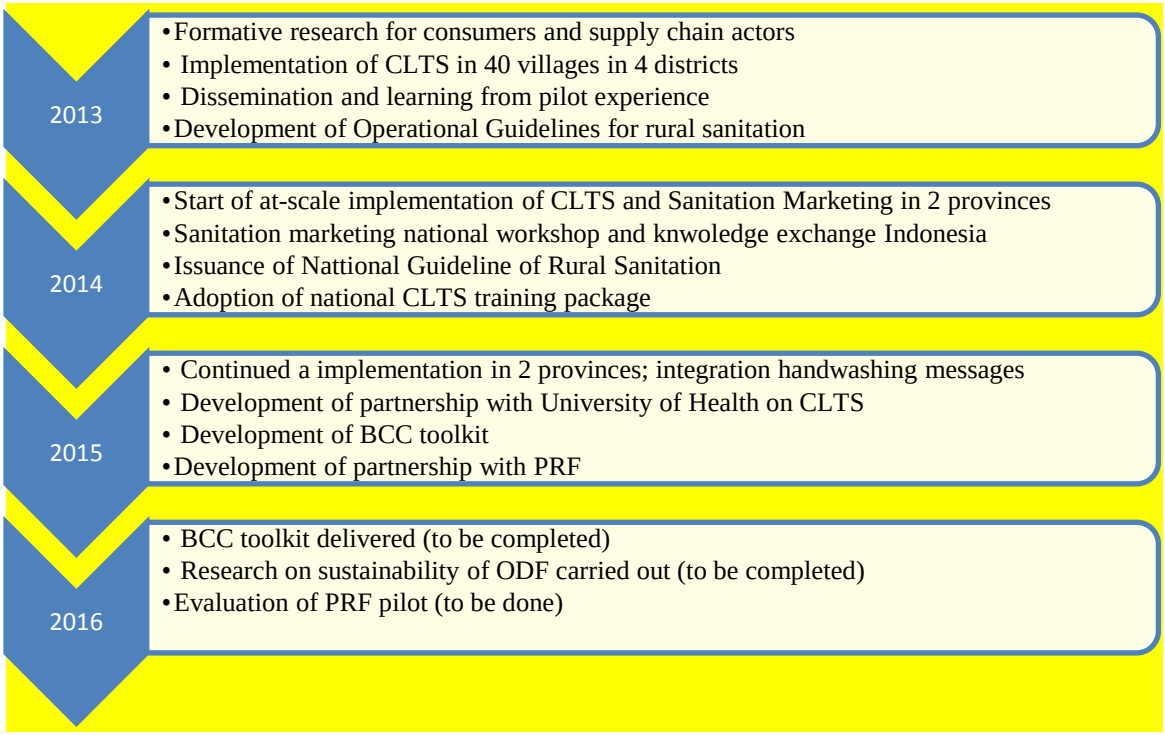
2. <u>Policy/strategy informed:</u> Sustainable implementation models and resources developed for replication of programmatic CLTS approach at national scale	• Materials, guidelines and manuals consolidated for national use by government and partner agencies • Systematic approach developed for building capacity and incentivizing CLTS trainers and CLTS facilitators • National guidelines for ODF verification and monitoring established	**Achieved** • Tools used to recruit and train enterprises and sales agents compiled into Sanitation Marketing toolkit containing eight handbooks and guides • CLTS training package produced, but no formal policy for incentivizing front-line workers adopted • National guidelines for ODF verification issued and applied; monitoring forms developed • Curriculum for University of Health and Science developed that includes modules on rural sanitation and in particular CLTS
3. <u>Knowledge deepened:</u> *Government and partner strategies and approaches for sanitation demand generation and marketing informed through evidence from implementation*	• Evaluation of base and endline are used for developing knowledge products • Evidence-based lessons have been identified, documented and disseminated in real-time during implementation (through learning events)	**Achieved** • Impact evaluation ongoing (endline to be completed by June) to determine impact of CLTS and Sanitation marketing (P151311) • Qualitative evaluation of sustainability of ODF in 40 villages ongoing and research brief to be issued by April 2016 • Infographic with evidence from consumer and supply chain research issued and disseminated (see annex B • During implementation, lessons shared with government partners at national learning events, numerous workshops and Technical Working Group Meetings
4. <u>Innovative approaches and solutions generated:</u> Government has adopted Behavior Change Communication (BCC) and sanitation marketing as a programmatic approach for at-scale implementation with development partners	• Formative research for supply chain analysis and consumer demand has informed the strategy • BCC and marketing materials, manuals and training materials are jointly developed by government at national level, and used for implementation at local level • National programs are adopting BCC materials and sanitation marketing approaches through a systematic capacity building and support mechanism	**Partially achieved** • Nation-wide consumer and supply chain research completed, jointly with other development partners; findings led to adaptations in Sanitation Marketing implementation strategy • BCC campaign package is under development (completed by June 2016), including national logo and various tools for interpersonal communications, advocacy package and training manuals • Sanitation marketing toolkit developed and scheduled for adoption by March 2016; no formal organization (franchise/association) established, but informal coordination approach to encourage NGO-led replication of sanitation marketing • Sanitation BCC package will be mainstreamed in national SBCC strategy for nutrition (under HGNDP); BCC package to be introduced under PRF3

4. Implementation process, challenges and results

26. The TA program was designed and managed by the Water and Sanitation Program, while partnerships were sought through contracted resource agencies to support government-led implementation, undertake capacity building for clients, and to facilitate joint learning and problem solving with respect to the new programmatic approach being introduced. The resource agencies for supporting CLTS capacity building were SNV (Netherlands Development Organization) and PADETC (a not-for-profit Lao organization). For sanitation marketing, Population Services International (PSI), an INGO[36], was contracted and led the capacity development of the private sector and supported government to take on new roles with respect to market facilitation for sanitation. An upfront overview of the activities is illustrated in

27. Figure 5.

Figure 5 Overview of major activities under the TA



28. Challenges for rural sanitation provision in Lao PDR are well documented[37], and pertain to the persistent inadequate budget allocations for a nation-wide rural sanitation program, limited human resources and capacities available especially at district level, virtually non-existent sector monitoring, and a lack of harmonized approaches that emphasize

[36] Firm contracts were also concluded for the execution of the nation-wide formative research for supply and consumer research, as well as for the development of the BCC campaign, under close guidance and supervision by WSP.

[37] World Bank Water and Sanitation Program. Service Delivery Assessment for Water and Sanitation in Lao PDR, 2014

demand creation, behavior change communications and which facilitate the involvement of the local private sector for the supply of affordable and aspirational toilets.

4.1 Demand creation through Community-Led Total Sanitation (CLTS)

4.1.1 Implementation process and challenges

29. Community-Led Total Sanitation (CLTS) is an approach used to create demand for sanitation. Using emotional drivers such as disgust, shame (or other locally suited motivators), external facilitators empower the community to collectively stop open defecation and start to build and use toilets. Often, village regulations are used as a way to help support this change. The event by which this community awakening takes place is referred to as "triggering"[38].

30. Interventions were focused in seven districts in Champasak province (out of 10) and three districts in Sekong province (out of four), and were identical to areas where complimentary sanitation marketing activities were to take place under government leadership, with support from a resource agency specialized in social marketing. The completion report for the CLTS technical assistance is available upon request as supporting documentation.

Planning for scale

31. Provincial health departments and provincial Nam Saat offices in Champasak and Sekong provinces, as well as the district health office and Nam Saat offices are the modal agencies for rural sanitation. Broader CLTS committees were set-up in every target province and district, with members drawn from Health and Nam Saat office, Cooperation and Investment Planning, Education office, Rural Development office, Administration office, Lao's Women Union and Youth Union.

32. The TA intended to reach a stretch target of 400 villages across 10 districts in two years (2014-2015) encouraging provinces and district leaders to start thinking of implementation at a district-wide scale. The 15 villages per district would be covered in the first year (2014) and 25 in the second year (2015), with decreasing technical assistance support in the second year, requiring all operational costs for the CLTS process to be financed through the provincial and district Nam Saat budget. Setting an ambitious target was important in order to learn what level of scale could realistically be achieved in a resource constrained environment, both in terms of human resources to implement the work, and in terms of the operational budgets available at district level to do so.

33. As resource constraints became apparent, especially due to late and lower than expected allocations to the districts, not all 400 villages could be covered in the period. The plan was revised to cover calendar year 2016 aiming to reach a reduced number of 310 villages[39]. Hence, implementation followed the following phasing:

i. 40 villages (already implemented in 2012-2013)
ii. 184 villages (over 2014 and 2015)

[38] Typical activities during a triggering event include village open defecation mapping, shit calculation, and the infamous "walk of shame" to frequently places where people go for open defecation.
[39] The impact evaluation – first phase - focused on 150 villages across 10 districts, while the second phase requires at least 160 villages (excludes the 40 villages in 2012/2013)

iii. 126 villages (over 2016)[40]

34. The district wide approach, a globally recognized best-practice for sanitation, is specifically relevant for Lao PDR as previous CLTS interventions typically took place in just a few villages in a single district with intense hand-holding support. A sequence of different activities for implementing rural sanitation at scale through the district wide approach is illustrated in annex E.

Focus of the CLTS technical assistance

35. The CLTS technical assistance covered three interrelated components:

i. Development of management capacity, planning and monitoring at provincial level
ii. Capacity building for implementation of demand creation through CLTS at all levels
iii. Development of a scalable capacity-building package for the national level

36. Program coordination structures (CLTS committees) were established at provincial and district levels, with the Nam Saat office as the central point of the coordination system. CLTS Committees were also set-up at the village level. The development of simple budget and planning tools was instrumental to support Nam Saat to secure at least a minimum amount of resources, although often budget requests were not fully honored.

37. A team of 25 national CLTS trainers (master trainers) from Nam Saat central and provinces was established, trained and are now available to deliver Training of Trainers across the country. The master trainers cascaded their new knowledge and skills to other Nam Saat staff at the provincial and district level. A total of 469 provincial and district level officials have been trained in CLTS related topics. Training sufficient staff at district level proved to be a challenge, as in some cases, there is only one Nam Saat district staff member for 50 villages. Therefore, in some districts, CLTS teams included staff and cadres from the Lao Women Union, and other units under the Health office.

38. CLTS related training covered a range of topics and field-practice, including pre-triggering, triggering, post-triggering, verification and ODF declaration. Other topics included: facilitation and community mobilization, latrine technical construction, informed choice product catalogue, education sessions on handwashing with soap, and the use of monitoring tools/forms. The experiences of applying a simple monitoring system were shared nationally to inform a future institutionalized rural sanitation monitoring system[41].

39. In addition, roadshows were organized to raise awareness of higher-level leaders, who were not CLTS team members but whose support would be critical for implementation. These advocacy roadshows discussed the status of sanitation and its impact on development in Lao PDR and built essential support for the CLTS approach amongst stakeholders external to Nam Saat, including provincial vice governors and district chiefs. Ownership of provincial and district administrators was critical because of budgetary control, and because of their role

[40] Implementation of CLTS is currently ongoing for these 126 villages, with financial support of East Meets West Foundation

[41] At every level increasing level of aggregation of results took place, with village level using three forms, district level four forms and at provincial level five forms. The TA did not have resources to help institutionalize a national MIS for rural sanitation (or integrate this into existing health sector MIS)

in mobilizing support and motivating communities and village leaders around sanitation and ODF targets[42].

Development of national CLTS package

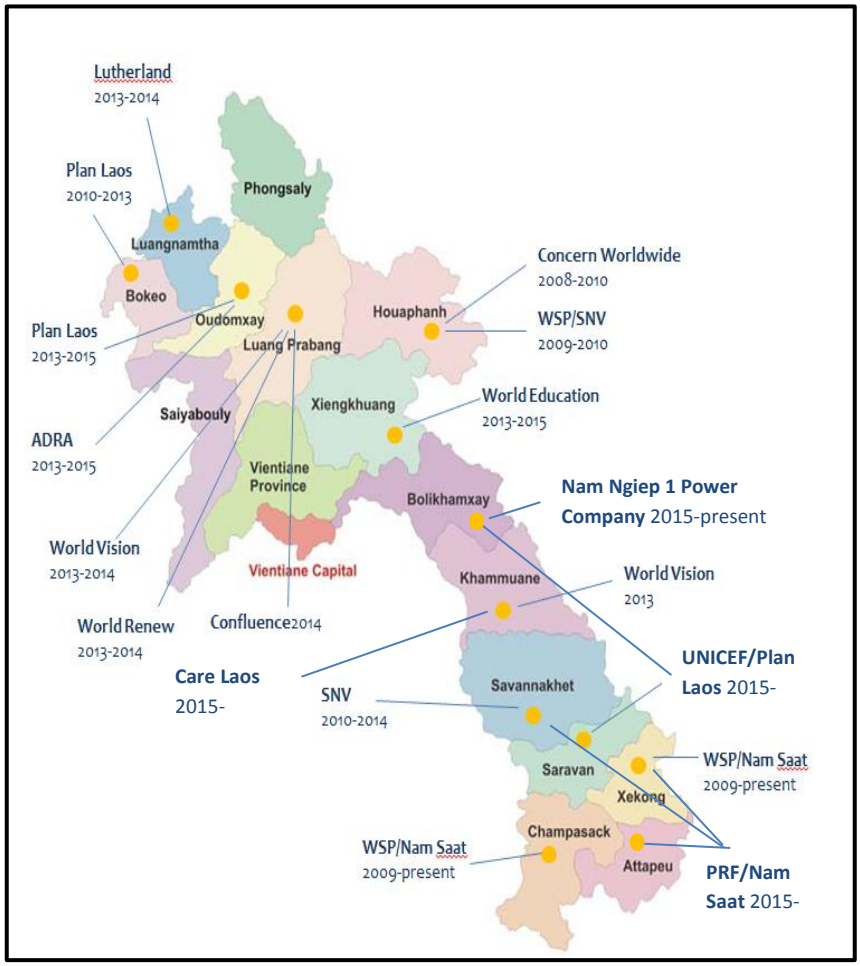
40. Following the operational guidelines for rural sanitation, issued in April 2014 by Nam Saat, a national CLTS toolkit was developed for standardizing replication. This is relevant as by 2015 there are over 10 local and international NGOs supporting the government in rolling out CLTS across 31 districts in 10 provinces. Nam Saat Central team lead the revision of an already existing CLTS package and improved this based on consultation with World Bank, SNV, PADETC, UNICEF, Plan International and World Vision.

41. The final package was then presented at a national learning event before finalization in September 2015[43]. The sector-wide adoption of CLTS needs to be appreciated against a backdrop of previously supply-driven hardware approaches, with little behavioral focus and attention for bottom-up community mobilization. Advocacy videos on CLTS were also developed to further raise awareness on the approach (available at http://youtu.be/n7ljD6Gw1lY). Figure 6 illustrates the scale-up of the CLTS approach as of 2013. As part of the national nutrition mapping under MoH leadership with EU/UNICEF support, in which CLTS is one of the priority interventions, an updated map will be available by mid-2016, which will be updated annually.

[42] This is consistent with findings from the consumer research about behavioral drivers for households to invest in sanitation. Being seen to comply with government rules and instructions featured as a motivator especially for males.

[43] The event was chaired by the Vice-Minister of Health and attended by senior officials including Provincial Governors and Provincial Heads of Health Offices. In total 10 provincial delegations attended the event.

Figure 6 Map showing locations of CLTS interventions in Lao PDR as of 2015



4.1.2 Sharing lessons and fostering replication at national scale

Knowledge exchange and the development of CLTS curriculum for new health staff

42. Several visits from other provinces (supported by development partners) took place to Champasak and Sekong province to learn from the sanitation program, including how linkages with the market-based approaches have been combined (see also section 4.2). Knowledge exchange to Indonesia in 2014 were organized (see annex C for participant list). The Indonesia visit was a particularly good occasion to observe an at-scale program led by local governments, using a district-wide approach, and featured a wide engagement of the entire health system at various levels (village cadre, health center staff and district health office). The experience of Indonesia in institutionalizing a national pre- and in-service training program, including on-line learning, within national health schools sparked particular interest[44]. This motivated Lao officials to pursue a similar approach.

43. Box 2 provides further detailed on the curriculum that has been developed thus far and that will be taught to future health staff within Lao PDR.

[44] See WSP, 2016. Building Rural Sanitation Capacity Nation Wide in Indonesia. World Bank. Washington

Box 2 Overview of mainstreaming CLTS in the national health university curriculum

The National University for Health and Science in Vientiane is currently revising a curriculum for an Associate Degree for the Public Health Program. In close collaboration between the University and Nam Saat, the new revised curriculum will include a subject on rural sanitation, with an emphasis on the CLTS approach, as part of the Associate Degree in the Public Health program. The CLTS modules were developed based on international and local experience acquired by Nam Saat over the past few years. The associate degree takes three years to complete, slightly less than for a bachelor degree, for students who graduated from high school and for in-service government staff who graduated from a college for nurses/heath workers.

On average, every year, 45 students enroll in the Public Health program, with most of them subsequently finding jobs as health workers at the provincial and district level. Existing health Centre staff are encouraged to enroll in this program to upgrade and update their knowledge and skills.

The curriculum on CLTS is spread out over three modules, with a total teaching time of 46 hours. The curriculum also includes a field-based practice of 80 hours. It is expected that in the 2017/2018 academic year, the curriculum will be taught for the first time by the Nursing Faculty at the University of Health and Science in Vientiane capital, ensuring that sufficient number of lecturers have been trained and exposed to CLTS activities beforehand.

The curriculum will be enhanced as soon as BCC materials and toolkits have become available, in order to expand the demand creation skills of students. The development of the above curriculum was informed by a wider capacity needs assessment and a capacity building framework developed under this TA, which is also available as supporting documentation.

Scaling up CLTS approach through partnership with PRF

44. Although the scale-up (see Figure 6) is remarkable, challenges with funding as well as with human resources for CLTS implementation remain a huge bottleneck, especially in the context of remote rural districts. With long travelling distances from district to village level, dispersed and numerous villages per district (around 80), and with only around 1-2 Nam Saat staff at district level, the tasks becomes daunting (see annex C). Therefore, WSP initiated a dialogue with the WB-funded Poverty Reduction Fund (PRF) to explore avenues to leverage PRF's Kumban Facilitators (KBF) and Village Implementation Teams (VITs) as a platform for supporting service delivery (see Box 3).

Box 3 Information and rationale for partnership with Poverty Reduction Fund as service delivery structure

The Poverty Reduction Fund (PRF), under the supervision of the National Committee for Rural Development and Poverty Reduction, is mandated to help the government to implement its policy to reduce rural poverty in line with the 8th NSEDP. It operates in 44 poor districts in 10 provinces, implementing bottom-up planning processes and providing communities with block grants to implement priority infrastructure subprojects. The PRF has also started to improve the livelihood and nutrition status of villagers on a pilot basis. The PRF has trained many village level leaders, including Kumban Facilitators (KBF) and the Village Implementation Team (VIT). There are three KBF in every kumban where the PRF operates, and 44% of them are women. The VIT consists of village leaders selected by villagers to implement infrastructure subprojects. The PRF provides them with repeated training in leadership, community facilitation and bottom-up processes. The village level institutions and kumban human resources that the PRF has developed are considered to be a useful platform through which multiple agencies can deliver last mile services at a lower cost, while clearly keeping the institutional mandate with such line agencies, in the case of sanitation, with Nam Saat/MoH. At the same time, such cooperation supports the aim of poverty reduction by the PRF.

45. Following exposure visits by PRF representatives / leadership to CLTS villages, and after a cost-analysis showed that at-scale service delivery using PRF platform would lead to 40% efficiency gains, a pilot partnership was agreed for the period Oct 2015-Sept 2016. The pilot partnership will be implemented in 40 villages, in 27 village clusters (kumbans), and six districts within four of the PRF's target provinces, with TA being provided to Nam Saat and PRF-staff. A detailed Standard Operating Procedure was developed that would allow PRF and kumban facilitators to carry out the CLTS process, without the need to integrate this in the same time-frame as the Community-Driven Development cycle in any particular village[45].

46. A cooperation agreement between PRF and Nam Saat was signed and is being revisited (see annex D). Thus far a total of 122 PRF and Nam Saat district staff and kumban facilitators have been trained through the TA. By end of February 2016, 28 villages have been triggered, with over 1,511 households participating, an initial expression of interest to build toilets amongst 27% of the villagers, and the start of latrine construction activities in 28 villages. The pilot will be evaluated by October 2016 and lessons learnt will inform the further deepening of the scale-up under PRF3. As part of the WB-funded Health Governance and Nutrition Development project (HGNDP), CLTS will be implemented across 876 villages in 12 districts of 4 provinces in the period 2016-2021, combined with nutrition BCC interventions.

4.2 Sanitation marketing approach

4.2.1 Implementation process and challenges

47. Sanitation marketing is an approach that aims to increase access to sanitation by applying commercial marketing techniques to stimulate demand and to strengthen private sector capacity to deliver affordable, safe, aspirational and durable latrines to rural, lower-income populations. The approach focuses on strengthening the role of the local private sector in service delivery, who most of the households would turn to for purchasing and installing their toilets. The marketing approach views households as consumers, recognizing their individual preferences rather than homogeneous beneficiaries for whom standardized "toilets" (or toilet parts, often unused) are being procured through government or "project" procurement channels. This sets sanitation marketing apart from conventional supply-led approaches to sanitation service provision[46].

48. In 2011-2012 the World Bank, in collaboration with iDE, an iNGO, supported a "proof-of-concept" pilot in two districts of Champasak and Sekong to use consumer-driven design to develop affordable and marketable sanitation. In close collaboration with provincial government and local businesses, an aspirational product line of three toilet options was developed and tested, and business models were developed, including packaging of product and services. The pilot examined future directions for sales, social marketing and distribution

[45] Within PRF districts, not every village will have the opportunity to benefit every year from a community grant (infrastructure or livelihood grant), thus kumban facilitators and village implementation teams can support a CLTS process, even in a year where the concerning village would not be eligible for a grant in the CDD cycle.

[46] Such traditional approaches typically supply latrines to a selected number of households through project-procurement chains, which often cannot be easily accessed by household themselves. Limited funds for full-subsidy approaches put limits to the scalability of these interventions. If delivered without adequate behavior change or demand creation, project supply of latrines could put the sustainable use at risk. Scaling-up rural sanitation will require sanitation market development, delivery of effective behavior change communication, as well as a strong enabling environment with a focus on equity. For more information refer to "What Does it Take to Scale up Rural Sanitation? (Perez, et al., 2012)

strategies. The initial product line consisted of two types of pour-flush toilets (one basic and one higher-end version), as well as an aspirational waterless-toilet.

49. This TA, through engaging PSI as a resource agency, sought to scale up the approach in 10 districts in order to find best practices for implementing sanitation marketing in rural Lao PDR. The completion report of the sanitation marketing assistance is available as supporting documentation. The scale-up consisted of three interlinked components:

i. Strengthening the capacity of the private sector through new business models
ii. Strengthening ownership of government and its ability to facilitate sanitation marketing
iii. Developing models and partnerships to increase financing options for household sanitation

Capacity building business and sales agents and the One-Stop-Shop business model

50. This component involved "recruiting" interested enterprises and training them in latrine manufacturing and business skills, as well as training sales agents to conduct door-to-door sales. Over the life of the project, 12 enterprises were recruited and trained in 10 districts. Not all businesses would fit the criteria that were developed based on best practices in other countries in the region. Network standards were used in order to ensure that enterprises would have a certain level of basic commercial and technical capacity, motivation and working capital to allow responding to demand created.

51. Business skills training was provided in order to give participants further knowledge, skills and confidence to conduct daily business operations. Latrine manufacturing training was also provided, ensuring a high-quality product. Despite the training provided – including refresher training enterprises (three) were dropped from the network due to issues such as low quality latrine production, or inability to meet capital or labor requirements, and new enterprises (four) were recruited. Some districts (Lamarm and Dakcheung in Sekong) proved challenging, due to a lack of suitable enterprises present in the district, coupled with other barriers for marketing such as poor road accessibility. Eventually, businesses were identified in these districts but were not included in the network to maintain quality standards (nevertheless some basic training was provided to them).

52. Based on rapid market assessments and early implementation lessons, it was decided not to include the waterless toilet in the product range, as consumer demand for dry solutions was low, and a strong preference was found for pour-flush latrines due to benefits of no-smell and easiness to clean.

53. Figure 7 illustrates the product options that sanitation enterprises in the network are offering, with price levels varying from LAK 500,000 (USD 60) to LAK 650,000 (USD 78), excluding transport. These price levels do not include the superstructure or shelter, which households were advised to make from natural materials, while saving to upgrade to more durable structures.

Figure 7 Pour-flush toilet products developed for marketing purposes under the network

54. A ‘one-stop-shop’ model was introduced to make the process of acquiring a latrine easier. Previously, consumers who wanted to buy a latrine were discouraged because they were forced to visit multiple vendors to acquire the different components needed, and had to organize their own installation and transport services. Under the ‘one-stop-shop’ model, households only have to visit a single vendor, and depending on preference could use transport and installations services or self-install. The streamlining of the supply chain is illustrated in

55. Figure 8 and
56.
57. Figure 9, illustrating the changed consumer interface once One-Stop Shops are introduced.

Figure 8 Fragmented supply chain for consumers to acquire toilets

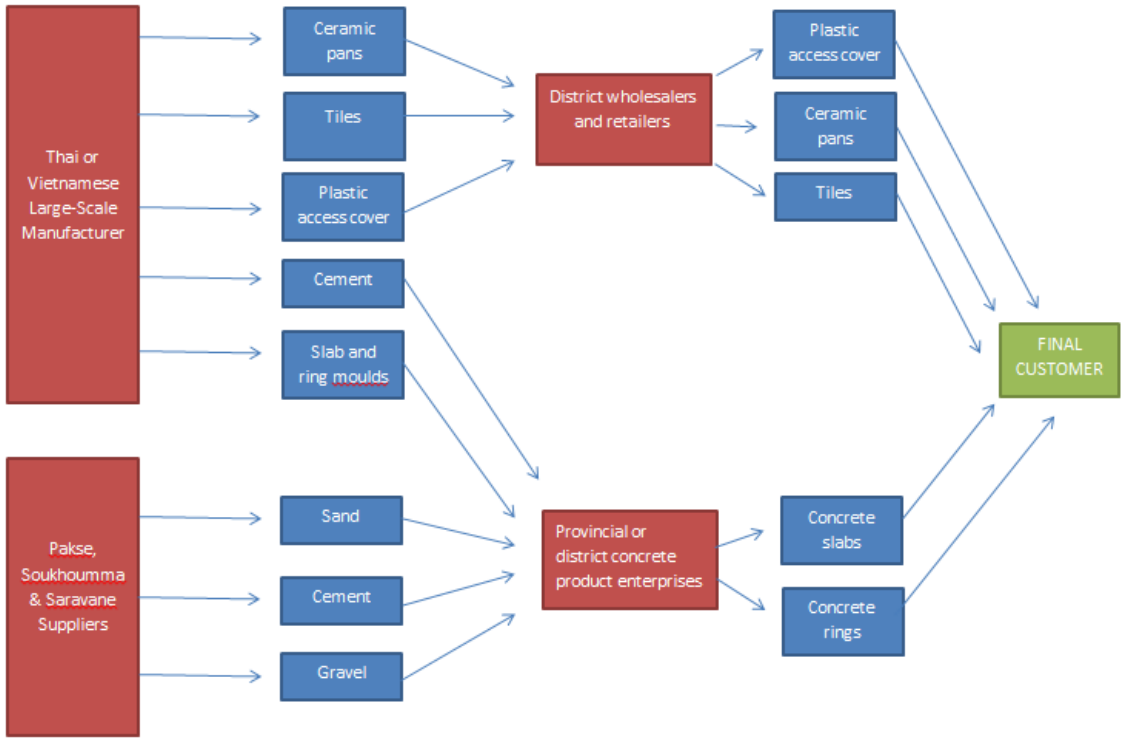
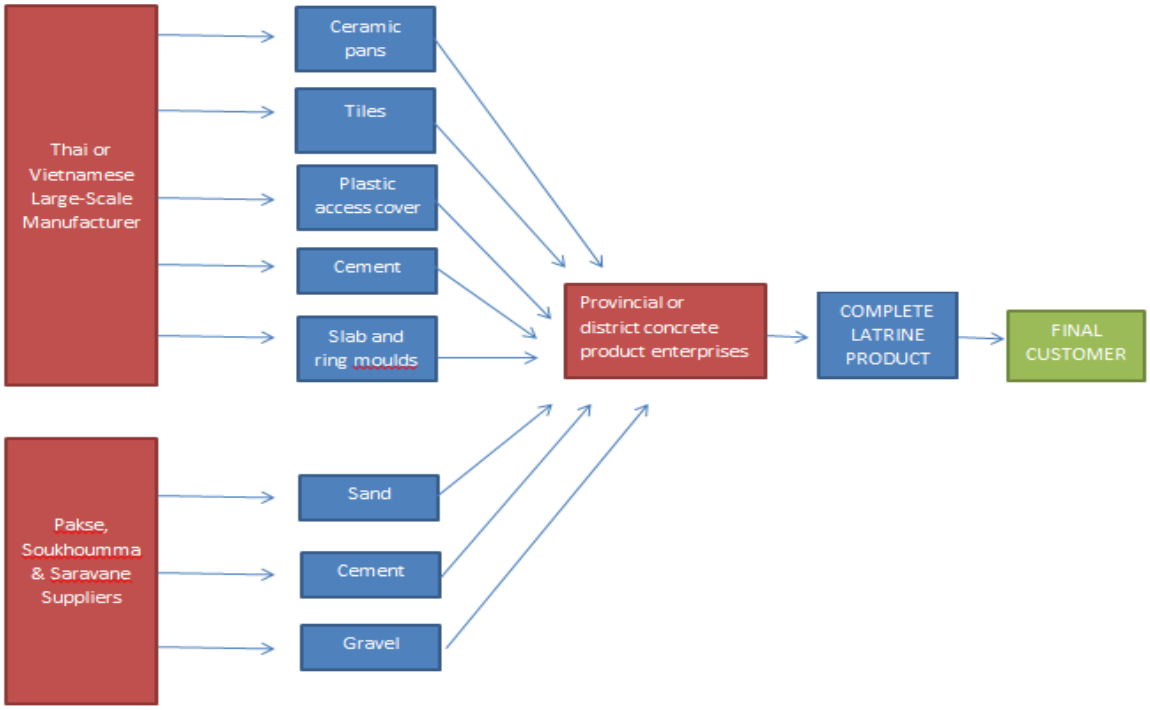


Figure 9 Streamlined supply chain with the One-Stop-Shop model



58. In total, 102 sales agents were recruited and trained during the TA. Several recruitment strategies were employed, the most successful of which was gathering recommendations for suitable candidates from village chiefs within the high priority zones of each district. Sales agents attended an initial five-day training, and were closely supervised during their first three months, enabling them to conduct direct sales for groups and individuals, deal with objections from consumers, and fill out order forms. Initially, sales agents were managed by the resource agency's provincial coordinators in order to give entrepreneurs time to improve their business and management and skills.

59. Management of sales agents was transferred to enterprises at the end of the project. Although all latrine sales through the enterprises at the end of the TA were made through their sales agents, the management coordination of sales agents remains a difficult task for businesses to handle, especially given the high turnover and difficulties to maintain motivation among the sales force. This is illustrated by the fact that by end of December 2015, only 10% of the total sales agents trained remained active[47]. Challenges encountered in developing the network of enterprises and sales agents are further elaborated in Box 4.

[47] The sales industry typically has a high turnover rate of 30% annually, however a combination of the challenging conditions and learning by doing (in terms of sales agent recruitment strategy) explain the very high turnover during the two-year TA period.

Box 4 The challenges of selling sanitation in rural areas

Sustaining an active sales force: recruitment, motivation and management

Sales agent recruitment and retention proved to be one of the most challenging tasks. Agents must meet certain criteria and be willing to meet the (considerable) challenges of the job. Initially, village health staff were recruited as sales agents, a practice quite common in other countries. However, despite the fact that sanitation marketing produces a public health benefit, some key stakeholders felt that there was a conflict of interest if public sector cadres, including village chiefs, would be working on commission for the private sector, and the approach was stopped. Instead, sales agents were recruited from other groups such as students. Although they were good in sales, their time commitment and inability to cover remote target districts posed a challenge to sustain this strategy. A final iteration of the recruitment strategy was to identify sales agents in villages where CLTS triggering had taken place, based on recommendations from village chiefs (this included the use of so-called village Latrine Champions, who already bought a latrine). This strategy, although having the downside of creating a larger group of village-based sales agents that need continuous coaching and supervision, thus far seems the most appropriate. It circumvented the perceived conflict of interest of formal village chiefs, while village-based sales agents would still be able to cover other "volunteering" roles within their communities (for which occasionally a small compensation would be paid).

Once recruited, continuing to motivate sales agents was difficult. Motivation levels were particularly low during the rainy season, when travel was difficult, and during the harvesting season, when villagers were usually working on their farms and were therefore unable to attend sales events. Agents earned money on a commission-only basis, and not every sales pitch they gave ended in a sale, so many of them gave up.

For one enterprise, sales agents were given a minimum guaranteed salary (of around LAK 400,000 or USD 50/month) from the enterprise, with the opportunity to improve this through commission. However, this arrangement was not feasible for small companies, who found it hard to bear the salary costs if sales could not be maintained at a consistent level. Instead, for some enterprises, commissions were structured in a way that a small deposit upon ordering could be retained by the sales agents, even in the case of order cancellation. Such order cancellations happened for reasons that households were not able to either prepare the cash upon delivery, failed to dig the pit, or due to free latrine distribution in some areas, immediately dampening demand and creating expectations among villagers. Out of 2239 orders, only 1465 materialized in sales (65%).

The use of close supervision and motivation tools and strategies made sales agents more effective but did not necessarily reduce turnover. Thus, continuous recruitment and coaching will be a requirement, and – based on experiences in other countries - this may prove challenging for a majority of businesses, whose core capacity lies in construction. Hence, bundling the management role of a sales force, for example a social franchise or business associations, may be a solution in the medium term, or continued external support by NGOs may be needed.

Strengthening government's ability to facilitate sanitation marketing

60. The broader goal of the TA was to help delineate institutional arrangements and functions for sanitation marketing, understand government capacity for market facilitation and provide information to all stakeholders on market-based approaches to sanitation. This starts with recognizing the government's role in private sector development for sanitation as being supportive as opposed to implemental. In this role, government partners can ensure that barriers to market remain low, competition is encouraged and that price controls and other detrimental interventions - such as untargeted, direct subsidies through public or "project"

procurement – are avoided. This would help to create a market environment that allows consumers to have a choice in a variety of affordable, high quality products. The Government's role in rural sanitation, primarily taken on by Nam Saat, was thus articulated as follows:

- Manage regulations on latrine installation to ensure environmental health and safety standards are met and that private sector is aware of such standards
- Ensure transparency and adequate information provision to all private sector players
- Ensure alignment of all sanitation activities with national strategies and policies, such as the harmonization of targeted pro-poor support mechanisms
- Implement nationwide BCC campaigns to encourage uptake of latrine and implementation of CLTS activities at the village level
- Facilitate linking of private sector players with CLTS activities[48], legitimizing market-based approaches, and helping enterprises to identify high priority areas based on CLTS plans
- Potentially deliver targeted, partial subsidies aimed at reaching the very poor (e.g. vouchers) and inform and coordinate such schemes with private enterprises[49]

61. During the TA, frequent communication with Nam Saat at provincial and district level was required. Expectations and understanding of the supportive role of government for market-based approaches needed to be clarified, and the benefits of such partnerships with the private sector needed to be articulated.

62. Due to low capacities, limited resources and a lack of experience with training and coaching enterprises and sales agents, these roles – in the context of Lao PDR and many other countries– are not well suited to be taken on by government as direct implementers. Other mechanisms to provide such services at-scale would be more suitable, such as social franchise models, business associations, or potentially government-run small and medium enterprise development or vocational training programs (see section below).

Models and partnerships to increase financing options for household sanitation

63. The range of pour-flush sanitation products brought to market, costs in the range of LAK 500,000 (USD 60) to LAK 650,000 (USD 78). However, that is still a significant sum for many rural families to pay in cash upon delivery, hence the need to evaluate financing options available to them.

64. The TA program carried out a review of potential financial institutions and consumers to understand: i) Micro Finance Institution (MFI) strategies with regard to pro-poor financial products and level of penetration in rural areas, ii) MFI motivation to include sanitation financing under consumptive loan products, and iii) household preferences for sanitation loan financing. Unfortunately, it was not possible to find a suitable partner institution that was financially stable, socially oriented, with a geographic coverage in the 10 districts, had reasonably aligned operations and policies, and the potential ability to scale up and serve larger geographic areas.

[48] This means that government staff would not take up sales agents roles, but that village sanitation committees and village-based sales agents know where and how to contact suppliers

[49] An impact evaluation using output-based subsidies for poor households is currently being implemented in partnership with Nam Saat, East Meets West Foundation and WSP.

65. However, one financing model was piloted in conjunction with village banks in Soukhoumma District, under the GiZ Access to Finance for the Poor program[50]. The pilot was designed to understand the willingness of consumers to borrow and the capacity of village banks to meet demand for sanitation loans. To date, only five loans were used for sanitation, which formed part of larger home improvement loans issued by the village banks to consumers (not dedicated sanitation loans). A consumer survey in Soukhoumma district (n=66) revealed that 50% of households said they did not need a loan, while the other half stated they did not qualify for a loan, most likely due to the restrictions of households to have more than one outstanding loan with a village bank at any given time. At the same time, two-thirds stated they were not interested to use a loan for sanitation. These results are consistent with the national consumer research findings[51], which indicate that households are more likely to save for such investments or borrow money from family members[52].

66. Other available financing options may be explored under the Poverty Reduction Fund, which has established and capitalized 'self-help groups' with seed money. These groups are currently being evaluated and may undergo further changes for PRF3. Opportunities exist to introduce saving schemes for sanitation through these groups[53].

4.2.2 Sharing lessons and fostering replication at-scale

Combining sanitation marketing with CLTS

67. In order to institutionalize market-based approaches, the following lessons on how to best link sanitation marketing with CLTS activities were learned during implementation and articulated during learning events.

- ***Timeliness:*** after district staff are trained in CLTS, implementation of triggering and follow-up can start quite rapidly. However, the time it takes to prepare a district for the implementation of a sanitation marketing approach is much longer (1-2 months at a minimum). Suitable enterprises have to be identified, motivated, trained and coached on a one-on-one basis so that they can provide high quality latrines, understand and adapt the business model and develop a sales force. Therefore, preferably, supply chain facilitation efforts need to start ahead (or at least at the same time) as a demand creation program.
- ***Maintain quality:*** CLTS programs mobilize entire communities and villages throughout kumbans and districts, and hence positive word of mouth communication is vital to create and maintain trust in sanitation products. Government "endorsement" of enterprises and their products is vital and could be taken to the next level through a formal accreditation or quality assurance scheme.
- ***Coordination across district boundaries.*** In some districts enterprises that were able to produce high-quality, durable sanitation products could not be found. Hence

[50] These village banks were to form part of a still-to-be established micro-finance institution, that would be formally registered with support of GiZ technical assistance

[51] Emerging markets Consulting: "Consumer research to Inform Rural Sanitation Behavior Change and marketing Communications for Lao PDR: Final Report"

[52] While some households expressed interest in installment payments, care has to be taken in advising small businesses to adopt such schemes, due to their weak working capital and difficult to manage the collection process. In Mounlapamuk district, the scheme was successfully tested, especially when village authorities were used to collect money for due installments.

[53] Or perhaps in some provinces through more mature village banks or MFIs (Sekong and Champasak did not have such mature village banks yet)

coordination between district and provincial staff is important to arrange for supply chain linkages beyond district boundaries. Additional effort is needed to motivate businesses in neighboring districts to deliver to remoter areas (which tend to decrease the profit margin on their products). In such remote situations, a form of grant support for transport costs may be desirable.

- ***Limitations of market-based approach*:** Sales agents and businesses were informed in which villages CLTS would happen and encouraged to conduct sales events in those locations. Nevertheless, they were not always sufficiently motivated to travel to remote target areas (due to high opportunity costs). Identifying village-based sales agents from CLTS-targeted villages, and combining a voluntary role as CLTS-village committee members with that of a sales agent can help strengthen business links[54].
- ***Informed choice for dry toilets***. Despite a strong preference for pour flush latrines among rural households, households may not be able to invest in such facilities immediately. This could be due to lack of savings and financing options, as well as a lack of a developed supply chain to provide easy access to a low-cost pour-flush latrine. Hence, households must also be informed about dry-pit (but easily upgradeable) options during the CLTS process, in order to enable villagers to stop open defecation sooner.

68. A national sanitation marketing learning event took place in April 2014 and was attended by representatives from 14 provinces across the country. In addition, officials from the Health, Education and Rural Development offices of Luang Nam Tha, Oudomxay, Saravan and Attapeu provinces, and staff from Plan International, visited Sekong and Champasak to learn from the sanitation marketing approach in the field.

The development of a sanitation marketing toolkit

69. A Sanitation Marketing Toolkit was produced, and is available in both English and Lao languages. The toolkit is important to align sanitation marketing approaches implemented by other development partners, and facilitate future replication in other regions. This alignment will ensure that businesses are trained in set of Standard Operating Procedures (SOPs) and that a standardized business support structure can be developed in future phases of sanitation marketing. The toolkit includes guides for market facilitators, as well as workbooks and manuals for enterprises and sales agents (see illustrations in

70. Figure 10):

- Business Skills Training for Sanitation Entrepreneurs: Facilitator's Guide
- Business Skills for Sanitation Entrepreneurs: Participant's Workbook
- Latrine Entrepreneur Operating Manual
- Latrine Production and Installation Training, Facilitator's Guide
- Latrine Production Manual
- Latrine Sales Agent Training, Facilitator's Guide
- Latrine Sales Agent Trainee Handbook
- Sanitation Marketing Implementation Manual

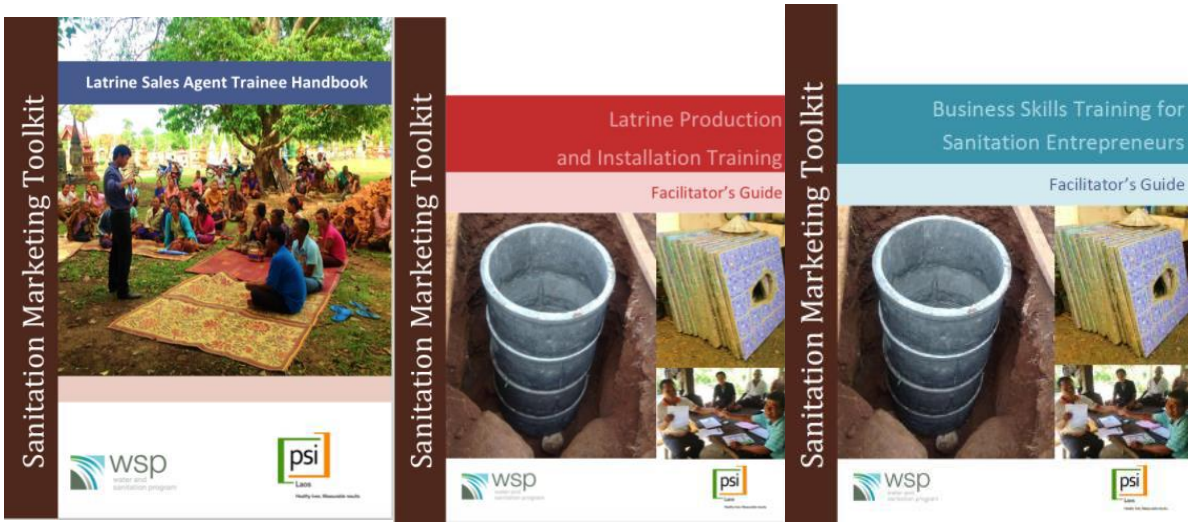
The purpose of the *Sanitation Marketing Implementation Manual* is to provide guidelines and best practices for scaling up sanitation marketing in Lao PDR. It includes the messages, tools,

[54] All Nam Saat district staff and CLTS facilitators now have all the contact and business information from the active sanitation enterprises, to further help create linkages as the CLTS program continues. Salaried government staff and village chiefs are not eligible to work as sales representatives

and processes that have been most effective for implementing sanitation marketing. This manual can be used by either public or private entities looking to replicate these efforts in other regions of the country.

A promotional video to explain the concept of sanitation marketing has also been developed and is available at http://youtu.be/aV4hYVgxmvM

Figure 10 Illustrations of sanitation marketing toolkit



Exploring potential for at-scale marketing platforms for increased sustainability

71. Three models for the sustainable scale-up of sanitation marketing were considered: one involving handover of sanitation marketing activities to various departments of the public sector, and two involving the development of a social enterprise, franchise or association that is able to deliver the services of the network to members and partially fund its own activities through revenue generation.

72. The first potential model for sustainable scale-up intended to use the Lao government to provide business skills training, sales agent training, sales and promotional materials, production and installation manuals, quality assurance services to sanitation enterprises, and support rural microfinance initiatives. The Small and Medium Enterprise Development and Promotion Office (SMEDPO) was evaluated as a potential actor for increasing capacity of sanitation enterprises in business skills and sales force management, potentially through collaboration with local vocational training programs. Provincial Nam Saat was considered for playing the role of quality assurance auditor[55]. Without substantially increased financial and human resources for SMEDPO, Nam Saat, or the presence of SME/TVET programs dedicated to sanitation supply chains, these options do not present a viable model for scaling up at this stage.

[55] Such roles would include observing latrine production on-site to evaluate procedures according to a set of quality and safety standards, and checking installed latrines for quality and environmental health and safety issues. Nam Saat is only able to carry out this role in a minimum spot-check capacity.

73. Informed by a literature review and other global experiences, the pros and cons of establishing either a social franchise or sanitation entrepreneur associations in the Lao context were reviewed[56]. Although an association would present a scalable platform for recruitment, training and management of the sales force, and for arranging business skills and latrine production training for its members, such an association would require intensive support from development partners and government alike. Due to the complexities of registering local civil society organizations (CSO) in Lao PDR, a business association is not a feasible platform in the medium term[57].

74. A social franchise would function by creating a value proposition for enterprises - through a unifying brand - and would provide the same functions as mentioned above, i.e. management of the sales force and business training in standard operating procedures. This could possibly be expanded with providing additional technical and financial support services to enterprises (access to loans) and discounted raw materials through the central franchisor. The franchise model would require buy-in and cooperation from other development partners and government. However, given the nascent sanitation market, this model lacks financial feasibility at this stage[58].

75. The conclusion of this analysis is sobering but realistic, i.e. no viable scale-up mechanism/platform currently seems appropriate for the current stage of sanitation market development in Lao PDR. Nevertheless, a medium term scale-up strategy is proposed that may not immediately address all sustainability concerns but is probably is the most realistic, namely:

- A collaborative platform of government and all civil society organizations (and development partners) active in the sanitation space; potentially such a platform could be linked to the national Scaling-Up-Nutrition (SUN) initiative (i.e. an existing CSO platform is already in place)
- The alignment and implementation of a similar sanitation marketing approach[59], with all CSOs using the national sanitation marketing toolkit; the marketing approach could be further expanded by anchoring this under the umbrella brand of a future nutrition BCC campaign.

76. This collaborative model does not foresee support to a local sanitation marketing entity (such as a social franchisor), that would provide the continuous support needed to businesses and their sales force. However, a harmonized direct market facilitation model by NGO partners can still offer efficiency benefits, as it would avoid fragmentation and duplication of efforts.

[56] This detailed discussion and analysis (including financial analysis) is available in the completion report on sanitation marketing.

[57] In Indonesia, a successful association model has been developed for sanitation enterprises, working in partnership with the Ministry of Health in Indonesia. However, a local group of champion enterprises need to be present, which currently does not yet exist in Lao PDR.

[58] A start-up model is necessary with a minimum of 20 paying members (franchise fee) all operating at the level of the most successful enterprise at the end of the pilot implementation. These assumptions are not realistic at this stage of sanitation market development.

[59] Tailoring and local adaptation for business models, sales strategies and/or products may still be necessary for different regions.

4.3. Behavior Change Communications (BCC) for sanitation

77. The process of producing BCC materials was initiated as a sector-wide effort, led by Nam Saat, and co-funded through WSP, UNICEF, SNV and Plan (with most of the financing from WSP). The objective was to develop an evidence-based sanitation campaign based on formative research. A campaign logo and set of BCC materials would be developed that could be used at-scale nationally in terms of communication objectives and messages.

78. **Formative research to inform drivers and barriers for stopping open defecation and using latrines.** Seven out of seventeen provinces were surveyed to understand barriers and motivators for consumers to access sanitation services, using the SaniFOAM framework[60]. Seventy four percent of household samples is ethnic minority households which are living in rural remote regions with lower level of toilet ownership compared with Lao-Tai group. It also covered a supply chain analysis to understand the most common challenges for rural householders and businesses, and to inform the business models that were piloted under the sanitation marketing approach (see section 4.2).The findings of the research were shared widely and are summarized in the annexed infographic. Key findings are illustrated in Table 3 below.

Table 3 Key findings for the formative research

Key findings on consumer research	Key findings on Supply Chain study
Sanitation Behavior The research showed that among rural poor households: • 63% routinely openly defecate, usually in forest or bush areas near the house • 22% of households throw the baby's excreta into the latrine -- most households toss the excreta in the yard • 97% of respondents wash hands with water, with only 35% using soap ***Opportunity Determinants*** • **Access** - Access to latrines is crucial to ending open defecation, over 90% of respondents (open defecators (ODs) and Latrine Owners (LOs) agreed that people will stop open defecation (OD) if they have access to latrine • **Product Attributes** – Respondents expressed interest in latrines that deliver comfort (82%), durability (41%) and cleanliness with less odor and expense ***Ability Determinants*** • **Knowledge** – Roughly 30% of non-latrine owners are aware of the health benefits associated with latrine use whereas 80% associated OD with the spread of diseases. 13% of non-LOs do not know of any type of latrine while 80% are unaware that multiple latrine options exist. • **Skills** – 77% of non-latrine owners need helps or technical advice if they were going to construct own latrines, their potential source of support are trainers from the government (46%), masons (19%) and social circles (12%). • **Affordability** - Non-latrine owners were unable to	***The actors*** • No actor sells a complete latrine (except in some pilot programs such as PSI/WSP) – the chain is fragmented. • Businesses rely on other sources of income – they don't view themselves as part of the sanitation supply chain. • Most businesses are small and unregistered (and much less likely to be registered outside of capital districts). • Masons can be transient, travelling far to work for extended periods. • Concrete producers are busier in wet season, the opposite of masons and material suppliers. • Businesses do very little marketing (and there is almost no use of sales agents). ***Competition and margin*** • Gross margins of 15% to 40% are not excessive for such products in rural markets • Some actors think latrine product margins are less than those for other activities. ***Transport costs***

[60] SaniFOAM www.wsp.org/UserFiles/file/GSP_sanifoam.pdf

estimate or overestimate the cost of a latrine, and 73% of them think that they could not afford one without support. Among those who estimated latrine costs, 75% gauged that they need over 1 million LAK (120 USD), while suppliers noted that a basic latrine in rural Laos costs between 500,000 to 650,000 LAK (60 to 78 USD). • **Drivers** - Target populations often change their defecation habits (hide in bushes or the forest, pay money to use latrines in crowded places) driven by shame and the need for privacy. Convenience was among the key benefits ranked by households, for both men and women; • **Values** - Non-LOs think that LOs live better, happier lives and are wealthier while latrine owners think that ODs are poor or have low social status. • **Willingness to Pay** – 82% of non-LOs are disinterested in borrowing to pay for a latrine, they prefer to save. Affordability and product knowledge alone does not seem to trigger willingness to pay.	• Many villages are very difficult to access, and large numbers are not accessible for deliveries in wet season • Transport costs – for multiple orders to remote areas – can add up to 34% to cost of a latrine ***Finance*** • Actors report access to finance reported as a constraint, but no more than elsewhere, plus many have loans. • Businesses have concerns about customers' late or non-payment.

79. The next step in the development of the BCC campaign was the agreement of the creative brief for a creative agency, in which key parameters were set, such as the overall campaign goal: in this case for households to stop open defecation, and build or buy and use a latrine[61]. Communications objectives for the campaign were developed and requirements for target audiences and communication channels were set. As per the formative research, the main motivators for the campaign were privacy and respect, safety and convenience.

80. It was confirmed that decision making around latrines was found to be a joint family process, although men and women attached different benefits to owning and using a latrine. Motivators for buying and using latrines were found to be quite homogeneous across different ethnic groups, with convenience rating top rank. Messages to motivate women/mothers to start the discussion around using a latrine at home focused on the benefits of safety for defecation at night, privacy, as well as the convenience of owning a toilet also with respect to child defecation practices. For men, respect from peers and recognition by the government as a civilized member in the community were used.

81. The materials and messages, including motivators addressed to both men and women, underwent testing in various contexts, including among different ethnic groups, to ensure identification and comprehension is good. Slogan and tag lines were tested, and BCC material were mostly visual, as literacy is low, and officially endorsed materials can only be developed in official Laotian (not in ethnic languages).

82. While the campaign materials are still under development[62], Table 4 lists the expected content in terms of BCC materials, job-aids, training manuals and supportive advocacy packages. An illustration of draft materials is shown in Figure 10.

[61] Many other behaviors are relevant for sanitation and hygiene, including for example the maintenance of the latrine, the need for containment of animal waste, and the need for safe child feces disposal. However, due to limited time and funds, the focus of the campaign thus far was one on household sanitation use. In addition for handwashing with soap, messages and materials were developed earlier to be integrated in the CLTS process. This also included the promotion and demonstration on how to build simple handwashing facilities.

[62] Unexpected delays took place due to suboptimal performance of the creative agency

Table 4 Content of the behavior change communication toolkit (under development)

Sanitation campaign	Campaign logo and tag-line to be used on all materials (including other collaterals, such as T-shirts)
Job aids for village meetings and household visits	• Posters to be used during village meetings and for public display • Story cards for small group meetings and for counselling in household visits
Interpersonal communication training materials	Two training manuals for: • master trainers • provincial and district level trainers
Advocacy package to garner greater attention and resources for sanitation	2 sets of advocacy materials aimed at: • National level policy and decision makers • Provincial and district level decision makers
Sanitation sales kit	Materials for village-based sales agents, including: • Product catalogue • Flip-chart to motivate sales

83. It is expected that the sanitation BCC materials will be included under the national campaign for nutrition[63], while being augmented by additional nutrition-related behaviors, including infant and young child feeding, maternal nutrition, and also additional behaviors for hygiene and sanitation (e.g. safe child feces disposal). The BCC materials are expected to be used by CLTS facilitators and village-based nutrition communicators in the HGND project, as well by kumban facilitators taken on roles for sanitation under the partnership between Nam Saat and PRF.

Figure 11 Examples of draft visuals for sanitation campaign (story cards and poster)

[63] A national nutrition social and behavior change communication campaign will be developed with EU/UNICEF and World Bank support under the HGNDP project.

4.4 Results for sanitation access and achievement of ODF villages

The rural sanitation program in Champasak and Sekong delivered the following results.

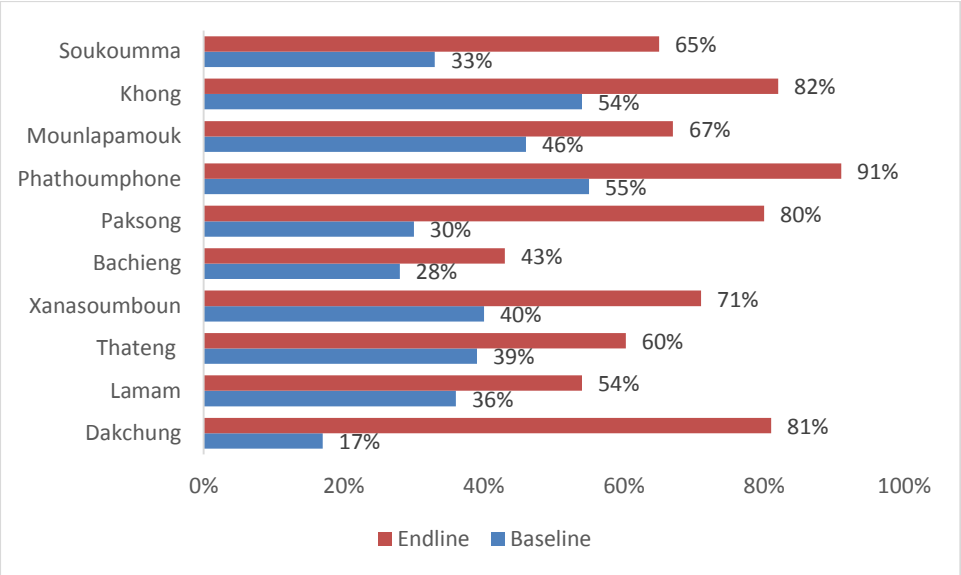
84. Almost 42% (266 villages) of all 625 villages in the 10 districts benefitted from a CLTS process in the period 2012-2016 (226 of the villages benefitted in 2014 and 2016). Across 184 triggered villages (2014-2015), a total of 9,478 villagers (56% of them female) attended the CLTS sessions.

85. Sanitation access increased on average by 32% (from 38% to 69% between July 2014 and February 2016), with the increase varying across districts from 15% to 64%. The rate of change in those villages is around 20% annually. This is eight times as fast as the national rate of change for rural sanitation access from 2000 to 2015 (17% to 56%, which is 2.6% per year).

86. As a result of the CLTS process 6,600 households (around 39,600 people) have started to use latrines,93% of which have been pour flush (7% are dry pit latrines, mostly in Dakchung district).

87. Figure 12 shows the progress of sanitation access in the 226 CLTS villages for each of the districts. While eight districts performed very well, much less progress was made in Bajieng and Lamam districts, partly due to remoteness (Lamam), but also due to less active Nam Saat staff involvement.

Figure 12 Sanitation access from baseline (July 2014) to endline (February 2016) across CLTS villages per district



88. In total, 113 (or 43%) of the 266 villages achieved Open Defecation Free status with the earlier 40 villages (2012-2013) having an ODF achievement rate of around 70% (28 out of 40), and the later batch of 226 villages (2014-2016) a rate of 38% (85 out of 226). The latter rate may increase over time due to the continuation of Nam Saat activities, while it is common that ODF achievement rates of at-scale CLTS programs are much lower as compared to small pilots with intense handholding[64].

89. Below shows that Paksong, Pathounpone and Thatheng districts had the highest ODF achievement rates. The high-performing district of Thateng already declared 35 out of 49 villages ODF by February 2016 and is expected to declare the entire district ODF in April 2016. However, although only few villages (or none at all) villages achieved ODF status, a considerable number of households gained access to sanitation in the CLTS villages in the 10 districts. While achieving ODF remains an important collective target and can motivate districts and communities[65], substantial increases in sanitation access at village level - without reaching the high bar of ODF - need to be recognized as important results.

[64] The motto "pilots never fail, pilots never scale" underscores the typically high ODF-achievement rates, in the range of 50 to 75% for small-scale pilots (such as the 40 villages). A review of CLTS in the East Asia and Pacific region (UNICEF, forthcoming) confirms ODF rates of 20-30% are more realistic within an at-scale program.

[65] The impact evaluation in Sekong and Champasak will also test the effectiveness a cash incentive for villages achieving ODF.

Table 5 Number of ODF villages per districts and increase in household with toilets

	Villages with CLTS intervention		Villages achieved ODF		ODF achievement rate (%)	Households gaining access [a]
District	**2011-13**	**2014-16**	**2011-13**	**2014-2016**	**2011-2016**	**2014-2016**
Mounlapamok	-	17	-	6	35%	707
Sanasomboun	-	46	-	6	13%	562
Bachieng	10	20	8	7	50%	269
Soukhoumma	-	19	-	10	52%	546
Khong	-	15	-	8	53%	629
Pathoumpone	10	20	6	11	56%	900
Paksong	10	20	4	12	53%	916
Thatheng	10	39	10	25	71%	1219
Lamam	-	15	-	0	0	187
Dakcheung	-	15	-	0	0	665
Total	**40**	**226**	**28**	**85**	**42%**	**6,600**

[a] This excludes households that gained access for the 40 villages where CLTS took place in 2012-2013

90. Based on survey data, one in every five households that installed an improved latrine (20%) in districts with marketing activities bought these from sanitation businesses trained under the sanitation program. A total of 1465 latrines were sold through these businesses. Since businesses did not register the villages of latrine sales, the number of latrines sold to the CLTS villages cannot be determined. Although active linkages to CLTS villages were made with the businesses, their sales agents would naturally also sell in other villages, perhaps closer to the businesses. Hence it is likely that over 40,000 people in total gained access due to the TA.

91. Four customer satisfaction surveys were carried out over 2014-2015. In the final round[66], which was largest and most in-depth (n=160), 75% reported that the quality of their latrine was "good" and 23% said it was "very good". 93% of respondents reported having their latrine delivered on time, and 91% were satisfied with the installation service from their enterprise. Interestingly, 86% of respondents also reported that they thought their latrine was not expensive, in other words, good value for money. The survey also showed that 80% of households were still using their latrines six months after installation. 77% of households reported that all members of the family used their latrine when they needed to defecate, possibly pointing to low latrine usage when out in the field and by young children.

[66] Detailed results of the customer satisfaction survey can be found in the Sanitation marketing completion report.

92. In order to better understand the achievement and sustainability of ODF, a qualitative research has recently been fielded in a sub-set of the 40 villages that were triggered as early as 2011/12[67].

93. The research will help to understand what enabled fast change, who has been left behind and what are the key barriers for some villages to start addressing their sanitation situation. It is expected to be completed in April 2016 and will be used to further inform government policy and future program design.

[67] Based on administrative data the reversion to open defecation (so-called "slippage") is not expected to be very high in this sample, as most households have pour-flush latrines, which are more durable and peasant to use as dry traditional pits. This will be further investigated in the field research.

5. Conclusions and recommendations for way forward

5.1 Conclusions

94. The TA program exposed numerous challenges in implementation and allowed rich learning from the implementation in the two southern provinces. Key lessons and conclusions are summarized below, emphasizing those with programmatic relevance that relate to strengthening institutional service delivery systems. In addition a number of important learnings at implementation level are highlighted, so that operational processes can be improved to make last-mile delivery more effective and efficient.

Programmatic lessons for strengthening institutions for service delivery

- *Engagement of national, provincial and district senior decision makers and administrators has not been sufficient to make adequate resources for implementation available in a timely fashion. This has hampered the effectiveness of the TA compared to an environment where domestic resource mobilization is agreed upfront, such as under a lending Operation.*

95. Provincial and district decision makers (vice governors, director and senior staff of Health departments) were engaged through sanitation orientation roadshows. Moreover, the Director of DHHP and Nam Saat were actively involved and mobilized the deputy minister of MoH to attend national learning events and ODF celebrations, encouraging provinces and districts to prioritize sanitation within their budget allocations. However, the reality on the ground has been sobering: despite adequate planning, basic operational costs were insufficient to execute rural sanitation promotion in most, but not all of the districts. This has compromised the effectiveness of the TA, leading to delays in implementation and a reduced scale of implementation compared to what was initially foreseen. Future technical assistance would thus be best aligned in areas i) with less severe funding constraints, such as in WB project areas, or ii) if domestic budget has been committed at the highest level and an – at least partially - funded district plan is in place. In the latter case, technical assistance could be made available on a demand-driven basis once district budgets have been secured.

- *Supporting provinces and districts with practical planning and budgeting tools has helped to develop realistic implementation plans and mobilize a minimum level of operational resources to carry out sanitation activities. Top-level advocacy would be needed to allow a formal addition of rural sanitation as a dedicated sub-program budget line, recognize sanitation expenditure as an explicit sub-program.*

96. Since the programmatic approach is relatively new to many provincial and district implementers, abilities to plan and budget for such "software" activities is limited (e.g. operational costs for implementation of CLTS facilitation and training, and costs for market facilitation). The use of practical planning and budgeting tools has helped districts to submit implementation plans based on realistic targets given their limited staffing, indicating that working in 15 new villages per district annually is already an ambitious level of implementation. The absence of a dedicated budget line for rural sanitation spending has hindered the planning and resource mobilization process. Top-level advocacy may be needed to alter this situation and introduce rural sanitation as a dedicated sub-program.

- *Human resources at Nam Saat district level are constraining district-wide implementation of a rural sanitation programmatic approach. Existing human capital at kumban and village level developed under the Poverty Reduction Fund can support the efficiency of rural sanitation service delivery. Such a partnership does not replace the institutional mandate and technical leadership from the Ministry of Health, in particular Nam Saat for sanitation. A scale-up will require district health offices to make funds available. Only then the efficiency gains from the pilot partnership with PRF can be consolidated through a district-wide approach*

97. With long travelling distances from district to village level, numerous and widely dispersed villages in each district (around 80), and around 1-2 Nam Saat staff at district level, last mile service delivery becomes a daunting task. A partnership between Nam Saat and PRF as service delivery platform can leverage well trained human resources for social mobilization and collective village plan implementation (i.e. kumban facilitators and village implementation teams). In the pilot partnership under this TA, limited to 40 villages across six districts, operational resources for Nam Saat to execute their role in the partnership were not available at the time they were required and thus were covered through the TA. The pilot‘s focus was on operational learning of the integration process and identifying lessons for deeper engagement beyond CLTS. The limited number of villages per district in the pilot means that efficiency gains will not yet be fully realized but could be maximized if capacities are consolidated through a district-wide approach in the scale-up.

- *Developing national guidelines, toolkits and training materials through government-led and sector-wide collaboration is essential to ensure government adoption of the programmatic approach and wide uptake of such packages by other partners and projects. Close institutional coordination with government and partner nutrition stakeholders can help to scale-up the implementation of the sanitation programmatic approach, including CLTS, BCC and sanitation market development.*

98. World Bank/WSP, UNICEF, SNV, Plan International and other NGOs successfully assisted DHHP and Nam Saat in developing the required guidelines, tools and manuals for the implementation of a demand-responsive programmatic approach. Examples are the operational guidelines for rural sanitation, the sanitation marketing toolkit, the CLTS training package, and the sanitation BCC toolkit. Conducting in-depth annual learning events, as well as exposure visits on several aspects of the programmatic approach has been essential for consensus and capacity building among national and provincial staff. With sanitation now being a priority intervention component of the national nutrition action plan, the replication of the programmatic approach, using government adopted packages and tools, is likely to result in harmonized and more efficient service delivery.

- *Developing sanitation related knowledge, capacities and skills of existing and future staff of district and provincial health offices and Nam Saat requires institutional anchoring with relevant local universities and schools, such as the University of Health and Science, and potentially other institutes for in-service training.*

99. Inspired through the national sanitation training program in Indonesia, DHHP has led a process to engage the University of Health and Science to integrate sanitation-related content, including CLTS, into the Program of Public Health. Institutionalizing training programs on sanitation for existing and new health staff in district and provincial health

offices/Nam Saat, requires a comprehensive longer-term effort to develop and test the curriculum, obtain formal approval on module credits and examination standards, and ensure adequate training of lecturers.

- *Sanitation marketing and supply chain development are not an "easy" fit with existing capacities of district and provincial Nam Saat staff. Ensuring a clear articulation of governments supporting role in market facilitation is critical. Given the nascent nature of the sanitation market in Lao PDR, a collaborative model is proposed for the medium term to provide external NGO-led facilitation and support to private sector actors.*

100. Three models for the sustainable scale-up of sanitation marketing were considered: one involving handover of sanitation marketing activities to various departments of the public sector, and two involving the development of a social enterprise (franchise) or association that is able to deliver value-adding services to its members and partially fund its own activities through revenue generation. However, none of these options are deemed feasible at this stage of rural sanitation market development. A collaborative direct market facilitation model by NGO partners is most appropriate and can still offer efficiency benefits, as it would avoid fragmentation and duplication of efforts through the use of the national sanitation marketing toolkit.

Operational lessons for strengthening last-mile delivery

101. Informed by the implementation challenges in Champasak and Sekong provinces, the following operational lessons have emerged:

- *Regular capacity building for CLTS:* High turnover of district CLTS/sanitation teams is a given in the context of Lao PDR, and needs to be factored in the capacity building costs required to maintain CLTS capabilities at district level.
- *Articulation of district and village roles:* District and village leadership and a clear understanding of their respective roles is critical for achieving progress. This includes their role in facilitating linkages with businesses and coordinating events with village-based agents. Once the BCC toolkit has been developed, village Sanitation committee members and/or nutrition communicators can strengthen the CLTS process through additional interpersonal communication events and household visits.
- *Understanding ODF achievement-rates:* Realistic expectations for ODF achievement rates are needed in a larger-scale program and need to be combined with recognizing success in terms of increases in sanitation access.
- *Financing mechanisms for the poorest households.* Villages with supply-driven, untargeted subsidies were difficult to motivate. However, given the lack of viable financing options and consumer preferences to save for toilets, partial smart subsidies may be needed to help the poorest invest in a durable latrine[68]. A harmonization of pro-poor support is needed with a clear targeting mechanism and without undermining the nascent market (e.g. vouchers or household output-based cash transfers).

[68] The ongoing qualitative research on achieving ODF (By April 2016) as well as the impact evaluation (by August 2016) will shed more light on which households have been left behind through implementing CLTS and sanitation marketing

- *Adaptation of products, services and business models.* Once demand is created, there is a clear willingness to pay for high-quality pour-flush toilets in the range of USD 65-90[69]. Very high satisfaction was found with both product and the services of One Stop Shops[70]. In remote areas, it is still important to promote dry pit options as a low-cost alternative to stop open defecation, while households may save or wait until the harvest season to invest in a more durable latrine. Self-construction and sourcing of materials through local retailers may continue to be necessary due to a lack of businesses that could qualify as One-Stop-Shops.
- *Ongoing support and incentives to motivate business and sales agents.* Maintaining the interest of local businesses and sales agents in sanitation marketing requires pro-active and continuous engagement from an external market facilitation agency with Nam Saat support. One-Stop-Shops benefit from a close collaboration with districts government and village leaders, while sales agents are best recruited among village volunteer cadre to avoid conflict of interest with public roles. Structuring incentives to maintain motivation is critical.

5.2 Recommendations and way forward

Recommendations for the Ministry of Health

1. Development of a national rural sanitation sub-program with dedicated budget line under MoH

102. Advocacy is needed so that the new programmatic rural sanitation approach can be adopted widely and provincial health offices and Nam Saat receive the funding they need to go to scale. Rather than as a sparsely funded sub-activity under MoH's national program on Health and Hygiene Promotion, the establishment of a sub-program on rural sanitation and hygiene would be best[71]. The program budget – in addition to salaries - would have to cover expenditures for basic operational costs, CLTS and BCC activities, pro-poor incentives, monitoring and other indirect sector coordination cost. The development of a harmonized financing guideline will need to be part of such program, articulating a policy for pro-poor support and incentives for village ODF achievement in the context of the existing inequalities in access. To meet the national sanitation access target of 80 per cent by 2020, over 200,000 people would need to gain access annually (2017-2020). This translates into a minimum budget requirement of USD 2.3 to 2.8 million annually, or USD 10.8 million over the 2017-2020 period (an annual investment of USD 14 per capita). It assumes that USD 3.8 million is allocated over this period for targeted subsidies to poor, USD 1 million for ODF-awards, and the remaining 55 per cent for software expenditures. This budget estimate does not include the recurrent administration and salary costs of government at different levels, neither does it include external technical assistance for market development.

2. Integration of rural sanitation program, especially CLTS, sanitation marketing and BCC within multi-sectoral nutrition programs and particularly the government's nutrition Social and Behavior Change Communications Strategy.

[69] This is for the underground and mid structure, excluding shelter and transport.
[70] Of those that bought their toilet at a One Stop Shop, 80% used the installation service and 20% self-installed.
[71] This could also include rural water supply, however, the government is currently considering of the rural water supply mandate should not be transferred to the newly created Department of Water Supply under MPWT.

103. With increased funding allocated to nutrition, including the World Bank-funded HGNDP as well as USAID and future EU/UNICEF support, the government has the opportunity to integrate rural sanitation activities across all these programs (already foreseen for HGNDP), maximizing the use of the national toolkits, sanitation BCC materials and training manuals developed under this TA. The materials and messages (ongoing development), including motivators address to both men and women have been included (e.g. a focus on privacy and safety for women, and for men motivators that speak to gaining respect from community and government as a model civilized family). . Motivators for stopping open defecation and latrine usage were found to be rather similar among different ethnic groups, and hence a unified set of BCC materials is appropriate, provided messages are verbally delivered in local languages using mostly visuals, as literacy is low (also officially endorsed materials can only be developed in official Laotian, not in ethnic languages). Another concrete example is for MoH to promote the use of the sanitation marketing toolkit under the CSO Forum of the Scaling-Up Nutrition Initiative, since donors as EU and USAID will continue to implement nutrition and WASH programs with the help of NGO partners.

3. Mobilize high level ministerial support and guarantee funding commitment to scale-up sanitation service delivery through Poverty Reduction Fund.

104. Informed by the lessons of the pilot partnership between Nam Saat and PRF, a realistic scale-up plan needs to be developed, reflecting allocations for minimum operational budgets for Nam Saat in a selected number of districts. This commitment is required to effectively lead the partnership and ensure the institutional mandate of Nam Saat is sufficiently funded to reap the efficiency gains of working in partnership with the PRF.

4. Support the institutionalization of a capacity development program for sanitation skills targeted at existing and future health staff at district and provincial levels

105. The ongoing collaboration between Nam Saat and the University of Health and Science needs to be pursued so that sanitation-related curriculum can be implemented from academic year 2017 onward. Also, opportunities to integrate sanitation curriculum into other appropriate training institutes, such as for health centre outreach workers, need to be seized, drawing on the guidance and tools produced under this TA.

Recommendations for World Bank

1. *Aligning Water Global Practice technical assistance strategically with HGNDP Operation*

106. Sanitation is already an integral and costed part of HGNDP, and Nam Saat is one of the implementing partners under DHHP. Hence, the financial resource environment for implementing CLTS combined with integrated sanitation and hygiene BCC activities, as part of wider village-level nutrition SBCC interventions, are well secured. To ensure optimal effectiveness of future TA, a geographic focus on the 12 districts in four provinces of HGNDP's community interventions is recommended, with the following focal areas:

- *Assistance for sanitation marketing and market facilitation*: this function cannot yet be delivered through district Nam Saat or other public agencies[72]. Thus complementary bank-executed TA is justified to make affordable and accessible products available to rural households once demand is created. This TA should also include capacity building for district, kumban and village-cadres to help facilitate linkages with local supply chain actors and villages CLTS/sanitation committees.

[72] Or through another national platform that would support marketing (such as a franchise or association)

- *Assistance to expand behavioral focus of sanitation and hygiene BCC to "baby WASH"* : as part of HGNDP – with complementary support of EU/UNICEF – SBCC materials, including mass media, for a range of nutrition and WASH behaviors will be further developed, integrating the sanitation BCC toolkit which is already available. Complementary Bank executed TA will be made available to provide technical guidance to this process, with a special focus to include so-called "baby-WASH" interventions[73]. Behaviors to be addressed, which are deemed to be particularly relevant for stunting prevention, are: i) safe disposal of child feces, and ii) separating infants and toddlers from chicken and other animal feces.

107. In addition, Bank-executed TA will be used to provide increased implementation support during HGNDP implementation, due to the low capacity environment in target districts.

2. Scaling-up and deepening the scope of collaboration between Nam Saat and PRF under PRF3[74]

108. Informed by an evaluation of the pilot partnership, a detailed scale-up strategy will be developed. However, given the known risks of having inadequate resource for Nam Saat to carry out their mandate, the following two-pronged approach for horizontal scaling is recommended:

- *Going district-wide in the six pilot districts*: Since capacities of Nam Saat, PRF district and selected kumban facilitators have been developed already, a gradual horizontal scaling in the six pilot districts is proposed, with scope and timeline dictated by Nam Saat operational budget availability. Once a district implementation plan has been agreed between PRF and Nam Saat, and district funds from Nam Saat have been released, demand-responsive Bank executed TA will be mobilized in the following areas: i) capacity building of Nam Saat and PRF kumban facilitators in CLTS and BCC, ii) marketing support to identified local latrine suppliers, iii) monitoring support, and iv) lesson sharing and evaluation across districts. World Bank will also aim to bring in other partners and NGOs working in these districts.
- *Geographic expansion of pilot to HGNDP districts*: Although financial resources may be sufficient for Nam Saat in HGNDP districts, a constraining factor for implementation will be human resource levels. Hence, the 12 districts form an ideal location for leveraging kumban facilitators and village implementation teams, whose members would be selected to lead the CLTS/sanitation village committee or who may be recruited as village nutrition facilitators[75]. Complementary Bank executed TA would focus on capacitating Nam Saat and PRF district and kumban facilitators[76] and overall implementation support to allow rapid learning for a streamlining of the standard operating procedures. Scale and timeline for expansion of Nam Saat – PRF partnership under HGNDP needs to be defined[77].

[73] For a discussion on the importance of baby-WASh see Mahmud, Iffat; Mbuya, Nkosinathi. 2016. Water, Sanitation, Hygiene, and Nutrition in Bangladesh: Can Building Toilets Affect Children's Growth?. World Bank Study;. Washington, DC: World Bank

[74] While not covered this report, additional bank executed TA is also planned to help improve the sustainability of rural water schemes under PRF3, through piloting a number of management and post construction support models

[75] Both men and women are required for these roles.

[76] This would focus on technical support, as financial resources are available under HGNDP and PRF3 for direct training costs of CLTS implementers

[77] Proposed scaling model is to work in a few districts in 1 province, aiming to cover 15-20 villages annually, and then expanding to districts in other provinces.

- *Working with kum ban facilitators as sales agents*. Since these facilitators are volunteers with small allowances, covering multiple villages, KBF would be excellent candidates to be further trained in facilitating supply chain linkages and acting as sales agents under PRF3. The TA will focus on fostering this innovation.

109. Finally, it is proposed that TA will be used for expanding the scope of the partnership by developing detailed technical guidance for PRF to support potential financing mechanisms under PRF3[78], such as:

i. the use of Self Help Groups or more formal saving and loan schemes that allow households to invest in sanitation;
ii. the use of infrastructure and/or livelihood grants for pro-poor support for the poorest households in the community. This would only be possible upon prioritization of the community and the development of an ODF-plan, as well as transparent criteria for eligibility of poor households.

3. Programmatic and policy assistance and advocacy for rural sanitation

110. It is recommended that the World Bank would engage in high-level dialogue with Ministry of Health on prioritizing resources for rural sanitation, specifically to articulate a sub-program and financing guideline under the new WASH policy, slated for approval by mid-2016. In order to ensure the effectiveness of future TA, a joint work program would be developed with MoH's DHHP that would ideally rely on a combination of TA and domestic resources. Areas for future assistance would focus on key institutional gaps:

- *monitoring for sanitation*: synergies could be developed with the ongoing initiative to expand the DHMIS with additional nutrition-relevant indicators;
- *human resource development*: partnership with the University of Health and Science would be continued and expanded to other relevant human resource development initiatives for the health system[79];
- *knowledge management*: resources would be used to document, disseminate and share lessons and solutions for WASH-nutrition integration that are relevant nationally as well as globally.

[78] This is especially relevant since HGNDP does not provide any partial support or financing mechanism to poor households

[79] Potentially the human resources development program financed by ADB for health workers may benefit from inclusion/updating of sanitation and hygiene modules

6. References

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- World Bank Water and Sanitation Program (2016) Building Rural Sanitation Capacity Nation Wide in Indonesia. Washington.

7. Annexes and supporting documentation

Annex A: Number of village ethnic group in the project target area

Annex B: Infographic for sanitation consumer research and supply chain analysis

Annex C: Participant list international knowledge exchanges carried out under the TA

Annex D: Revised draft Cooperation Agreement between PRF – Nam Saat

Annex E: Sequencing of rural sanitation activities

Supporting documentation/resource pack contains

i. CLTS training package and guideline
ii. CLTS completion report by SNV
iii. Sanitation marketing completion report by PSI
iv. Sanitation marketing toolkit and guides
v. Final report on Consumer Research and Supply Chain study
vi. Behavior Change Communication toolkit (to be finalized)
vii. Capacity building needs assessment report
viii. Curriculum package for University of Health and Science (to be finalized)

All supporting documentation in the resource pack is available from WSP Lao PDR

Annex A: Number of village ethnic group in the project target area

Province	District	2011-13	2014-16	Total	# Ethnic minority
Champasak province	Mounlapamok	-	17	17	4
	Sanasomboun	-	46	46	9
	Bachieng	10	20	30	15
	Soukhoumma	-	19	19	0
	Khong	-	15	15	9
	Pathoumpone	10	20	30	2
	Paksong	10	20	30	24
Sekong province	Thatheng	10	39	49	48
	Lamam	-	15	15	15
	Dakcheung	-	15	15	15
	Total (#)	**40**	**226**	**266**	**141**
	Total (%)				**53%**

Annex B: Infographic for sanitation consumer research and supply chain analysis

Sanitation Market and Consumer Insights

Brief for Lao PDR

January 2016

While sanitation practices have improved across Lao PDR, open defecation and poor sanitation are still persistent problems in rural areas, especially for the poorest households and among non-Lao-Tai groups. This brief presents key findings on rural sanitation behavior and supply chains, and highlights opportunities for addressing sanitation challenges in Lao PDR.

Key Statistics

RURAL VILLAGERS WITHOUT ACCESS TO IMPROVED SANITATION, 2013[1]

56%

ECONOMIC COST OF POOR SANITATION, in health and productivity[2]

USD 620 MILLION
annual estimate for 2013

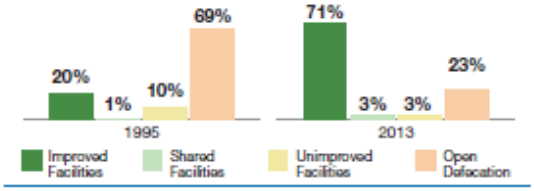
RETURN ON INVESTMENT IN SANITATION, Rural Areas, 2013[3]

USD 4
per dollar invested

Sanitation Trends

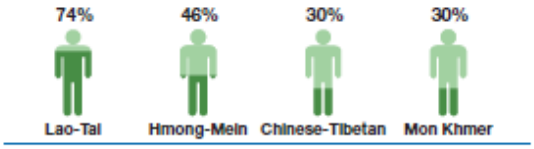
Over Time

Sanitation Access by Year[4]



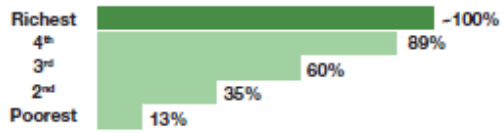
Ethnic Groups

Access to Improved Facilities by Ethnic Group[5]

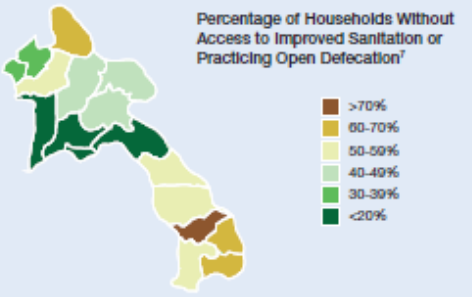


Wealth

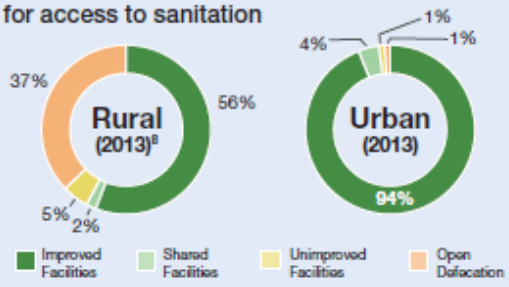
Households Using Improved Sanitation by Wealth Quintile[6]



Sanitation access is lagging in the northern and southern regions...



for access to sanitation



Human Capital Impacts

49% of rural children were stunted in 2011[9]

11% of child deaths per year are due to diarrhea[10]

- **Almost half of rural children in Lao PDR suffer from stunting,** meaning that children are too short for their age. This condition also impacts their cognitive development, and is linked to open defecation and the ingestion of feces.
- As adults, stunted individuals are **less able to contribute to the nation's growth.**[11]
- Poor sanitation also contributes to **premature deaths**, with diarrheal disease accounting for about 1,700 child deaths annually in Lao PDR.[12]

1 WHO-UNICEF JMP 2015.
2 Hutton, Larsen, Lakbouapao, and Voladet, 2009.
3 Bostman, Hutton, and Rodriguez, 2013.
4 WHO-UNICEF JMP 2015.
5 Lao Social Indicator Survey (LSIS) 2012.
6 Lao Social Indicator Survey (LSIS) 2012.
7 Consumer Research to Inform Rural Sanitation Behavior Change and Marketing Communications for Lao PDR, Annex 1, 2014.
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9 Investing in the Next Generation Research Brief, Water and Sanitation Program, World Bank Group. December 2014.
10 Nutrition at a Glance, Lao PDR. World Bank. December 2013.
11 Investing in the Next Generation Research Brief, Water and Sanitation Program, World Bank Group. December 2014.
12 Institute for Health Metrics and Evaluation, available at http://www.healthdata.org/search-gbd-data?s=laos%20Diarrhea (2010).

WORLD BANK GROUP
Water

Annex C: Participant list international knowledge exchange carried out under the TA

Activity name / type	Description	Participants
Exchange visit to Indonesia on scaling up rural sanitation and sanitation marketing (South-south knowledge exchange) 30 Aug – 06 Sep 2014	This is the joint event among the three countries, namely Pakistan, Philippines and (Laos. **Outputs** ▪ Understanding of how the demand-creation approaches on sanitation at scale have been managed. ▪ Experiences of countries have been shared/learned from each other, while networking has been built. ▪ Country action plan	Eight people from Laos in total, including: 1. Dr. Bouakeo Suvanthong, Deputy Director, National Center for Environmental Health and Water Supply, Ministry of Health 2. Dr. Vilayvone Mangkaseum, Deputy Chief, Environmental and Occupation Health, Hygiene-Health Promotion, Ministry of Health 3. Dr. Vat Kongkeo, Deputy Director, Health Department, Champasak Province 4. Dr. Khamlay Santiphoum, Deputy Director, Health Department, Sekong Province 5. Ms. Thipphaphone Thipphasouda, Technical staff, National Center for Environmental Health and Water Supply, Ministry of Health 6. Mr. Bounthavong Sourisak, Community Development Specialist, WSP 7. Ms. Viengsompasong Inthavong, Water and Sanitation Specialist, WSP 8. Ms. Jenni Livingston, M&E Advisor, Netherlands Development Organization (SNV)

Annex D: Revised draft Cooperation Agreement between PRF – Nam Saat

Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

Government's Office

National Committee for
Rural Development and Poverty Reduction

No.0613/PRF

Vientiane Capital, 30 June 2015

Cooperative Agreement

Between

National Center for Environmental Health and Water Supply (Nam Saat),

and

National Poverty Reduction Fund (PRF)

For a Pilot Partnership Program on Rural Sanitation

Presently, 93% of all Laotians without access to improved latrines live in rural areas, especially in poor and remote parts of the country. This is a main cause of health problems, especially diarrheal disease and stunting in those areas. In line with the 8th National Socio-Economic Development Plan (NSEDP), Government of Lao PDR (GoL) aims to improve rural sanitation and mandated the **National Center for Environmental Health and Rural Water Supply (Nam Saat)** under the Ministry of Health (MoH) to improve the delivery of rural sanitation services. The Operational Guidelines issued by MoH in 2014 provide concrete directions to achieve Open Defecation Free villages, based on a process of demand creation using a community mobilization approaches, called Community-Led Total sanitation (CLTS), combined with supply side interventions to strengthen the local supply chain of sanitation services. Typically Nam Saat's role is to facilitate a community awakening ("triggering"), where villagers are motivated to collectively stop open defecation and start building and using latrines under the guidance of a self-formed village CLTS committee. Nam Saat's role is to follow-up and support the communities by facilitating linkages with local sanitation suppliers and trained masons so as to offer villagers a choice of toilet options they like and can afford. For those villages where everyone is motivated to invest in and use a latrine, Nam Saat will carry out a verification process, after which the Open Defecation Free status is declared and the community receives official recognition for this achievement. In addition to its rural sanitation mandate, Nam Saat also provides rural water supply

infrastructure, capacity building and support to user groups and village authorities, to whom the infrastructure assets are handed over.

The **Poverty Reduction Fund (PRF)**, under the supervision of the National Committee for Rural Development and Poverty Reduction, is mandated to help the GoL implement its policy to reduce rural poverty in line with the 8th NSEDP. It operates in 44 poor districts in 10 provinces, and implements bottom-up planning processes and provides communities block grants to implement priority infrastructure subprojects. The PRF has also started to support investments to improve the livelihood and nutritional status of villagers on a pilot basis. To carry out these programs, the PRF has trained many village level leaders, including Kum ban Facilitators (KBF) and Village Implementation Teams (VIT). There are two to three KBF in every kum ban where the PRF operates, and 44% of them are women. The VIT consists of village leaders selected by villagers to implement infrastructure subprojects. The PRF provides them repeated training in leadership, community facilitation and bottom-up processes. The village level institutions and kum ban human resources that the PRF has developed are considered to provide a useful platform through which multiple agencies, in cooperation with the PRF, can deliver last mile services at a lower cost. Under such cooperation, the relevant partner agency, such as Nam Saat, would assume the institutional mandate for sector specific issues, such as sanitation for the case of Nam Saat, and is overall accountable for achieving the ultimate objective of the partnership, such as ODF in the case of the partnership with Nam Saat. At the same time, such cooperation is aligned with and supports the PRF's objectives of poverty reduction.

The Nam Saat and the PRF have hereby agreed to enter into a partnership on a pilot basis to allow the Nam Saat to use the PRF village platform to implement sanitation activities. To support this partnership, the World Bank team, through the Global Water Practice - Water and Sanitation Partnership (WSP) will provide Nam Saat and the PRF necessary technical assistance and implementation support.

The partnership will be implemented in 40 villages, in 27 village clusters (kum bans), and 6 districts within four of the PRF's target provinces over a duration of about 11 months from Oct 2015 to Sept 2016:

1. Savannakhet Province: four villages in Nong district and 10 villages in Sepon District;
2. Salavan Province: 6 villages in Ta Oi District;
3. Xekong province: 10 villages in Toumlan District and 4 villages in Darkcheuang District;
4. Attapeu Province: 6 villages in Phouvong District.

Note: The increase in sanitation access and ODF success rate for the target villages under the Partnership is expected to vary, depending upon the willingness of the villagers, access to finance and saving mechanisms, availability of supply chain, and conditions of access roads. The results of Partnership will be evaluated at the end of pilot phase to inform expansion or replication to other provinces. The principles of cooperation articulated in this agreement

may be revised or retained and the scope of activities may be expanded depending upon the evaluation of the pilot phase.

In order to achieve the objectives of the partnership, this cooperation agreements defines clear roles and responsibilities of each party and emphasizes coordination and implementation arrangements from the national to local levels, as follows:

A. Roles and responsibilities of the Department of Hygiene and Public Health Promotion under the Ministry of Health

1. National Center for Environmental Health and Water Supply (Nam Saat):

a. Assume the primary responsibility in the implementation of CLTS and related activities and helping the pilot villages achieve Open Defecation Free status.
b. Develop overall standard operating procedure, implementation roll out plans, etc. together with the PRF, to implement the Partnership
c. Develop standardized technical guidance notes, CLTS training materials, toilet technology models, norms, etc. as relevant for the Partnership and consistent with PRF Project implementation;
d. Prepare and send the memo to the relevant sectors in provincial, district and villages to inform them regarding the implementation of this Partnership;
e. Organize the Partnership launch meetings along with PRF at the provincial and district levels and provide oversight for all trainings related to this pilot at the different levels;
f. Coordinate with the relevant sectors to establish the steering committee at the provincial and district levels;
g. Prepare and collect data to be used as the initial indicators before the Partnership kicks off;
h. Prepare and build capacity as required for the provincial and district trainers and equipment/tools to be used in the trainings at the different levels;
i. Develop the overall capacity development plan, with support of WSP, to ensure the Nam Saat and PRF staff as well as PRF kum ban facilitators and village leaders are sufficiently equipped to implement the partnership.
j. Participate in the coordination and review meetings on a regular basis as per time schedule;
k. Provide the trainers to train the district team and provide technical support as per action plan;
l. Prepare and agree with PRF the overall budget plans, including cost of training, food, travel and accommodation, to implement and monitor the implementation of the partnership and carry out follow-up activities in pilot districts and villages;
m. Coordinate and share information regarding the implementation of the Partnership with the PRF's national office regularly, starting with the community level preparatory processes right up to the declaration of the open defecation –free villages;

2. *Provincial Department of Public Health*
    a. Assume the primary responsibility in the implementation of CLTS activities and the achievement of Open Defecation Free status among pilot villages at the provincial level.
    b. Provide necessary technical support, training to trainers, facilitate linkages with supply chains, etc. in each district within the province;
    c. Coordinate with the provincial PRF office in the implementation of the Partnership and provide necessary technical and logistical support, as defined in the Agreement.
    d. Receive and summarize the reports on the progress of the Partnership from the District Health Office on a monthly basis, and report to Nam Saat
    e. Facilitate setting up of a joint committee of Provincial Department of Public Health and Provincial PRF, under the oversight of Provincial Vice Governor, for coordination and implementation review;
    f. Be the focal point for all coordination and solutions in the implementation of the Partnership at the provincial level and reports the progress to the Nam Saat through the joint committee;

3. *District Health Office*
    a. Assume the primary responsibility in the implementation of CLTS activities and the achievement of Open Defecation Free status among pilot villages at the district level.
    b. In partnership with District PRF office, (i) arrange training for and provide technical support to Kum Ban Facilitations (KBF) and Village Implementation Teams (VIT) for implementing CLTS triggering events, (ii) prepare village level WASH/ODF plan, (iii) carry out behavior change communication (BCC) during village meetings; and (v) implement other follow-up activities in line with the standard operation procedures and technical guidance notes of the Partnership.
    c. Facilitate the linkage between VIT, villagers, KBF and toilet suppliers and provide information on low-cost toilet options

d. Work closely with and advise relevant PRF district staff in the supervision of Kum ban Facilitators and VIT in aspects related to the implementation of the Partnership;
e. Organize trainings for toilet suppliers/masons for toilet construction and support KBF to facilitate links with them as part of the village PODF planning and post-triggering follow-up process;
f. Coordinate with the district PRF office in the implementation of the Partnership and provide necessary technical and logistical support, as defined in the Agreement;
g. Use the relevant portions of monthly reports prepared by Kum ban Facilitators on WASH and other PRF activities to summarize and submit the reports to the Provincial Department of Public Health (Nam Saat section)

All costs, including incremental operating costs and direct costs, for Nam Saat staff associated with carrying out the activities provided above in the Section A will be borne by Nam Saat, based on a clear work plan and budget.

B. Roles and Responsibilities of the Poverty Reduction Fund

1. National Poverty Reduction Fund (PRF);

a. Assume overall responsibility to deliver community facilitation services as described in the MOU.
b. Assist the Nam Saat in the development of the standard operating procedure to implement the partnership.
c. Facilitate, and participate where necessary, in the meeting and trainings at the provincial and district levels;
d. Facilitate the establishment of the provincial steering committee;
e. Develop the detailed budget plan for the activities to be implemented by the PRF under the partnership in line with the overall budget plan prepared by the Nam Saat, subsuming all operational costs of PRF staff, KBF and VIT, as well as the direct costs for delivering training to KBF, and supporting the use of behavior change communication tools for village level use.
f. Develop reporting mechanisms for the partnership, integrated in the PRF"s standard monthly village level activity reports;
g. Coordinate and share information with the Nam Saat and Water and Sanitation Program regarding the implementation of the Partnership on monthly basis during the pilot, based on consolidated monthly monitoring reports from district PRF staff and KBF
h. Participate in the evaluation of the Pilot Partnership

2. Provincial Poverty Reduction Fund

a. Assume overall responsibility to deliver community facilitation services as described in the MOU at the provincial level;

b. Supervise the District PRF Office in pilot districts to ensure that the Partnership would be implemented in line with this MOU;
c. Report the implementation progress in the activities for which the PRF is responsible to the Provincial Department of Public Health, the provincial steering committee and the National PRF Office;
d. Be part of the joint committee meetings of Provincial Department of Public Health and Provincial PRF for coordination and implementation review;

3. *District Poverty Reduction Fund*
   a. Assume overall responsibility to deliver community facilitation services as described in the MOU at the district level;
   b. Confirm the villages' readiness to cooperate with the district Nam Saat to implement the pilot Partnership;
   c. In partnership with District Health Office, arrange training for, and provide facilitation and day-to-day guidance to, Kum Ban Facilitations (KBF) and Village Implementation Teams (VIT) for (i) implementing CLTS triggering events, (ii) preparing village level WASH/ODF plan, (iii) carrying out follow-up village meetings, (iv) carrying out behavior change communication (BCC) during village meetings, and (v) implementing other follow-up activities in line with the standard operation procedures and technical guidance notes of the Partnership;
   d. Support VIT and KBF in communicating with toilet suppliers and District Nam Saat to strengthen supply chain linkage;
   e. Supervise and provide necessary non-technical guidance KBF and VITs to ensure that the Partnership is implemented in line with the standard operating procedures and the technical guidance notes applicable to this Partnership;
   f. Advice and facilitate KBF and VIT in data collection and reporting of CLTS progress and related activities as part of their monthly reporting system;
   g. Prepare activity plans, budgets, incur expenses in connection with approved activities (such as trainings, reviews, facilitation support to KBT and VITs, etc.) and report progress as per norms and procedures of PRF;
   h. Report implementation progress to the Provincial PRF Office;
   i. Convene implementation review meetings and coordinate with the District Health Office in the implementation of the Partnership and provide necessary technical and logistical support, as defined in the Agreement;

All costs, including incremental operating costs and direct costs, associated with carrying out the activities provided above in section B will be borne by the PRF.

Roles and Responsibilities of Kum ban Facilitators and Village Implementation Teams

1. *Kum ban Facilitator:*
   a. Coordinate with the VIT and participate in village meetings to discuss water, sanitation and hygiene issues, in particular open defecation;
   b. Inform and motivate Self-Help groups (SHG) to save and accumulate funds for latrine constriction, as per the regular procedures on SHG

c. Participate in the training and review meetings at district level (as needed) to discuss the implementation of CLTS and related activities;
d. Be responsible for facilitating the PRF's established CDD processes to help the community identify problems, assess situation, present different options and create demand for WASH improvement;
e. With the technical guidance and handholding support of District Health Office and together with the VIT, (i) collect basic information data, (ii) facilitate CLTS triggering events, (iii) prepare village level WASH/ODF plan, (iv) carry out behavior change communication (BCC) tools during village meetings; and (v) implement other follow-up activities in target villages in line with the standard operation procedures and technical guidance notes of the Partnership;
f. Coordinate with District Public Health Office to facilitate linkage with supply chains, masons, etc. with the communities in targeted villages;
g. Facilitate VIT institute/implement community level monitoring activities such as community based surveillance of open defecation (OD), participatory monitoring of ODF plans, community feedback loops
h. Involve in the verification process for the declaration of the Open Defecation Free (ODF) villages;
i. Participate in the training and meetings convened at the district PRF and District Health Office.
j. Compile CLTS related data, including sanitation access data, collected by VIT as part of overall PRF monthly report to submit to the District Health Office and District PRF Office;

2. *Village Implementation Team*
   a. Coordinate with the KBF and participate in village meetings to discuss rural sanitation issues in particular open defecation;
   b. Be responsible for facilitating the PRF's established CDD processes to help the community identify problems, assess situation, present different options and create demand for WASH improvement;
   c. With the support of KBF, (i) help Nam Saat implement CLTS triggering events, (ii) collect basic information data (baseline and monthly progress), (iii) prepare the village level WASH/ODF plan, (iv) carry out behavior change communication during village meeting and self-help groups; and (v) implement other follow-up activities in line with the standard operation procedures and technical guidance notes of the Partnership;
   d. Facilitate communication between villagers and toilet suppliers through KBF District PRF, to foster supply chain linkages;
   e. Implement community level monitoring activities such as community based surveillance of open defecation (OD), participatory monitoring of ODF plans, community feedback loops and also involving in the scrutinizing process for the declaration of the Open Defecation Free (ODF) villages;
   f. Participate in the trainings on CLTS and related activities to be provided by the District Health Office;

g. Collect CLTS related data, including sanitation access, as part of overall PRF monthly report and submit to KBF.

All costs, including incremental operating costs and direct costs, associated with carrying out the activities described above in section C will be borne by the PRF.

C. Role and Responsibilities of the Water and Sanitation Program (WSP)

In coordination with the World Bank's PRF project implementation support team, the WSP has agreed to provide the following technical assistance to Nam Saat and PRF to support the implementation of WASH integration activities:

a. Provide technical assistance to Nam Saat for developing WASH integration plan; Standard Operating Processes customized to CDD processes of PRF; need based training and exposures on WASH;
b. Provide technical support to the Nam Saat for (i) customizing existing guidelines for PRF including training manuals and methodologies, evidence based BCC tools, latrine technology and supplier trainings; and (ii) providing technical training to and building capacity of PRF field staff, KBF and VITs on CLTS;
c. Support Nam Saat in coordinating with other development partners in the water, sanitation and hygiene sectors operating in the pilot locations to achieve maximum impact;
d. Regularly review monthly progress data and implementation issues in monthly coordination meetings between PRF national, Nam Saat Central and WSP.
e. Monitor and analyze data provided by the Provincial Department of Public Health and District Health Office before, mid and after the implementation of the pilot Partnership;
f. Undertake process monitoring, carry out qualitative assessments and participatory learning event at least once in six months (mid and end of the Pilot) to identify and document implementation gaps, best practices; and establish feedback loop leading to improved implementation.
g. Independently evaluate the pilot Partnership and identify areas of improvement, expansion or replication in other provinces – evaluation results expected to be available within 2 months of the completion of the Partnership.

Remarks: this Cooperative Agreement will be amended as appropriate, and when deemed necessary by all concerned parties;

This Agreement shall be effective when it has been signed.

Deputy Director of National Center for Environmental Health and Water Supply	Director of Poverty Reduction Fund

Bouakeo Souvanthong Seal and Signature	Bounkhouang Souvannaphanh Seal and Signature
Attested by Head of the Planning and Cooperation Office National Committee for Rural Development and Poverty Eradication Chit Thavisay Seal and Signature	

Annex E: Flow diagram of the sequence of different activities

1. National program on rural sanitation

1.1 National WASH policy and strategy
- National sanitation target of 80% by 2020 (NSEDP)
- Village ODF of at least 2000 villages by 2020
- National committee on sanitation

1.2 National capacity building plan with dedicated budget
- National CLTS facilitators pool

1.3 National program methodology (incl. Operational Guideline on Rural Sanitation, CLTS guideline, BCC tools, Sanitation Marketing toolkit..etc.)

1.4 Dedicated budget line for implementing sanitation program

1.5 Conduct joint annual review meeting

1. ENABLING ENVIRONMENT FOR IMPLEMENTATION AT NATION-WIDE

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2. Arrangement

1.1 Provincial kick-off meeting

1.2 Establish provincial task force

1.3 District kick-off meeting

1.4 Establish district CLTS committee

1.5 Village baseline data/information collection

2. ARRANGEMENT

3.1 Training

Train Nam Saat

3.2 Pre-triggering
- Inform villages about the intervention

3.3 Triggering
- Schedule with villages about triggering event
- Conduct triggering event in each village
- Team review meeting

3.4 Post-triggering follow-up (CLTS & BCC)
- Conduct follow-up until ODF verification stage
- Introduce sanitation marketing

3.5 ODF status verification
- Gather verification team and committee
- Train verification team and committee, village representatives
- Verification result meeting in each village
- Verification result and planning meeting at district level

3. IMPLEMENTATION AND MONITORING

4.1 ODF village declaration
- Arrange for declaration
- Facilitate communities and governments in organizing the declaration

4.2 Completion
- Completion review meeting at district
- Lessons learned, next steps/direction for expansion

4. COMPLETION