Hygiene framework

This document sets out a framework for hygiene promotion and behaviour change in the countries where WaterAid works. It is based on the current literature on hygiene promotion and draws on our experience in South Asia, the Pacific region and Africa. It builds on and supersedes WaterAid's *Hygiene promotion policy* (1999), providing guidance for our country programmes, setting out key principles and minimum commitments for our work on hygiene. It is also intended to inform and assist other organisations that work on hygiene in the context of water, sanitation and hygiene (WASH) programmes.

This document should be cited as *WaterAid (2012) Hygiene framework*. WaterAid, London, UK.

It can be found in the publications section of WaterAid's website – **www.wateraid.org/publications**.

Cover photo: WaterAid/Zute Lightfoot

Children wash their hands at the WaterAid handwashing point by the school toilet block, Juru Primary School, Juru sector, Rwanda

Contents

Glossary

Baseline study A study carried out prior to programme implementation that provides information on key indicators, such as latrine coverage and use. Information obtained by a baseline study informs subsequent monitoring and evaluation activities.

Child to child (CtC) A hygiene promotion approach based on the belief that children can be highly influential in improving the health of others, especially with regards to raising hygiene awareness in the family.

Community-led total sanitation (CLTS) Community-led total sanitation, an approach using the promotion of sanitation to bring about a collective community decision to reject open defecation. Communities strive to achieve open defecation free (ODF) status. CLTS in its 'pure' form does not recommend or subsidise specific sanitation technologies.

Critical times In connection to handwashing, this generally means washing hands after defecation, handling children's faeces or cleaning their bottoms, and before eating, feeding children, and handling food or water.

DALY Disability adjusted life year: the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability[1].

Formative research Research carried out prior to programme implementation to obtain information with which a hygiene promotion programme can be designed.

Excreta Faeces and urine.

Faecal-oral transmission The route by which disease-causing organisms (pathogens) excreted in the faeces of infected humans (or animals) enter the human body through the mouth. Such organisms may be carried from faeces to mouth via contaminated fingers, food, flies, fluids (eg water) or soil (also referred to as 'fields' in the 'F diagram' – see Figure 5 on page 15).

Hardware The 'hard' or physical infrastructure (eg latrines or wastewater treatment facilities) that makes sanitation services and hygiene practices possible.

Hygiene	Personal and household practices that serve to prevent infection and keep people and environments clean. Examples of hygiene practices include handwashing, bathing and management of stored water in the home, all of which aim to preserve cleanliness and health. The World Health Organisation (WHO) defines hygiene as 'the conditions and practices that help to maintain health and prevent the spread of diseases'[2].
Hygiene education	All activities aimed at raising awareness and conveying knowledge of the links between hygiene practices and health.
Hygiene promotion	Systematic approaches to encourage the widespread adoption of safe hygiene practices in order to reduce diarrhoeal and other water- and sanitation-related diseases. Hygiene promotion focuses on determinants of behaviour change, which may not necessarily be directly related to knowledge of the health consequences of poor hygiene[3].
Morbidity	The incidence of ill health.
ODF	Open defecation free – an aspiration in total sanitation approaches.
Pathogen	A bacterium, virus or other microorganism that can cause disease.
Participatory methodologies	The use of methods, materials and techniques that encourage the active involvement of individuals in a group process, regardless of their age, sex, or economic or educational background. Participatory approaches aim to build self-esteem, make decision-making easy and enable people to learn from each other.
PHAST	Participatory hygiene and sanitation transformation. A participatory methodology designed specifically for and frequently used in the water, sanitation and hygiene sector.
Sanitation	In the narrow sense, the safe disposal or re-use of human excreta. In the broad sense, it is often referred to as environmental sanitation – excreta management together with solid waste and storm water management[4].
SARAR	Self-esteem, associative strength, responsibility, action planning and resourcefulness. SARAR was designed as a methodology for community action planning. Other approaches such as PHAST are based on SARAR principles.
Social marketing	An approach that uses marketing principles to achieve social benefits, such as changes in attitudes and behaviours, which are deemed to be good for society as a whole[5].

Software   Activities that mobilise households and communities and establish the 'soft' infrastructure necessary for the functioning of water, sanitation and hygiene services (eg the institutional mechanisms and governance required to maintain good hygiene behaviour, such as community health clubs).

Sustainability   The conditions conducive to services or practices and their outcomes continuing over time. No time limit is set on those continued services, behaviour changes and outcomes.

TSSM   WSP's Total Sanitation/Sanitation Marketing programme.

Wastewater   Water that has already been used, ranging from raw sewage to washing water.

WASH   Water, sanitation and hygiene.

WHO   The World Health Organisation.

WSP   The Water and Sanitation Programme of the World Bank.

WaterAid/GMB Akash/Panos

Millie, Chairwoman of the IDEA WASH Committee, Lakatoorah tea garden, Sylhet, Bangladesh

Pascal, who has a physical disability, washing his hands outside the family's new latrine, Hambale, Chipenbele, Zambia

Background to this framework

Introduction

Professionals in the water and sanitation sector increasingly recognise the importance of hygiene in achieving the maximum benefit from improvements in water and sanitation services. A growing body of research highlights the positive impacts that practising good hygiene can have on the health of individuals and their communities, as well as its various social and economic benefits.

However, hygiene is frequently neglected in the water and sanitation sector, as well as in the health sector. Possible reasons for this neglect include the difficulty of changing people's behaviour and the time required to do so; the difficulty in measuring behaviour and behaviour change; the personal and private nature of hygiene behaviour; and the fact that hygiene is related to neglected conditions: diarrhoeal and respiratory diseases – the two biggest killers of children[6]. The difficulty of measuring behaviour has likely also led to under-investment in research on hygiene promotion and behaviour change[7].

Safe hygiene practices are not automatically adopted following the provision of water and sanitation services. Much of the success of their adoption hinges on their compatibility with existing beliefs and practices, as well as psychological factors, environmental conditions and the availability of cleaning materials and 'hygiene aids'[6]. Research confirms that motivations for changing behaviour are not necessarily directly related to health benefits, but rather to benefits gained from, for example, improved social status, convenience, safety, comfort, privacy or smell. Even when people are aware of the links between health and practising good hygiene, this knowledge does not automatically translate into the adoption of safe hygiene practices[8].

Therefore, it is important to determine what motivates the sustained adoption of hygienic practices in different contexts. In the water, sanitation and hygiene (WASH) sector, the term 'hygiene education' is increasingly replaced with 'hygiene promotion', marking a shift from instructive approaches focused on health to others that take wider motivational factors into account and are more likely to result in permanent behaviour change.

Purpose of this framework

Since the mid 1990s, WaterAid has increased its emphasis on hygiene alongside its water and sanitation work, although levels of staff expertise and resourcing have varied[9]. Since the development of our *Hygiene promotion policy* in 1999, no organisation-wide framework or strategy for hygiene promotion has been developed, nor have previous publications been updated. By building on the *Hygiene promotion policy* and our subsequent experience, this framework serves as a strategic guidance document for WaterAid country programmes as they develop or refine their approaches to hygiene. It sets out key principles and minimum commitments for hygiene promotion, on the basis of which detailed practical and context-specific guidelines can be based.

The specific **aims** of this framework are:
- To establish a common understanding within WaterAid of hygiene promotion and associated terminology.
- To highlight the importance of hygiene promotion in water and sanitation programmes and policies.
- To give an overview of hygiene promotion approaches used in WaterAid country programmes.
- To outline key principles and minimum commitments for WaterAid's hygiene promotion work.

The framework's **structure** is as follows:
- Part 1 gives a background to the framework.
- Part 2 provides an overview of existing literature on hygiene promotion.
- Part 3 contains a brief history and overview of WaterAid's hygiene-related work.
- Part 4 sets out key principles for country programmes on hygiene promotion, within the framework of a programme cycle.
- Part 5 outlines WaterAid's minimum commitments for hygiene promotion work – these make up WaterAid's policy on hygiene promotion.

Contextualising this framework

Figure 1 illustrates how a framework document like this one is situated under WaterAid's *Global Strategy 2009-2015*[10]. The minimum commitments identified in this framework and in other framework documents comprise WaterAid's more detailed policy statements. Detailed guidance and context-specific strategies regarding implementation of work in hygiene promotion lie 'downstream' of frameworks.

Figure 1 – Frameworks and other WaterAid documents

WaterAid's Global Strategy 2009-2015

Policies	**Frameworks**	**Guidelines**	**Country strategies and country thematic strategies**
Short documents (typically 3-4pp).	Longer documents (typically 30-50pp).	Longer documents (typically 30-50pp).	Reasoned statements about how the themes are to be addressed in country programmes.
Presenting WaterAid's minimum commitments.	Presenting the scope of the theme, a conceptual framework, discussion of the issues, WaterAid's minimum commitments and references.	Presenting detailed guidance on how to operationalise a framework.	
Indicating how those commitments will be monitored.			

Increasing level of detail and contextualisation

This document should be used alongside the following WaterAid frameworks, policies and guidelines:

- Water quality guidelines and country policies[11]
- *Equity and inclusion framework*[12]
- *Sustainability framework*[13]
- Counting users and post-intervention surveys guidance notes[14]
- *Sanitation framework*[4]
- *Urban framework*[15]
- *Menstrual hygiene matters: A resource for improving menstrual hygiene around the world*[16]
- *Water security framework*[17]
- *Disaster management framework*[18]

Strategic fit

WaterAid's **vision** is of a world where everyone has access to safe water and sanitation. We recognise that an increase in sustainable and equitable access to safe water and sanitation must be accompanied by good hygiene practices. Good hygiene practices are integral to the effectiveness of water and sanitation services, and therefore to the strategic aims and indicators outlined in WaterAid's *Global Strategy 2009-2015*[10].

WaterAid's *Global Strategy 2009-2015* identifies **four global aims**:

1 To promote and secure poor people's rights and access to safe water, improved hygiene and sanitation, by working with partner organisations to deliver services and ensure communities' voices are heard in decision-making processes.

2 To support governments and service providers in developing their capacity to deliver safe water, improved hygiene and sanitation, to ensure improved financing, governance and management of the sector for equitable and sustainable delivery of WASH services.

3 To advocate the essential role of safe water, improved hygiene and sanitation in human development through evidence-based advocacy work to raise the profile of WASH in other sectors, especially healthcare and education.

4 To further develop as an effective global organisation recognised as a leader in our field and for living our values by improving our research and learning.

The importance of hygiene is emphasised throughout all four aims. We view hygiene promotion as a critical part of all our work and are committed to contributing to further research on behaviour change. Ultimately, by working with key sector and non-sector stakeholders, conducting research and supporting integrated service delivery, we aspire to see a world where everyone is able to practise good hygiene.

WaterAid's **strategic performance indicators**, developed in 2010 as a way to measure progress on our *Global Strategy*, include one indicator on hygiene. This indicator focuses on identifying the percentage of 'poor people practising sustained improved hygiene behaviour'[19], disaggregated by gender, disability, age and HIV/AIDS (noting that the feasibility of this will need to be evaluated once the methodology for measuring is refined). Although this demonstrates WaterAid's commitment to hygiene promotion and achieving sustained behaviour change, appropriate methodologies for collecting and harmonising data and (proxy) indicators need to be improved[20]. This framework recognises the need for a substantial amount of further research on hygiene and hygiene monitoring, and should be treated as a 'live' document that will be reviewed and modified over time.

WaterAid's understanding of hygiene promotion

This part provides an overview of the current literature on hygiene promotion, and sets the context for Parts 3, 4 and 5.

Terms and definitions

The World Health Organisation (WHO) defines hygiene as 'the conditions and practices that help to maintain health and prevent the spread of diseases'[2]. In WaterAid's *Sanitation framework,* hygiene is defined as 'personal and household practices such as handwashing, bathing, and management of stored water in the home, all aimed at preserving cleanliness and health'[4].

There are various categories of hygiene behaviour that have a significant impact on the transmission of water- and sanitation-related diseases. They are:

- Safe disposal of human excreta (including that of children and infants).
- Water source protection and use (from the water source to transportation, storage and 'point of use').
- Personal hygiene (washing of hands with soap at critical times[21], as well as body, face and clothes).
- Food hygiene (cooking, washing, storing, preventing cross contamination).
- Domestic and environmental hygiene (disposal of solid waste and animal excreta, control of wastewater and rainwater, cleanliness of the house and its surroundings)[22].

Hygiene is about behaviour; changing hygiene practices means changing behaviour. Research demonstrates that changing behaviour does not necessarily come about due to knowledge of the potential negative repercussions of a practice (eg the knowledge that not washing hands may have health implications); it is also dependent upon context – the beliefs, attitudes and opportunities of individuals and societies.

Hygiene promotion vs hygiene education

The water and sanitation sector is gradually moving away from the term 'hygiene education'. Hygiene education is about enhancing people's knowledge by raising awareness of the links between good hygiene practices and health. It is premised upon the belief that teaching people about how disease spreads will result in them changing their behaviour for the better.

However, motivations for changing behaviour are not necessarily directly related to health benefits. They may be more closely related to 'nurture (the need to protect children), affiliation (the need to fit in with family or group, avoiding disputes), comfort (convenience, time, weather, privacy), attracting others (pride, cleanliness, gaining more votes, attracting brides/bridegrooms), disgust with earlier behaviour (open defecation), dignity and responsibility, economics (saves money, makes money), and existing cultural beliefs'[23].

Hygiene education programmes – whether participatory or didactic – do not always build on and connect effectively to existing beliefs and practices, hence the critique that 'there is little proof that such educational approaches are effective, either in developing or developed countries'[24].

'Hygiene **promotion**' is a much broader concept than hygiene education. It refers to 'systematic approaches to encourage the widespread adoption of safe hygiene practices in order to reduce diarrhoeal and other water and sanitation related diseases'[25]. It builds upon what people know, do and want, and therefore focuses on identifying motivations for behaviour change based on existing practices and beliefs[26]. By identifying drivers of change and finding ways to trigger them, effective hygiene promotion reduces the main risky hygiene behaviours and practices among key target groups.
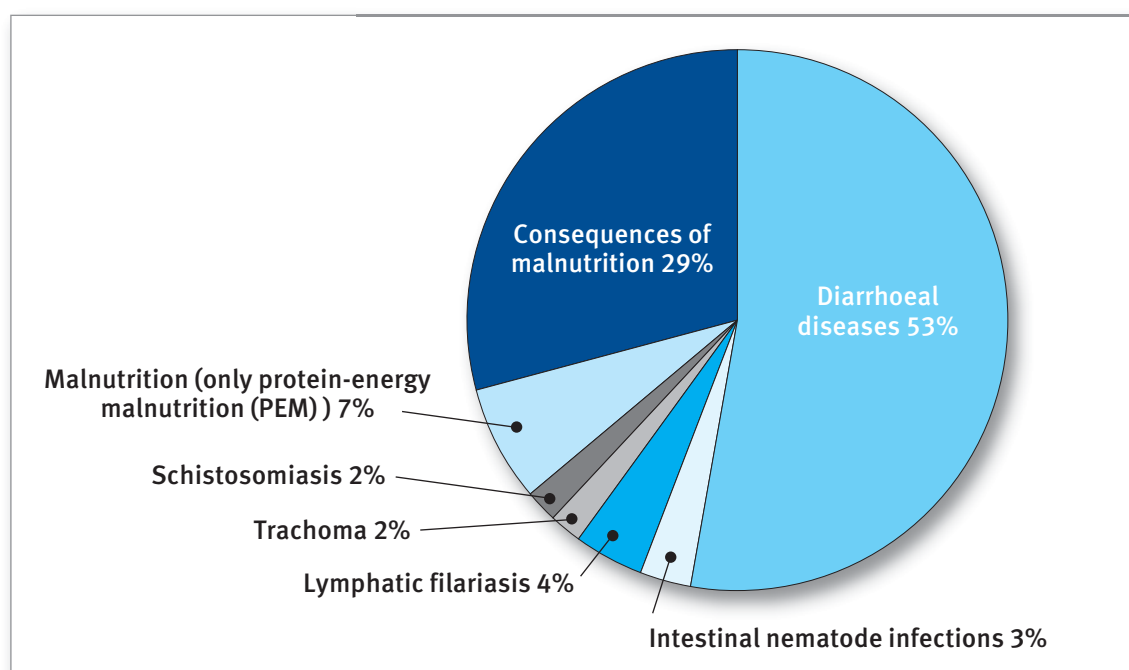

WaterAid/GMB Akash/Panos

Alo Rani Mondal (centre), a hygiene promoter in Kalshi Takar Baa slum, Dhaka, Bangladesh

Why hygiene?

Disease

Access to safe water, sanitation and good hygiene practices have a major role to play in the reduction of disease. Globally, improving WASH has the potential to prevent at least 9.1% of the disease burden (in disability adjusted life years, or DALYs[1]) or 6.3% of all deaths (2008 figures)[27]. Of the total burden of ill-health preventable by improvements in WASH, more than half is caused by diarrhoeal diseases (Figure 2). Diarrhoeal diseases also contribute to malnutrition, rendering people (especially children) more susceptible to other diseases. Other diseases associated with poor WASH include schistosomiasis, trachoma, soil-transmitted helminth infections and tropic enteropathy[28].

Figure 2 – Global contributions (in DALYs) of diseases to the total burden of ill-health that is preventable by improvements in WASH (2008 data)[29]

Consequences of malnutrition 29%

Diarrhoeal diseases 53%

Malnutrition (only protein-energy malnutrition (PEM)) 7%

Schistosomiasis 2%

Trachoma 2%

Lymphatic filariasis 4%

Intestinal nematode infections 3%

Diarrhoea

Although not **all** diarrhoea is due to poor WASH, diarrhoeal diseases represent a major part of the WASH disease burden, as the pathogens that are associated with diarrhoeal diseases are passed on primarily through the faecal-oral route.

The following figures are worth noting:
- Diarrhoeal diseases kill approximately 1.8 million people every year[30].
- Among infectious diseases, diarrhoea ranks as the third leading cause of both mortality and morbidity, after respiratory infections and HIV/AIDS[30].

Young children are especially affected:
- Young children bear 68% of the total burden of diarrhoeal disease[30].
- Globally, approximately 2.5 billion cases of diarrhoea occur among children under five years old every year. About 80% of these cases are in Africa and South Asia (Figure 3)[31].

- Diarrhoea is the second most common killer of children under five globally[30], and as of 2010, it is the most common killer of children under five years old in Sub-Saharan Africa[32].
- Nearly one in five child deaths is due to diarrhoea, about 1.5 million lives lost every year. This is higher than the number of deaths caused by AIDS, malaria and measles **combined**.
- Just 15 countries account for more than 70% of all annual deaths from diarrhoea among children under five (Figure 4)[33].

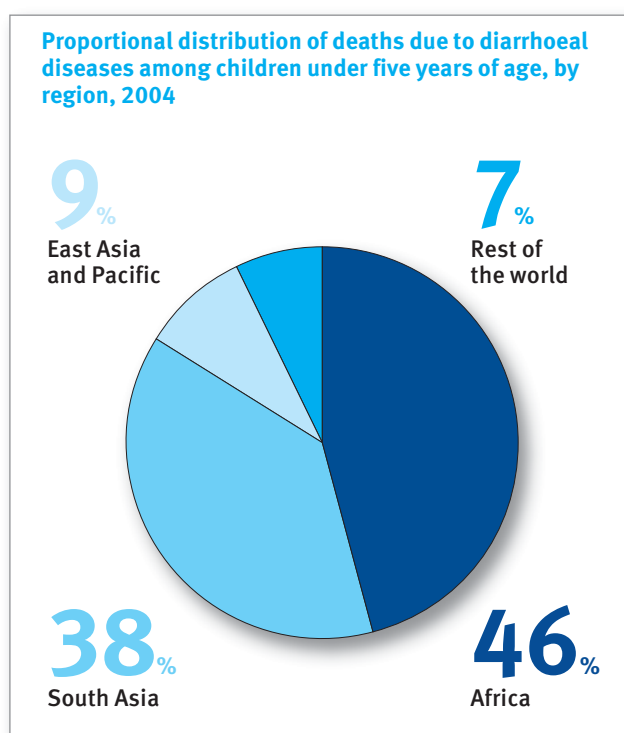Figure 3 – More than 80% of child deaths due to diarrhoea occur in Africa and South Asia[40]

Proportional distribution of deaths due to diarrhoeal diseases among children under five years of age, by region, 2004

9% East Asia and Pacific

7% Rest of the world

38% South Asia

46% Africa

Figure 4 – Nearly three quarters of child deaths due to diarrhoea occur in just 15 countries[34]

Rank	Country	Total number of annual child deaths due to diarrhoea
1	India	386,600
2	Nigeria	151,700
3	Democratic Republic of the Congo	89,900
4	Afghanistan	82,100
5	Ethiopia	73,700
6	Pakistan	53,300
7	Bangladesh	50,800
8	China	40,000
9	Uganda	29,300
10	Kenya	27,400
11	Niger	26,400
12	Burkina Faso	24,300
13	Tanzania	23,900
14	Mali	20,900
15	Angola	19,700

Diarrhoeal morbidity and mortality

The immediate threat from diarrhoea is dehydration and loss of fluids and electrolytes. While interventions such as oral rehydration therapy (ORT) have significantly reduced the **mortality** rate associated with diarrhoeal diseases, the **morbidity** rate has not necessarily reduced. Diarrhoeal diseases also prevent the normal intake of food and absorption of nutrients, leading to impaired physical and mental growth and functioning, and heightened risk of infection. They also cause an enormous economic burden in terms of healthcare costs and time lost at school or work[30].

Faecal-oral transmission

Most cases of diarrhoeal diseases are spread by disease-causing organisms (pathogens) that are found in human and/or animal faeces. The most common transmission mechanism of these organisms from excreta to a host is **faecal-oral transmission**. Figure 5 gives a visual representation of the transmission routes by which faecal material can be ingested, and ways to prevent this.

Figure 5 – The F-diagram of disease transmission[35]
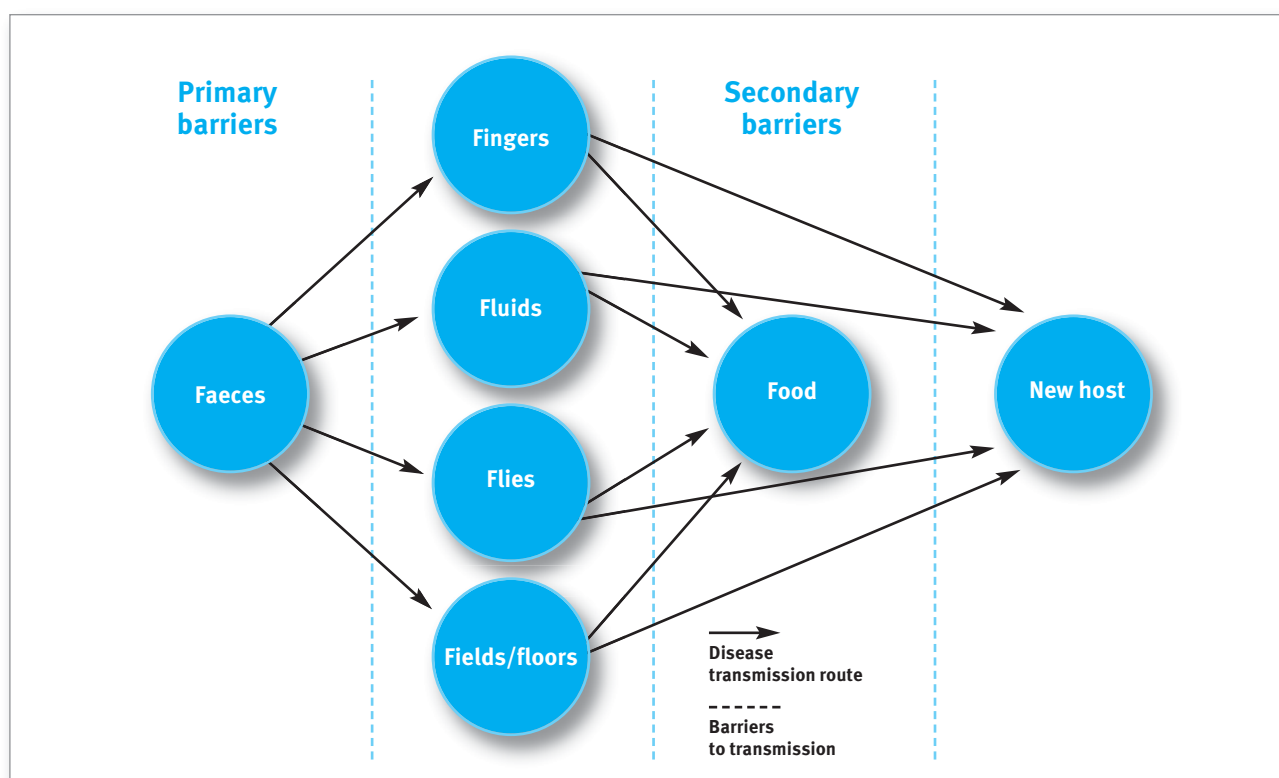
The main transmission routes are via 'the five Fs': fingers, fluids, flies, fields/floors and food. Faecal pathogens can reach a new 'host' and be ingested through any of these routes. For example, they can contaminate water that is subsequently used for drinking or in food preparation. Flies that land on faeces can carry pathogens to places where food is being prepared and/or consumed. Soil with faecal material can be taken into the home by animals or humans and unknowingly deposited in places where food is prepared or children play.

The most effective way of reducing transmission of disease is by putting in place 'primary barriers' and 'secondary barriers' that prevent pathogens from entering the environment or otherwise reaching new hosts[36].

The four arrows that originate from faeces on the left represent the primary routes by which infectious organisms enter the environment. Primary barriers stop this from happening. These include:

- The disposal of faeces in 'such a way that they are isolated from all future human contact (by the use of latrines, sewers, and burying).
- [The] removal of traces of faecal material from hands after contact with excreta (ie handwashing after going to the toilet).'[37]

Secondary barriers are 'hygiene practices that stop faecal pathogens that have got into the environment in stools or on hands from multiplying and reaching new hosts'[37]. They include:

- Washing hands before preparing food or eating.
- Preparing, cooking, storing and re-heating food in such a way as to avoid pathogen survival and multiplication.
- Protecting water supplies from faecal contaminants, and water treatments such as boiling or chlorination.
- Keeping domestic spaces free of faecal material.

The benefits of good hygiene practices

Water and sanitation interventions contribute to preventing disease transmission in various ways. For example, safe disposal of faeces is a primary barrier to prevent faeces from contaminating the environment. Pit latrines, used by both adults and children, can reduce diarrhoea by 36% or more[38]. Furthermore, improved water quality and quantity can be associated with up to a 20% reduction in diarrhoea[39].

However, even though the provision of improved water supply and sanitation facilities make it easier to practice good hygiene, on their own they are not sufficient to significantly decrease morbidity and mortality rates. As demonstrated by the figures below, good hygiene practices are of critical importance as they have a greater impact on health and ensure hygienic use and maintenance of facilities[40].

- Handwashing with soap at critical times, especially before eating and after contact with excreta, can reduce diarrhoeal disease by up to 47%[41], the prevalence of eye infections like trachoma and conjunctivitis by approximately 45%, and respiratory infections by about 20%[42, 43].
- Good hygiene practices can also reduce the prevalence of respiratory infections, skin infections, blinding trachoma, endo-parasites like roundworm and hookworm, and ecto-parasites such as scabies and fleas[44, 45]. Hygiene practices during delivery and postpartum (the period just after delivery), particularly handwashing with soap or equivalent, have been reported to reduce neonatal mortality[46].
- Face and body washing reduce the risk of trachoma and skin infections (although this is less well researched).
- Lack of food hygiene (particularly of weaning food) 'has been suggested as a major contributor to diarrhoea in low-income settings'[47, 48].
- Preventing children from coming into contact with animal faeces and keeping household surfaces clean, as well as fly control, will also lessen the risk of disease.

Rali Barik, washing her hands with clean water from a tubewell, Lakatoorah tea garden, Sylhet, Bangladesh

Cost-effectiveness of hygiene promotion

The disease burden attributed to poor water, sanitation and hygiene is proven to be extremely costly for households and health systems. Health costs are estimated at approximately US$340million globally for households lacking a water supply and sanitation, and approximately US$7billion for national health systems[49]. Out of all WASH interventions, hygiene promotion has proven to be particularly effective in reducing mortality and morbidity from child diarrhoea, and has been identified as the most cost-effective disease control intervention (Figure 6). The World Bank/WHO Disease Control Priorities Project has estimated that the cost-effectiveness of hygiene promotion lies at US$3.35 per DALY loss averted, followed by sanitation at US$11.15 per DALY loss averted, compared to much higher costs for oral rehydration therapy and expanded immunisation[50].

Figure 6 – Cost-effectiveness of child survival interventions[51]
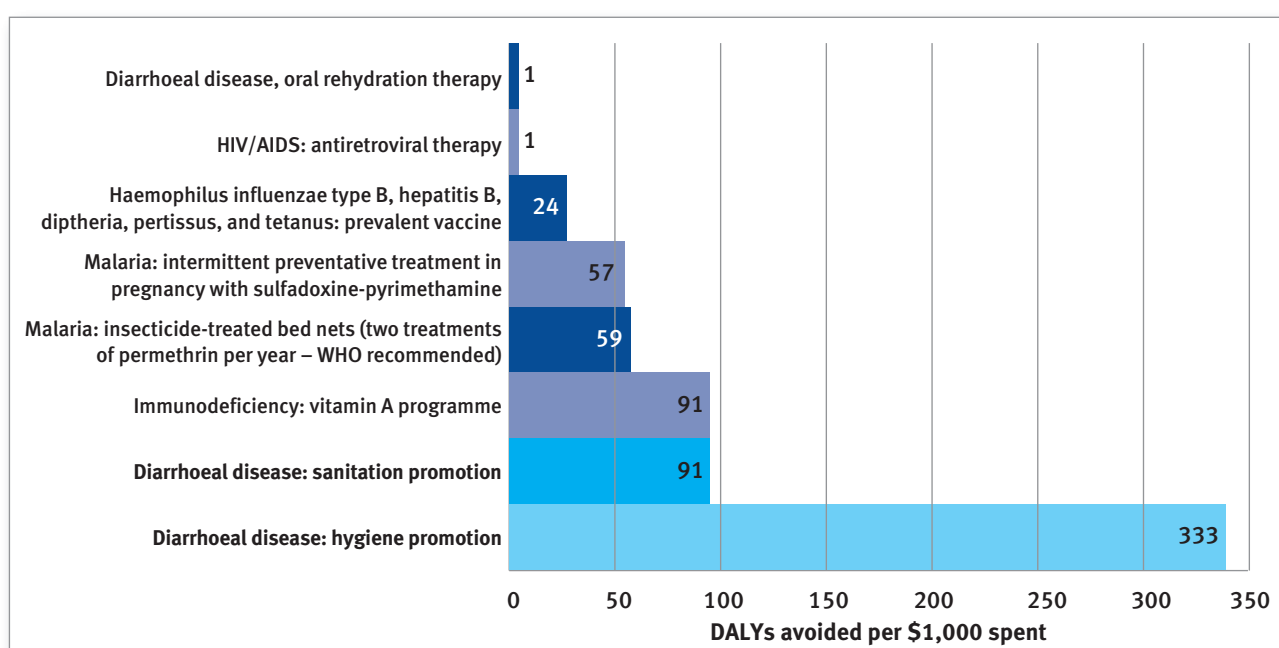
Furthermore, WHO research indicates a strong link between 'lower initial infant mortality rates and higher economic growth, [suggesting that] economic growth is higher in countries with lower initial infant mortality rates', and that 'a 10 year increase in average life expectancy at birth translates into a rise of 0.3-0.4% in economic growth per year'[52], indicating a strong association between improved water, sanitation and hygiene and economic returns (however, this is a correlation not causation).

Equity and inclusion in hygiene promotion

Hygiene promotion programmes take on different forms depending on their context. However, it is important that any programme is inclusive, ie relevant and accessible to all members of society. On the following page are examples of particular groups or circumstances for which hygiene is especially important, based on experiences from WaterAid's country programmes and their partners. This is not meant to be a comprehensive overview but rather a way to highlight some of the most vulnerable or at-risk groups.

School-aged children

Schools can serve as hubs for the transmission of faecal-oral diseases, which have damaging impacts on children's physical and cognitive development. According to WHO, pre-school and school age children are particularly vulnerable to infections of round worm and whip worm, which, along with other water- and sanitation-related diseases, including diarrhoea, can result in significant absences from school[53].

However, schools can also play an important role in hygiene promotion. Hygiene messages in school curricula, community outreach activities and school health clubs can play a pivotal role in promoting good hygiene practices, together with the provision of safe sanitation and drinking-water. When children are included in programmes as active participants, they can become powerful agents of change in their own households and in their communities by passing on messages about good hygiene practices. As future generations of adults, children are also critical to ensuring the sustainability of behaviour change[54].

Child to child and **child to community** hygiene promotion approaches recognise the responsibility that children often have in developing countries for looking after younger siblings, and therefore the role they can play to influence their siblings and other family members to adopt safer hygiene practices.

WaterAid/Anna Kari
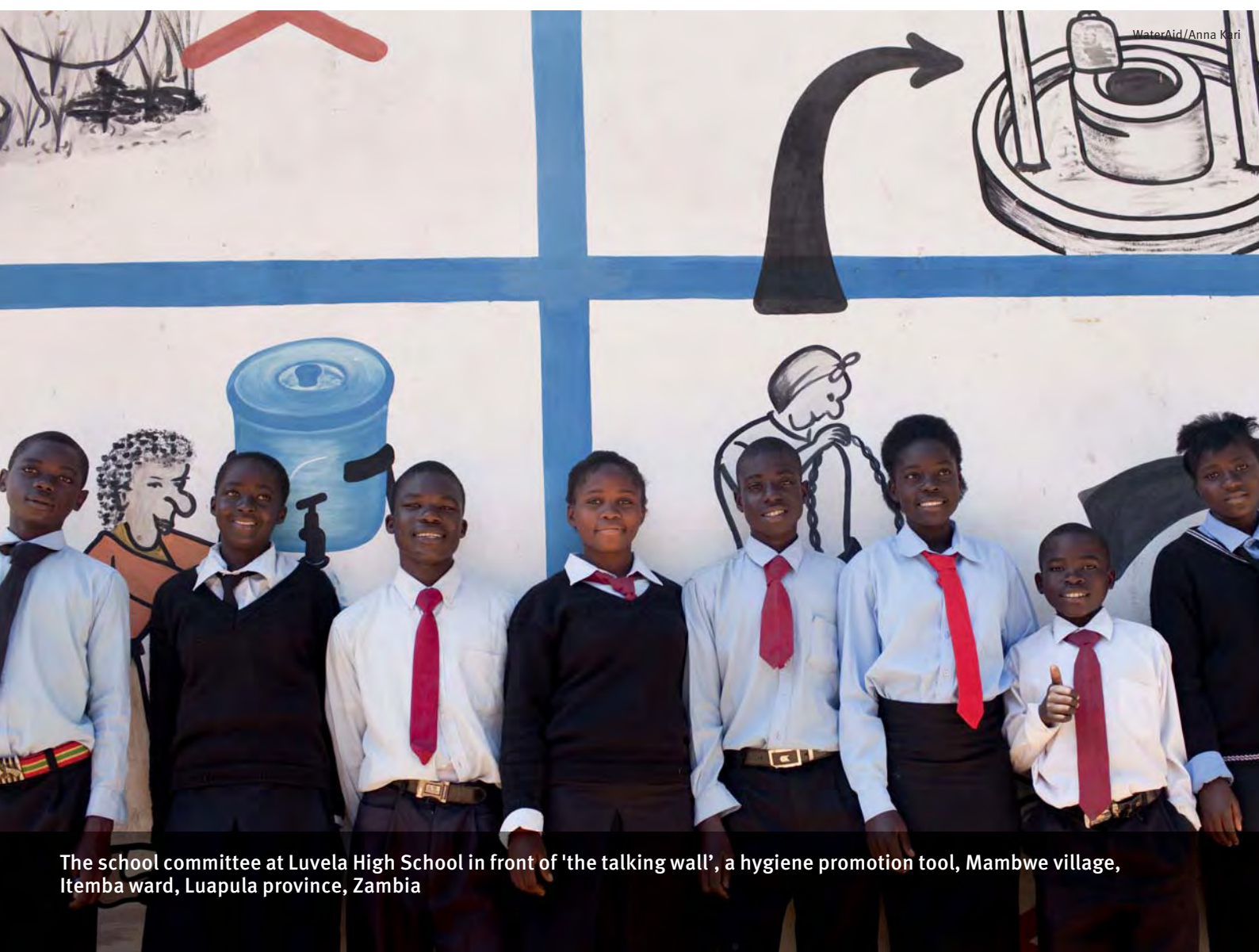
The school committee at Luvela High School in front of 'the talking wall', a hygiene promotion tool, Mambwe village, Itemba ward, Luapula province, Zambia

Menstrual hygiene management

Research on menstrual hygiene management indicates that inadequate facilities for cleaning and disposing of menstrual hygiene materials can have significant health implications for women and girls, and affect school attendance rates[55]. Hygiene promotion programmes should therefore include a focus on the 'production of easy and affordable access to sanitary napkins and related products, and their safe and dignified disposal after use' as well as adjustments to latrine construction and design that help girls and women to manage their hygiene better and in sufficient privacy during menstruation[56]. It is important that these are defined in context to ensure cultural appropriateness and incorporation of beliefs and attitudes around menstruation[57].

School environments that are not 'girl-friendly' are characterised by:
- A lack of latrines, or a reliance on latrines that are inadequate in terms of quality, design, safety, privacy or number.
- A lack of a clean water supply inside the latrines to wash hands and cloths.
- A lack of proper disposal mechanisms.
- A lack of an adequate and safe washing area.

These environments, whether in schools or other public and private places, can significantly hinder the ability of women and girls to practise appropriate hygiene during their menstrual cycle. Moreover, the taboos surrounding menstruation need to be challenged so that it becomes a subject that can be openly discussed by all, and taught about in school.

WaterAid has developed a detailed menstrual hygiene management resource[16] in collaboration with UNICEF, SHARE and Save the Children. This brings together good practice on supporting menstrual hygiene management, provides information for professionals from various sectors on integrating menstrual hygiene into their work, and offers guidance for WASH sector professionals to engage with the issue, as well as in advocacy.

Hygiene promotion for men

Hygiene is often considered to be in the domain of women and girls. However, men, women, girls and boys have different needs with regards to hygiene and have different roles to play in relation to promoting behaviour change within their families and communities. As men are often decision-makers and control household finances, their involvement is essential in supporting their partners and children to change behaviours. However, programmes often only require results based on impacts on women and children, and there is a general lack of awareness about tools to target men. Issues such as identifying what motivates men, how and where they can be targeted, how inclusion of men in hygiene promotion programmes can be resourced, and what support can be provided to health and sanitation facilitators (HSFs) are all important. The Nepal Water for Health (NEWAH) non-governmental organisation (NGO) was one of the first organisations to specifically include men in their hygiene promotion programmes[58]. The lessons learned from them and others can further the effective inclusion of men in hygiene promotion programmes, and achieve positive and sustainable hygiene behaviour change.

People living with HIV/AIDS[59]

Hygiene is of critical importance for people living with HIV/AIDS and their families or carers. The most common infections contracted by people living with HIV/AIDS are diarrhoea and skin diseases. The risk of contracting these illnesses can be reduced by hygienic practices such as handwashing with soap or an acceptable alternative at critical times, and washing the face and body.

Access to safe water and sanitation for people living with HIV/AIDS is essential, as their water needs are often more urgent, both in terms of quantity as well as quality. Safe drinking-water is essential for taking medicines, and antiretroviral drugs rely on at least 1.5 litres of safe water every day as well as sufficient nutrition to be effective. Furthermore, if a mother is unable to breastfeed her child because she is HIV positive, clean drinking-water and safe water handling are important for infant feeding.

People living with HIV/AIDS are often in a more vulnerable position as they need care, are more prone to infections, and may be unable to engage in income-generating activities. Stigma associated with HIV/AIDS may cause further marginalisation and exclusion. Girls and women are disproportionately affected by the HIV/AIDS epidemic as they are often caretakers of people living with HIV/AIDS or AIDS orphans.

Disabled people and older people

Hygiene facilities and behaviours are critically important for people living with disabilities and older people. Poor hygiene can cause disabilities (eg trachoma from poor face washing), and these people are often more susceptible to infections. They may also not be able to access hygiene promotion materials or be excluded from community activities because of stigma. Therefore, hygiene promotion programmes need to be attentive to and inclusive of the needs and preferences of people living with disabilities and older people, and they should recognise the marginalisation often faced by these groups in order to ensure that all can practise safe hygiene and access and use facilities hygienically. Hygiene promotion activities should be accessible to all and include messages about stigma as well as the way in which hygiene can contribute to the prevention of disabilities. Carers should be particularly involved in these programmes.

Hygiene promotion in emergency settings

In emergency settings, water, sanitation and good hygiene behaviour are often disrupted for short or long periods of time. Following natural disasters (slow-onset disasters such as droughts or rapid-onset disasters such as cyclones or earthquakes) or man-made disasters (eg political unrest), the people affected are generally much more vulnerable to illness and death from disease (most significantly from diarrhoeal diseases). This is often related to inadequate sanitation, unsafe water and poor hygiene. As an integral part of emergency water supply and sanitation programmes, hygiene promotion is particularly important in such situations in order to reduce the spread of diseases.

The Sphere Project has identified minimum standards and associated indicators and guidelines for water, sanitation and hygiene promotion in emergency contexts, set out in *The Sphere Handbook*.[60] The standard for hygiene promotion calls for 'all facilities and resources provided [to] reflect the vulnerabilities, needs and preferences of the affected population [and for] users [to be] involved in the management and maintenance of hygiene facilities where appropriate'[61]. Further information on hygiene promotion in emergency settings will be provided in WaterAid's forthcoming *Disaster management framework*[62].

Other at-risk groups

Other groups may be particularly at risk depending on the context, and other specific situations may exist. Programme design will need to account for this. Examples of at-risk groups include transient populations (such as pastoralists), mothers, children under five, those with different religious or ethnic backgrounds, and non-school attending children. The most effective communication channels to engage with these groups will vary, and could include, for example, hygiene promotion at clinics and other public spaces.

Furthermore, the design of hygiene promotion programmes is likely to differ depending on whether they are carried out in an urban, rural, small town, peri-urban or other context. Communication channels and tools will vary to address population density and size, but also in relation to levels of awareness, accessibility to hygiene-related materials (eg menstrual pads, cloths or soap), settlement patterns, risky practices and disease patterns.

WaterAid/GMB Akash/Panos

Debashish, son of WASH committee president Geeta Guala, plays a hygiene promotion board game with his friends, Lakatoorah tea garden, Sylhet, Bangladesh

Approaches to hygiene promotion[63]

There are different ways to develop and implement a hygiene promotion programme. It is now understood that 'educating' people to practise good hygiene because it has health benefits will usually not result in sustained behaviour change. Knowledge about the hygiene-health links is in many cases not sufficient to change people's behaviour. Therefore, hygiene promotion activities need to build on the key drivers for behaviour change, whatever those may be in a particular community or region (eg status, nurture or privacy).

Generally, hygiene promotion approaches are divided into two groups:
- Participatory, community-based 'total hygiene' approaches (including safe disposal of faeces through appropriate sanitation).
- Marketing approaches.

There is overlap between these two groups, as different elements from each can be combined to suit specific contexts[64].

Participatory community-based approaches

Participatory community-based approaches to hygiene promotion were developed following the limited success of top-down didactic approaches to development interventions. Participatory approaches instead draw from the disciplines of anthropology, sociology and psychology, and allow development organisations and governments to 'work *with* communities to arrive at sustainable and acceptable solutions to development problems'[65]. Participatory approaches are meant to 'build self-esteem and a sense of responsibility for one's decisions', while making the process of decision-making easy at the community level[66]. These methodologies are not unique to the WASH sector and are often used in many other development fields.

SARAR

The majority of approaches that are popular today are based on a set of key principles developed as part of a methodology called SARAR. The aim of SARAR is to encourage participants to think through problems, and support them to develop their creative capacities in problem-solving, planning and evaluation. SARAR stands for the following principles, which are considered to be the minimum attributes necessary for successful participation:
- **S**elf-esteem – built through active participation; a sense of self-worth as an individual as well as awareness of their importance for the development of the world around them.
- **A**ssociative strength – ability to work towards a common vision through mutual respect, collaborative effort and trust, resulting in better decision-making.
- **R**esourcefulness – local people are resourceful in taking initiative and finding solutions that affect their lives.
- **A**ction planning – local people think critically and are creative in taking action; they are not passive recipients and each person plays an important role.
- **R**esponsibility – taking responsibility for the outcomes that local people identify and commit to[65].

Types of participation[39]

'Participation' can mean several different things. In *Hygiene evaluation procedures. Approaches for assessing water- and sanitation-related hygiene practices* (p6) Almedom et al identify **three types of participation**: extractive, consultative and interactive.

Extractive refers to a process where people participate by answering questions posed by researchers/programme staff, although they do not have the opportunity to influence proceedings.

Consultative processes ensure that people participate by being consulted, but external researchers/programme staff identify problems and solutions, and these may be modified in light of people's responses. People do not have a share in decision-making and professionals are not required to adopt people's views.

Interactive participation means that people participate in joint analysis, leading to action plans and the formation of new local institutions or strengthening of existing ones. This type of participation involves seeking multiple perspectives and uses systematic and structured learning processes. People have control over local decisions and therefore have a stake in maintaining structures or practices.

SARAR principles are used to strengthen 'individuals and groups as their own major resource for change in both decision-making and planning'[67]. Strengthening the above listed attributes is expected – especially at community level – to lead to enhanced capacities for self-direction and management and will enhance the quality of participation among all the stakeholders.

Although originally designed for rural use, SARAR has been adapted for urban settings and applied across sectors. It is considered to be particularly useful where barriers are the strongest[68]. However, the approach can be limited by resistance to the use of qualitative and visual-based techniques and is dependent upon skilled facilitators[68].

The SARAR principles have frequently been used as a basis on which other approaches have been developed.

PRA – Participatory rural appraisal

Participatory rural appraisal (PRA) is built on the techniques used in rapid rural appraisal (RRA). RRA was developed in the 1970s as a simple and fast way of carrying out cost-effective qualitative research. Based on insights of social anthropology, it relied on listening research, combinations of iterative (visual) methods, and verification including triangulation of data from different sources. This was done using techniques such as observation, participation, interviews, short questionnaires, mapping and rapid report writing. Although these techniques can be effective, RRA is still primarily an extractive and externally-driven process[69].

PRA draws from the RRA techniques but uses them in a participatory manner to ensure community ownership, as opposed to being extractive. Some of the most common PRA tools include matrix scoring, social and resource mapping and modelling, wellbeing ('wealth') ranking, and sorting/ranking cards or symbols. PRA aims to be inclusive in order to ensure participation of those who are most marginalised[70]. Similar to SARAR, the skill of the facilitator is very important in PRA. This means the approach can be human-resource intensive and requires time from community members. But because it encourages participation of all community members and is based on interactive tools that enable participation regardless of literacy levels, it is seen as inclusive, cost-effective and efficient[70].

PHAST – Participatory hygiene and sanitation transformation

Participatory hygiene and sanitation transformation (PHAST) is based on the SARAR principles and is a participatory methodology developed specifically for the WASH sector. It is based on the idea that as communities gain awareness of their water, sanitation and hygiene situation through participatory activities, they are empowered to develop and carry out their own plans to improve their situation. This way, communities gain confidence in their own projects and have a say in what they do or do not want. This ensures that services respond to needs and that appropriate monitoring and evaluation activities can subsequently be carried out.

WaterAid/Layton Thompson

Women's association meeting on good hygiene practice, Touna in the circle of Bla, Mali

PHAST supports behaviour change in families, communities and schools, using local language, situations and perceptions. The approach uses seven steps to facilitate a participatory community planning process. Each step has between one and four activities that a group is facilitated to go through to improve their community planning on hygiene and sanitation[71]. Figure 9 (on page 43) outlines these steps, along with the activities and tools used to facilitate this process.

In order to be a completely **interactive** participatory process, PHAST requires skilled and experienced facilitators. It also requires in-depth training of community workers in participatory techniques, and therefore requires an intensive management structure. However, with proper guidance and management, trained community workers can become lasting assets to a programme and the community[71]. The approach can be quite time-intensive due to participatory exercises, and it is therefore important it is properly discussed with the community before being implemented[71].

Although PHAST has been the main methodology used for hygiene promotion in many organisations (including many of WaterAid's country programmes), it is not the only approach. Elements of PHAST have also been used to develop other approaches to ensure a programme is best suited to its context.

CLTS – Community-led total sanitation

Community-led total sanitation (CLTS) in its pure form is a 'no hardware subsidy' approach to rural sanitation that – through participatory methodologies – helps communities to recognise the problem of open defecation and take collective action to become 'open defecation free' (ODF). It aims – through activities such as community mapping, 'transect walks' and the use of the local equivalent of the word 'shit' – to generate a sense of disgust about open defecation, with the aim of 'triggering' a community into action to improve its sanitation practices and achieve ODF status. While its focus is on eliminating open defecation, it can also have an impact on other hygiene behaviours.

CLTS encourages people to change their behaviour without telling them exactly how. Because it does not rely on hardware subsidies or service delivery from external agencies, it ensures community members can take action in line with what is affordable and locally available and appropriate. It also has potential to empower community leaders and address other development issues, both in the target community and others[71].

CLTS has had mixed results. While it has been very successful in Asia (where it was originally developed and first implemented), in certain parts of Africa the messages have been seen as too blunt and have had to be modified to 'create triggers which do not excessively shame and disgust'. Refer to WaterAid's *Sanitation Framework*[72] for more information. In some cases, communities have been less responsive to CLTS where there have been previous subsidies. It is therefore important that CLTS is implemented in line with local contexts. As with all participatory processes, skilled facilitators are essential in carrying out triggering exercises in communities.

CHC – Community health clubs[73, 74]

Community health clubs (CHCs) are voluntary and free community-based membership organisations whose aim is to improve the community's health. Health outcomes are fundamental to the approach, as the CHCs aim to address the underlying causes of lack of safe sanitation and hygiene. The approach is based on regular meetings, facilitated by health extension workers who have been trained in participatory health promotion activities. It is open to anyone and encourages members to practise what they have learned at home through homework assignments and home visits for monitoring.

Key reasons for the success of CHCs are that they are sociable, competitive and involve increasing respect for others. The approach has also proven to increase learning, raise social status and create opportunities for income-generating activities due to improved health. Furthermore, it does not require literacy and has the potential to strengthen the position of women within the family and the community. It has resulted in a reduced workload for health extension workers and provides an important institutional link between members and government.
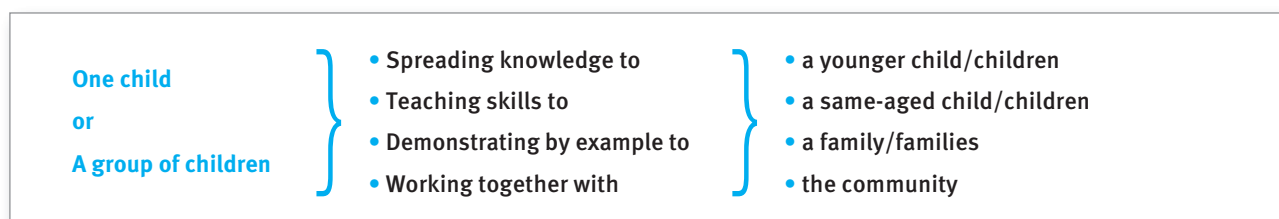
CtC – Child to child

Child to child (CtC) is described as a 'rights-based approach to children's participation in health promotion and development'[75, 76]. It is an approach to hygiene promotion based on the belief that children can be agents of change and promote the health not only of themselves but also of others, in their schools or in their community. Children are often responsible for caring for younger siblings and animals, as well as for collecting water and cleaning tasks. Therefore, the potential for children to raise awareness about hygiene with their family, at school or in their community is vast.

The CtC approach involves children in a way that is challenging, fun and interesting, while ensuring that key hygiene messages and associated practices are picked up. It facilitates children's understanding of development issues and healthy behaviour, and allows them to identify health/development priorities relevant to themselves and their communities[77]. The approach is anchored on the UN Convention of the Rights of the Child, which emphasises inclusion, non-discrimination and the best interests of the child. CtC approaches are often integrated into broader health and/or WASH programmes, and they have had particular impact as part of health education and promotion in schools, and with children in communities affected by HIV/AIDS, in difficult circumstances and in early childhood development.

Despite its noted success, there has been some concern that the approach could lead to exploitation of children instead of encouraging their empowerment, and that the teaching-learning method is teacher-centred. Therefore, training needs to be carried out effectively.

The matrix in Figure 7 on the following page gives a visual representation of how children can participate in and contribute to improving their own health and that of those around them.

Figure 7 – Child to child matrix[78]

| One child

or

A group of children | } | • Spreading knowledge to
• Teaching skills to
• Demonstrating by example to
• Working together with | } | • a younger child/children
• a same-aged child/children
• a family/families
• the community |

Marketing approaches

In the present context, marketing approaches primarily refer to social marketing, which is defined as 'the use of commercial marketing techniques to promote the adoption of behaviour that will improve the health or wellbeing of the target audience or of society as a whole'[79]. It is about bringing together demand creation and supply-side interventions to achieve a benefit to society. This is based on the premise that a target audience must **want** and **be able to** change their behaviour.

Social marketing is based upon several key marketing principles (also referred to as the **4 Ps**):

- Product (eg a physical object such as a handwashing facility, a service or a practice/behaviour).
- Price (eg price of soap may impact upon how much people use soap to wash their hands, and may need to be subsidised to reach the most vulnerable/poorest).
- Place (products need to be available to the target group).
- Promotion (to encourage adoption of certain behaviour).

Sometimes additional principles are added, such as policy. A policy can be used to make certain behaviours easier to carry out (eg a policy that requires all schools to have handwashing facilities).

Social marketing therefore refers to the way in which enterprise approaches are combined with demand stimulation to address both the demand and supply side of changing hygiene behaviours (eg CLTS in its original form focuses mainly on the demand side; approaches such as TSSM, described below, and others have mixed demand and supply side interventions). The idea behind this in the context of a hygiene promotion programme is that even if the behaviour change itself has been achieved, the price and availability of products to facilitate the sustainability of this behaviour change need to be addressed (in relation to hygiene, this could be the availability and affordability of soap or the existence of a handwashing facility).

While social marketing approaches focus on creating demand and generating income by addressing supply, they may face challenges if no strong enterprise culture exists, and they may not always reach the poorest people, who may not have sufficient resources to invest.

A number of key social marketing approaches are currently being trialled in various countries. These approaches use a single, simple message aimed at changing an associated behaviour.

One example is 'Saniya', a hygiene communication campaign focused on handwashing after contact with faecal matter and the safe disposal of children's faeces. It is based on information provided by users so that messages reflect their priorities and rationale. It uses radio, theatre groups and face to face domestic visits to communicate its messages. The focus on a small number of practices means a small number of messages, which increases the likelihood of users picking up the messages and changing behaviour. Although the formative research required can be adapted for different contexts, it requires experienced field researchers. Furthermore, the approach relies on a mix of different types of promotion, from mass media to house-to-house visits, which makes monitoring relatively resource-intensive[80].

Another example is the Public Private Partnership for Handwashing with Soap (PPPHWS). This partnership combines 'the marketing expertise and consumer focus of the soap industry with the institutional strength and resources of governments to forge a partnership that will benefit the whole community'[81]. The approach targets those most at risk (poor people, particularly mothers and children) and brings together the skills of the private and public sector as well as various development partners, especially with regards to the design and implementation of the mass-media component of handwashing campaigns. However, it does require significant resources to put together teams to run large handwashing campaigns, public-private partnerships can be slow to show results, and there can be resistance to the involvement of the private sector[82].

Lastly, the total sanitation and sanitation marketing (TSSM) approach focuses, like other marketing approaches, on generating demand as well as increasing supply of sanitation products and services at scale. As outlined in WaterAid's *Sanitation framework*[4], 'TSSM supplements community-level CLTS triggering with a formative research-based behaviour change communication strategy, and a market research-based supply improvement programme. This means that the programme is designed to be responsive to the variation in demands from community members with different levels of existing sanitation services and resources, so enabling community members to upgrade over time (an important factor for sustainability).'[4] Because it takes into account the supply side, TSSM can create drivers for good hygiene behaviour through marketing hygiene-related products such as handwashing facilities and soap. TSSM supports public financing for marketing to achieve public health gains, as well as private investment in latrines for private gain[83]. A challenge for the TSSM approach is that it may not reach the very poorest people.

Social marketing processes include market research, defining programme aims and objectives, product identification and development, the set up of supply mechanisms, message and material development, implementation of the promotion campaign, and monitoring and feedback. Many of these approaches are currently being tested and require further research and skills development.

Hygiene promotion 'hardware'

Although the 'software' side of hygiene promotion remains a key focus of programmes, convenient access to soap for handwashing or other enabling products that can facilitate the adoption of safe hygiene practices are also of critical importance. Enabling products 'influence individuals' opportunity to perform a behaviour, regardless of their ability and motivation to take action'[84]. Examples of enabling products in relation to handwashing include tippy-taps (to store and regulate flow of water in sufficient quantity), soap nets, soap on a rope or soap dishes (to manage and store soap or a locally available appropriate alternative). These could be located in the home, a public place such as a school, or at a washstand to ensure water and soap are in one place[85]. Furthermore, the appearance of enabling products may have an influence on whether or not they will be used, and hence their design needs to take into account user practices and preferences.

WaterAid/Caroline Irby

Mr Massabidi washing his hands with a tippy-tap, Miggoda parish, Wakiso, Gombe, Uganda

Monitoring and evaluation

Monitoring and evaluation (M&E) of hygiene promotion programmes is essential to assess progress against programme objectives, and whether the direction or focus of a programme may need to be altered. This section summarises our understanding of the key issues around M&E.

What should be monitored?

Prior to the start of a hygiene promotion programme, formative research is carried out to develop an understanding of existing beliefs and practices, and cultural, political and economic issues that need to inform programme design. The findings from the formative research phase should feed into the development of programme indicators (which can be qualitative and quantitative). Information against these indicators is subsequently collected during a baseline study prior to programme implementation (M&E specifically in relation to WaterAid's work is discussed in Part 4 Hygiene promotion – principles). This way, progress can be monitored at different time intervals against the baseline data, using the same data collection methods and tools that were used during the baseline study.

Figure 8 – WaterAid's hygiene promotion programme cycle
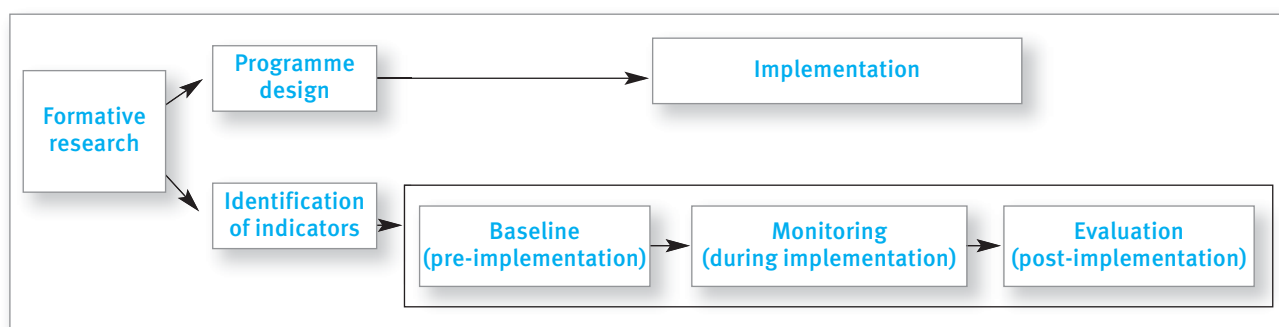
While the ultimate goal of a hygiene promotion programme is to reduce the morbidity and mortality rates of WASH-related diseases, it is quite difficult to establish a causal relationship between the implementation of a hygiene promotion programme and a reduction in such diseases. This is because the prevalence of WASH-related diseases can be influenced by many other factors. Because of this, **proxy indicators** are considered a satisfactory alternative for monitoring and evaluating hygiene promotion programmes. A proxy indicator could for example measure the presence of handwashing facilities with soap in a community, and evidence of use. While this in itself may not give evidence of **sustained** behaviour change, an increase would give a good indication of whether or not people are washing their hands regularly.

These types of indicators ensure that monitoring and evaluation is carried out at **outcome** level. Monitoring at **impact** level would be focused on monitoring the health impacts of a hygiene promotion programme, which is difficult to do without use of proper trials, significant financial resources and large sample sizes.

How should monitoring and evaluation be carried out?

There are a variety of data collection methods and tools that are used to monitor and evaluate hygiene promotion programmes. Examples include household questionnaires, community mapping, focus group discussions, health walks, in-depth discussions with key informants, and observation[86, 87]. It is generally recognised that methods that rely too heavily on questioning about behaviours and practices, rather than observation, can be subject to serious bias and consequent inaccuracy.

The way in which methods are combined will depend on the approach used (eg PHAST, CHC or CtC) and the scale and level at which a programme is carried out (eg personal, household, community or institutional (eg school) level). Frequency of monitoring by organisations in charge of implementation of a hygiene promotion programme will also depend on the scale, resources available and timeline.

Furthermore, when carrying out this type of qualitative research, it is important that **triangulation** is carried out. Triangulation refers to the gathering of information on the same subject, but obtained by different researchers, from different sources, and by using different data collection methods.

Who monitors?

For those carrying out monitoring and evaluation, it is critical to understand the reasons **why** people behave the way they do. If a hygiene promotion programme is carried out at the community level, it is important that a representative part of the community is involved in the research and analysis, so as to maximise ownership of the programme and the impact of the programme's objectives.

The more monitoring communities themselves carry out, the more potential there is for ownership of the programme and for progress towards the programme's objectives.

Challenges to monitoring and evaluation

The monitoring and evaluation of hygiene promotion programmes – particularly when measuring **sustainable** changes in hygiene behaviour – is very complex and still represents a challenging area of work for those in the WASH sector, as well as the health sector. It is an area that needs significant further research, on if, how and when hygiene behaviour change is sustained, and on how and at what level M&E should be carried out (eg outcome vs impact).

A further challenge relates to data collection, management and comparison. Stakeholders may use different methodologies for collecting data and for setting reliable indicators to evaluate programme progress. This hampers effective comparison of data within and between countries[88].

Furthermore, **self-reporting** on hygiene behaviour has inherent biases. Household questionnaires may not necessarily capture actual hygiene practices (eg handwashing rates may be overestimated, unhygienic behaviour may not be reported). Despite the grey areas that exist in the knowledge on hygiene promotion (eg with regards to assessing the effectiveness of food hygiene and how to achieve uptake of hygiene practices at scale[45]) the past few years have seen a substantial amount of research and learning with regards to drivers of hygiene behaviour, the cost-effectiveness of hygiene promotion and its impacts on public health.

Shamola Rani Mondol, local WASH committee member, brushing her teeth with clean water from the new water point, Kalshi Takar Baa slum, Dhaka, Bangladesh

Part 3

Hygiene promotion at WaterAid

The principles and minimum commitments in Parts 4 and 5 of the framework should ultimately be grounded in WaterAid's experience in its country programmes. This part provides a brief overview of WaterAid's work on hygiene promotion.

History of hygiene promotion at WaterAid[89]

Since the mid 1990s, hygiene promotion has been included in WaterAid's strategies, policies and programmes. The momentum behind hygiene promotion as a crucial component of 'software' approaches gained strength in WaterAid in the late 1990s and early 2000s, with the appointment of a Hygiene Adviser, the development of a hygiene promotion policy, and the organisation of various international workshops on hygiene promotion, which aimed to strengthen the knowledge and skills base in our country programmes. Table 1 gives an overview of the history of hygiene promotion at WaterAid.

Table 1 – Timeline of hygiene promotion at WaterAid

1995	Hygiene promotion is integrated into **WaterAid's first five year strategy 1995-2000**
1996	Development of a **hygiene education policy**
1997	Appointment of a **Hygiene Adviser**[90]
1997-2001	Various **support visits** are made by the Hygiene Adviser to country programmes to provide guidance and support to in-country specialist staff
1998-2000	Several **international hygiene workshops** are held (Bangladesh, Ghana, Uganda) resulting in the development of hygiene promotion materials; the sharing of experience, knowledge and skills between individuals, partners and country programmes; the identification of gaps in hygiene promotion in participants' programmes; strategies for bridging the gaps; and revision of the 1996 hygiene education policy
1999	**Hygiene promotion policy** is approved
2000	All WaterAid country programmes have **staff members responsible for hygiene promotion**
2002-2004	**Indicators** for hygiene promotion and behaviour change are developed and piloted[91], and show some differences in sustained behaviour changes between countries

2006	**Hygiene promotion activities** form a significant component of country programmes' work, and are reported on in six monthly reports (although reporting is focused on activities and outputs rather than behaviour change outcomes). Overall, reporting and evaluation reflect steady improvements in behaviour change, although not across all three hygiene practices identified in the policy (safe disposal of excreta, protection of domestic water supply, effective handwashing) or consistently across country programmes[92]
2009 (Jan)	WaterAid co-organises the Asia Sanitation and Hygiene **Practitioners' Workshop** in Bangladesh (with IRC International Water and Sanitation Centre, Water Supply and Sanitation Collaborative Council (WSSCC) and BRAC)
2009 (Oct)	WaterAid launches its new *Global Strategy 2009-2015*. Hygiene forms a core part of the strategic aims and their indicators, given equal weight to water and sanitation. Specific emphasis is placed on ensuring sustainability of improved hygiene practices (Aim 1). Emphasis is also given to increasing capacity of governments and service providers to deliver access to water, sanitation and hygiene (Aim 2), and the need for integration and prioritisation of WASH, specifically in the education and health sectors (Aim 3)
2009	Around this time, hygiene expenditure is identified explicitly in the global accounting system
2009 (Nov)	WaterAid co-organises the bilingual **West Africa Regional Symposium on Sanitation and Hygiene** in Ghana (IRC, Resource Centre Network (RCN) Ghana, West Africa Water Initiative (WAWI), WSSCC, WaterAid)
2010 (Feb)	WaterAid co-organises the second two-yearly **Asia Hygiene Practitioners' Workshop** in Bangladesh (BRAC, WSSCC, IRC, WaterAid), which forms part of five learning and sharing workshops on sanitation and hygiene in 2009 and 2010[93]
2010 (Aug)	**Strategic Performance Indicators (SPIs)** are finalised and include clear reference to the importance of integrating hygiene promotion into WaterAid's water and sanitation programmes
2010	WaterAid takes part in the **Asia Menstrual Hygiene Conference**
2011 (Mar)	WaterAid co-organises the **East Africa Practitioners' Workshop on Pro-Poor Urban Sanitation and Hygiene** in Rwanda (IRC, UNICEF, GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit), WSSCC, WaterAid)
2011 (Oct)	WaterAid takes part in WSSCC's **Global Forum on Sanitation and Hygiene** in India
2011	WaterAid in Australia publishes *Promoting good hygiene practices: Key elements and practical lessons*[94]
2012	**Menstrual hygiene matters: A resource for improving menstrual hygiene around the world**[16] published (WaterAid, UNICEF, Save the Children, SHARE)
2012	**Hygiene framework** published after wide consultation across WaterAid

This brief overview of WaterAid's hygiene-related work demonstrates that while there was substantial growth in the dedication to this subject in terms of both staff specialism and resourcing, the strong focus on hygiene slightly decreased after the cessation of the Hygiene Adviser role in 2004. Additionally, those who had a specific responsibility for hygiene in country programmes in 2000 have since moved on; specific expertise and skills with regards to hygiene promotion may have therefore been lost and may need to be rebuilt (eg through training of hygiene promoters, facilitators and so on).

Hygiene promotion in WaterAid country programmes

WaterAid country programmes have been involved in hygiene promotion work to various extents, and have used a variety of approaches to carry out this work[95]. Most country programmes refer to their hygiene work as 'hygiene promotion'. WaterAid Zambia's description captures many of the other country programmes' views on hygiene, recognising that:

> **It is not simply a matter of providing information... Hygiene promotion is more a dialogue between the target population's knowledge, practice and resources, and agencies' knowledge and resources, which together [encourage] risky hygiene behaviours to be avoided.**[96]

Similarly, WaterAid Ghana emphasises that:

> **The need and emphasis on hygiene promotion is rooted in the fact that getting people to change the habits of a lifetime is difficult, takes time and requires resources and skills. Hygiene promotion's reliance on participation and appropriateness provides better chances for sustained behaviour change.**[97]

Over the past few years, WaterAid country programmes have focused on **three main hygiene behaviours**:
- Handwashing at critical times.
- Safe management of domestic water (including storage and handling from source to point of use).
- Safe and hygienic management and use of latrines, and safe management/disposal of excreta.

Tenincoura, cleaning the new school latrines, Simba East School, Simba East, in the Tienfala commune

In addition to these, areas of focus have also included:

- Menstrual hygiene (India, Tanzania, Ethiopia, Nepal, Bangladesh).
- Personal hygiene issues (eg face washing, nail-cutting, use of sandals) (India, Madagascar, Mozambique, Tanzania, Ethiopia, Nepal, Ghana, Zambia, Uganda).
- Food hygiene (Nigeria, Nepal, Madagascar, Ghana, Zambia, Tanzania, Ethiopia).
- Household/compound hygiene (eg digging of rubbish pits, construction of dish racks, keeping surroundings clean, rubbish heaps and so on) (Uganda, Madagascar, Mozambique, Ghana, Nigeria, Malawi, Zambia, Nepal)[96].

Most country programmes use PHAST as their main approach to hygiene promotion. At times, some have combined elements from PHAST with those from CLTS and PRA to better suit particular contexts – for example the 'Mtumba' approach in Tanzania, which combines the strengths of PHAST, CLTS and social marketing[98].

Some country programmes conduct facilitation through volunteer facilitators or appoint community hygiene promoters, while others conduct hygiene promotion through area development committees (ADCs) or community committees (eg Zambia), cultural group formation and development (eg Bangladesh), or public health and awareness camps (eg Timor-Leste). Other countries use **child to child** and **child to community** approaches (eg Bangladesh, Tanzania, Burkina Faso, Mozambique, Uganda), as well as health clubs for children not attending school (eg Nepal), community hygiene clubs (eg Rwanda, Uganda), and school hygiene promotion and health clubs (eg Nepal, Bangladesh, Ghana, India, Mozambique).

With regards to **school hygiene promotion,** activities are carried out in virtually every country programme, albeit in different ways. Health and hygiene clubs, as well as the child to child or child to community approaches are very common in schools, but approaches such as teachers' orientation, students' brigade formation (eg Bangladesh), sanitation clubs (eg Mozambique), and the holding of commemorative events such as World Water Day and Global Handwashing Day are also used.

Various other methods and tools are also used, including menstrual hygiene focus groups (eg Bangladesh, Papua New Guinea, Nepal), house-to-house promotion (eg Ethiopia, Malawi, Mozambique, Burkina Faso, Nepal, Timor-Leste, Zambia), community meetings (eg Pakistan, Ghana, Madagascar), distribution of print and video materials (eg India, Nepal, Bangladesh, Mozambique, Mali, Timor-Leste), drama/dance groups (eg Madagascar, Uganda, Timor-Leste, Zambia, Malawi, Mozambique, Tanzania, Nepal), audio materials for the blind (eg Mali), training of hygiene promoters in methods such as PHAST (eg Ethiopia, Bangladesh, Malawi), public debates (eg Nigeria, Zambia) and journalist networks to link to the media (eg Mali, Liberia).

Social marketing appears to be the least common hygiene promotion approach in WaterAid country programmes. Some (eg Madagascar, Malawi, Timor-Leste) have carried out sanitation marketing whereas others have used radio spots (eg Mozambique) and sanitary pad manufacturers (eg India).

In terms of **hygiene hardware**, nearly every country programme has promoted some form of handwashing technology. These generally focused on flexible and locally available solutions such as:

- Tippy-taps (operated via rope or pedal – especially in East and Southern Africa).
- Tap stands with piped water supply.
- Rainwater harvesting systems with small reservoirs.
- Promotion of the use of soap or ash.
- Targeting of schools for expansion of handwashing facilities in every region, including the provision of menstrual management facilities (primarily in Bangladesh, Nepal, and India).
- Building laundry and bathing facilities (eg Madagascar, Zambia, Uganda, Ethiopia).

Investment in hygiene promotion is very low (just a few percent of country programme budgets), and although the numbers of people reached are reportedly high, it is not always clear how deeply WaterAid's hygiene promotion programmes penetrate into communities and households.

While there is a significant amount of information on the methodologies and tools WaterAid country programmes use, there seems to be less information about the success of these approaches in achieving **sustained** behaviour change, and what kinds of impacts these various approaches have had. This provides an area for future work and research in order to strengthen monitoring and evaluation of WaterAid's hygiene promotion programmes. In fact, many country programmes identified monitoring of hygiene behaviour change and achieving sustainable behaviour change as one of the key challenges of their work (eg Rwanda, Ghana, India, Malawi, Nigeria). Further challenges were identified in relation to the under-prioritisation of hygiene (eg Nigeria, Burkina Faso, Uganda), the lack of common understanding of hygiene among sector actors (eg Bangladesh, Ethiopia), poor quality in approaches and tools used (eg Ethiopia, Tanzania), lack of clear indicators (eg Ethiopia, Burkina Faso, Tanzania), community disengagement (eg Mozambique), and differential skills sets among partner organisations (eg India).

The above overview of the types of methodologies and tools used by WaterAid country programmes to carry out hygiene promotion programmes, as well as the challenges encountered, provides a basis for the principles and minimum commitments outlined in Parts 4 and 5. They have been developed based on the contexts within which WaterAid country programmes and their partners work, WaterAid's global strategic aims, and the in-depth literature and knowledge available so far on hygiene promotion and sustainable behaviour change.

Hygiene promotion – principles

This part of the framework identifies the principles to which every WaterAid hygiene promotion programme should strive to adhere: inclusive, integrated, fit-for context and sustainable. These principles are discussed below within each phase of the programme cycle (see Figure 8 on page 31).

Planning and design

Formative research

Formative research should be carried out as a first stage of planning a hygiene promotion programme. Formative research is a 'systematic approach [that] links key questions to appropriate methods'[99] in order to inform programme design. Its purpose is to obtain a comprehensive understanding about the socio-cultural and demographic aspects of a target group; the power relations and hierarchies that exist and histories behind these; knowledge about and attitudes towards disease and health; as well as existing hygiene practices. The research needs to also recognise gender differences, issues associated with chronic illness, disability and age, and any significant differences between religious or ethnic groups.

Therefore, formative research helps programme staff identify and understand the characteristics of a target population (interests, needs, behaviours) that influence their decisions and actions. It helps determine the focus of a programme and ensure it is in line with the context in which it is implemented[100].

Formative research is not meant to be carried out in a single community but rather at a larger scale, such as at provincial or state level. The depth and breadth (scale) of formative research will depend on the resources and time available, as well as the extent to which knowledge already exists about a target population.

The main questions formative research should address are:
- What are the main (socio-cultural) practices that are placing health at risk?
- Who are the 'at risk' groups? Who should the programme focus on?
- What will motivate the adoption of safe practices, ie what are the drivers of change?
- What are the main communication channels and hygiene approaches through which to reach the target group[99]?

Ethics

Because hygiene promotion engages with culturally sensitive and personally private aspects of life, it must be carried out with due regard to the need for confidentiality, avoidance of coercion or harm, and respect for the individual. Details of ethical considerations can be found in social research textbooks and in the policies of social research organisations.

Baseline studies

In addition to formative research, a baseline study should be carried out prior to the start of every hygiene promotion programme. A baseline study describes and quantifies the status of certain identified indicators (pre-intervention) on the basis of which subsequent monitoring can take place. Information collected as part of a baseline study can, for example, include latrine coverage and use, handwashing attitudes and practice, and diarrhoea prevalence. A baseline study can be carried out at various levels, depending on the type of hygiene promotion programme.

While formative research is linked to the **design** of a hygiene promotion programme, a baseline study is linked to the **monitoring** of the programme.

Focus

Once formative research and baseline studies are completed, it is important that the programme has focus. A programme should focus on a **limited** number of hygiene behaviours, rather than trying to address **all** possible transmission routes. A good hygiene programme prioritises what its resources will be directed at and who will be targeted; the planning phase should here give an indication of the most important risky behaviours and the most important target groups.

Developing indicators

On the basis of the focus of the programme, appropriate indicators should be identified for baseline studies and to be able to later on carry out effective monitoring and evaluation exercises. Identifying indicators that provide direct evidence of (sustained) uptake of hygiene practices is quite challenging; however, 'proxy indicators' are often able to give an indication of whether changes in behaviour are taking place. Examples of proxy indicators include visible hygienic maintenance and use of latrines; observed means of disposal of children's faeces; water quality as measured in the home; or presence of a handwashing facility and soap/ash near a latrine[101]. Indicators should be as specific as possible and related to the hygiene promotion behaviours selected for the programme. This ensures that hygiene behaviours are monitored according to the specific behaviours promoted[102].

Inclusion

The planning and design phases of a programme should ensure a programme is inclusive. This means that it should especially take into consideration girls and women, people with disabilities, older people, people living with HIV/AIDS, school-going and non-school going children, and any other groups that may be particularly vulnerable and/or marginalised. What the programme promotes should be appropriate for **all** primary stakeholders. It should be able to reach everyone through appropriate communication channels, as well as through appropriate facilities and supplies. This can be achieved by combining a variety of approaches.

Integration

Hygiene promotion programmes should follow an integrated approach. Integration has four dimensions: (a) across sectors, (b) across levels, (c) across interventions and (d) across institutions.

Firstly, a hygiene promotion programme should define the way in which it will link with programmes or policies in other **sectors**, especially in water supply and education. In relation to schools for example, hygiene promotion would need to address safe excreta disposal and handwashing, but also the adequacy of arrangements for menstrual hygiene management.

Secondly, depending on the scale of a programme, the design should define how it will be carried out at different **levels** (eg community, local, district and national). For example, hygiene practices could be promoted in a select number of communities through various combinations of methods and tools based on the SARAR principles, and key hygiene messages could then be reinforced through mass media campaigns or regular community visits by health officials.

Thirdly, hygiene promotion, sanitation promotion and water supply should work as an **integrated package**. Hygiene promotion is especially important when there is a lack of safe water supply and sanitation services. Although having water and sanitation services will make it easier to perform safe hygiene practices (eg washing hands with soap and water), merely having them does not guarantee safe hygiene practices. It is therefore important that hygiene promotion and the supply of safe water and sanitation services come as an integrated programme when possible; although this is dependent on context, resources and time, it may be appropriate at times to focus mainly on hygiene promotion. Also, if water supply and sanitation have already been provided, then hygiene promotion may be the only focus.

Lastly, a programme should have sufficient **institutional support** from local governments, donors and civil society organisations and fit within local government structures to ensure changed hygiene behaviours become permanent and risky habits are not taken up again once the programme ends.

Being systematic

Once the overall hygiene promotion approach has been determined, appropriate hygiene promotion activities and tools can be selected. Multiple activities and tools can be combined to ensure a hygiene promotion programme is best suited to the context in which it is implemented. Community level actions should always be based on participatory methods, although mass media approaches need not

be. The important thing is that the programme should systematically combine tools and activities in a coherent approach to hygiene promotion, whichever of the general approaches (eg PHAST, CtC, CHCs) is adopted. Figure 9 gives as an example the way in which the seven steps in the PHAST approach relate to activities and the tools needed to undertake those activities.

Activities and tools should be combined in such a way that they are inclusive, in other words, relevant for everyone who forms part of the target group. Hygiene hardware should also be accessible to and used by all members of society (eg handwashing facilities should be accessible to wheelchair users and it should be possible for people with disabilities to operate them).

Figure 9 – Example of PHAST steps, activities and tools

Seven steps to community planning for the prevention of diarrhoeal disease

Step	Activity	Tool
1 Problem identification	1 Community stories 2 Health problems in our community	1 Unserialised posters 2 Nurse Tanaka
2 Problem analysis	1 Mapping water and sanitation in our community 2 Good and bad hygiene behaviours 3 Investigating community practices 4 How diseases spread	1 Community mapping 2 Three-pile sorting 3 Pocket chart 4 Transmission routes
3 Planning for solutions	1 Blocking the spread of disease 2 Selecting the barriers 3 Tasks of men and women in the community	1 Blocking the routes 2 Barriers chart 3 Gender role analysis
4 Selecting options	1 Choosing sanitation improvements 2 Choosing improved hygiene behaviours 3 Taking time for questions	1 Sanitation options 2 Three-pile sorting 3 Question box
5 Planning for new facilities and behaviour change	1 Planning for change 2 Planning who does what 3 Identifying what might go wrong	1 Planning posters 2 Planning posters 3 Problem box
6 Planning for monitoring and evaluation	1 Preparing to check our progress	1 Monitoring (checking) chart
7 Participatory evaluation	1 Checking our progress	1 Various tool options

Implementation

Participatory skills

Implementation at community level should be carried out by skilled facilitators who are flexible enough to change methods and/or tools as needed. The extent to which implementation is participatory depends on the outcomes of the formative research and the programme design. For example, while implementation at the community level should be participatory, focused on facilitating a process that triggers action or change, mass media campaigns may be based on information gathered through non-participative or participative formative research methods in order to tailor and focus messages.

High quality training of participatory facilitators is critical and key to ensuring success is the selection crtieria for potential facilitators. Not all people are predisposed to being good participatory facilitators and it is important therefore that a selection process be set up to identify the best possible candidates for any training programme.

Monitoring and evaluation

Indicators

It is possible to carry out monitoring activities by identifying a limited number of proxy indicators in the planning and design phase of a programme (at the baseline survey stage)[103, 104]. Using a combination of monitoring methods and tools can then make it possible to assess change against these indicators.

Hygiene evaluation procedures[105] by Almedom et al outlines the specific ways in which qualitative information can be gathered, reviewed and interpreted, and is specifically geared towards the practical concerns of field personnel. These evaluation guidelines can be used at various stages of a programme – to provide baseline data prior to the start of a programme, to monitor progress of activities, or to measure change in hygiene practices at the end of a programme.

For WaterAid, it is important that monitoring and evaluation of hygiene promotion programmes should remain practical; therefore, it is more likely to be carried out at an outcome level only, not at impact level. This means that monitoring should focus on changes in hygiene practices, not on the health impacts that may follow, as these tend to be difficult and expensive to measure as the direct links between the interventions and the health impacts are hard to prove.

The frequency at which monitoring exercises are carried out depends on the timeframe of the programme, its scale, the resources available, and its linkages with the post implementation monitoring process. Furthermore, as emphasised previously, it is important to carry out a 'triangulation of sources, methods and investigators... crosschecking information on the same topic that has been gathered from different sources, using different methods and/or by different investigators'[105]. As mentioned in Part 2, while self-reporting on hygiene behaviour can be useful, it usually has serious inherent biases that can result in an inaccurate depiction of reality.

Advocacy

Advocacy activities are critical to influence other sector stakeholders on hygiene promotion. Advocacy towards governments and service providers can be used to improve sustainability by integrating hygiene promotion in water supply and sanitation schemes as well as health and education plans. For example, advocacy could be used to organise a national hygiene campaign with resources allocated for hygiene promotion work at the community level. Or it could focus on ensuring that hygiene features prominently within national water and sanitation plans and policies, or that a national hygiene promotion policy is created with appropriate resources and funding.

Advocacy on hygiene promotion will depend on context, time and resources available. It may involve a variety of influencing strategies as hygiene is even more of a 'soft' issue than sanitation. For example, while in Africa certain advocacy efforts can focus on governments' commitments to the eThekwini commitments (for example, the establishment of an institution responsible for sanitation or a separate budget line for sanitation), there are less clear cut targets for hygiene.

WaterAid/Layton Thompson

Yacouba and Tenincoura wash their hands outside the school latrine block, Simba East School, Simba East, in the Tienfala commune, Mali

The ultimate aim of advocacy efforts should be that hygiene is treated as an equally important part of water and sanitation programmes, that it is resourced appropriately, and that effective links are established with the water supply and the education and health sectors in order to ensure hygiene promotion programmes are integrated and sustainable. Hygiene promotion should address the needs of all, including those who are frequently neglected: women, children (girls in particular), people with disabilities, elderly people and those who are chronically ill.

Summary

All WaterAid-supported hygiene promotion programmes should be fit-for-context, building upon the existing practices, beliefs and desires of communities. They should be inclusive and relevant to everyone in the target group; integrated into sanitation and water programmes (where appropriate) as well as relevant education and health initiatives; and flexible enough to incorporate a variety of methods and tools that can be used at different levels of implementation.

Hygiene programmes should be planned, designed, and implemented in collaboration with permanent institutions to ensure long-term follow up. Appropriate indicators should be identified following initial formative research and preceding baseline studies, in order to ensure that programmes can be monitored and evaluated effectively. All of these aspects will contribute to the sustainability of a programme and enhance the possibility of permanent change in hygiene behaviours[106].

WaterAid/Zute Lightfoot

Alice Nirere washing her hands at a handwashing point using the water she collected from the underground rainwater harvesting tank, Ntarama orphan village, Bugesera district, Rwanda

WaterAid's minimum commitments

WaterAid country programmes and their partners will aim to follow a number of minimum commitments in relation to hygiene promotion programmes. These are outlined below:

General commitments

1 All water and sanitation programmes will include an appropriate hygiene component. In general, this will mean integrating hygiene into wider water, sanitation and hygiene programming, but in some cases where adequate water and sanitation facilities already exist, hygiene promotion may be the main or only focus.

2 WaterAid understands that hygiene promotion is about building on existing practices, beliefs and opportunities, and that knowledge about hygiene-health links alone is often not sufficient to achieve sustained behaviour change. The term and concept of 'hygiene **promotion**' (and not hygiene **education**) will therefore be used in all of WaterAid's hygiene-related work.

3 WaterAid will place particular emphasis on (a) the safe disposal of human excreta, (b) handwashing with soap or a suitable substitute (eg ash) at critical times, (c) arrangements for menstrual hygiene and management, especially in schools, (d) good food hygiene, especially in relation to weaning foods, (e) the cleanliness of homes and compounds, and (f) safe water management to the point of consumption.

Planning

4 In the planning of hygiene promotion programmes, ethical considerations will be given regarding consent, confidentiality and respect for culture and the individual.

5 Formative research will be carried out at an appropriate level as a first stage of planning a hygiene promotion programme.

6 A baseline study will be carried out at the start of every hygiene promotion programme. This is the basis for subsequent monitoring and evaluation in order to track changes in hygiene behaviour.

Design and implementation

7 For greatest impact, WaterAid's hygiene promotion programmes will generally focus on a **limited** set of hygiene behaviours, rather than trying to change everything at once.

8 A hygiene promotion programme will, if relevant to the focus of the programme, be integrated with/linked to activities within the health, water and education sectors[107].

9 The design of a hygiene promotion programme will identify, from the beginning, at which levels it will perform which activities (eg will hygiene messages be reinforced at district level through a media campaign or will the programme only focus on community level implementation?).

10 Appropriate participatory methodologies will be used to implement a hygiene promotion programme at community level. WaterAid will allow for flexibility in the use of approaches although they should be based on the SARAR principles and carried out by appropriately skilled facilitators.

11 The duration and frequency of hygiene promotion activities will be determined by the time taken to meet behaviour change targets, rather than to construct water supply and sanitation hardware.

12 Appropriate training of hygiene promotion facilitators/trainers (both paid and unpaid) will be included in programme implementation. While community health volunteers will often play a central role in hygiene promotion programmes, WaterAid expects all programmes it supports to include paid health/hygiene professionals both at managerial and field levels. Skills training of partner staff and community members may be necessary.

13 Hygiene 'hardware' options will be available to ensure suitability for different groups of people (eg older people, pregnant women, people living with HIV/AIDS, children, people with disabilities). Where appropriate, WaterAid will stimulate the local private sector to provide these products.

14 Disadvantaged and at-risk groups will be considered in the design and implementation of hygiene promotion programmes (women, young people (girls in particular), people living with HIV/AIDS, people with disabilities, older people, non-sedentary groups, and others depending on the context).

15 Social inclusion and equity analyses will be included in all stages of hygiene promotion.

16 Communication methods and materials should be culture- and location-specific, accessible and relevant to all of those within the target group.

17 Hygiene promotion activities will concentrate on achieving sustainable changes in key hygiene behaviours (identified through formative research) and reinforcing hygiene messages by working through existing institutional structures of community and partner organisations whenever possible. Interventions will be implemented in collaboration with other long-term agencies whenever practicable, such as government and non-government organisations, WaterAid partners and non-WaterAid partners, health-focused agencies and those with different developmental aims.

18 Consideration will be given to national technical standards needed to ensure sustainability (including in relation to disaster risk) and environmental protection. These should include a mix of self-supply products and commercial products (where appropriate).

Monitoring and evaluation

19 Until further research is carried out that will provide more direction for effective monitoring and evaluation of hygiene, WaterAid will carry out monitoring and evaluation using a limited number of proxy indicators of outcomes. These will be identified during the programme design phase, against which monitoring and evaluation can take place. They must be consistent with the key post-implementation monitoring (PIM) indicators. Indicators may include (on the day of an unannounced visit) evidence of use of handwashing facilities or evidence of the hygienic use of latrines. Sought outcomes could include a steady rise in the percentage of households that have and use handwashing facilities with soap and/or ash, located near the toilet or home.

20 Monitoring and evaluation will be carried out at outcome level only, not at impact level. This is because it is much harder to measure causal linkages between a hygiene promotion programme and, for example, a reduction in WASH-related diseases, as there may be other variables involved. Outcome level monitoring uses proxy indicators that can give a steer as to whether or not safe hygiene practices are on the rise.

Learning

21 WaterAid will regularly undertake focused hygiene studies in order to better understand the effectiveness of our hygiene promotion work, and to develop more robust means of monitoring hygiene behaviour changes. These studies will likely be triggered through the analysis of results from effective monitoring.

Advocacy

22 WaterAid advocacy on hygiene will focus on influencing both policy and programmes of governments and service providers, to ensure prioritisation of hygiene and long-term resource allocation, as well as inclusion of hygiene promotion in WASH interventions. It is important that the links between water, sanitation and hygiene are understood up to national government level, and that the cost-effectiveness and importance of hygiene promotion and behaviour change are recognised. Hygiene promotion should not be seen as an add-on to water supply and sanitation programmes but as an integral part of them.

23 WaterAid will ensure that hygiene promotion principles and minimum commitments are reflected in global, regional and national advocacy and campaigns messages (eg evidence of the cost-effectiveness and public health impacts of hygiene promotion). Emphasis should especially be given to the public health and socio-economic benefits good hygiene practices can bring.

24 WaterAid will work to advocate for closer linkages between the WASH sector and the health and education sectors as principle players in bringing about sustainable hygiene behviour changes.

WaterAid/GMB Akash/Panos

Ram, washing himself at a water pump, Lakatoorah tea garden, Sylhet, Bangladesh

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83   For more information see Water and Sanitation Programme (no date) *Total sanitation and sanitation marketing project* [online]. Available at: http://www.wsp.org/wsp/node/130 (accessed 3 August 2012)

84   Devine J (2010) Beyond tippy-taps: The role of enabling products in scaling up and sustaining handwashing. *Waterlines,* vol 29, no 4, pp304-314

85   The Water and Sanitation Programme of the World Bank (WSP) has compiled a list of enabling products, which can be referred to at www2.wsp.org/scalinguphandwashing/enablingtechnologies

86   Different methods and tools that can be used for monitoring and evaluation are described in detail in Almedom A M, Blumenthal U and Manderson L (1997) *Hygiene evaluation procedures: Approaches and methods for assessing water- and sanitation-related hygiene practices*. INFDC, IT Publications, London, UK; as well as in Boot M and Cairncross S (Eds) (1993) Actions speak: The study of hygiene behaviour in water and sanitation projects. IRC/LSHTM, Delft, The Netherlands.

87   More detailed information on post-intervention monitoring (PIM) can be found in WaterAid (2010) *Guidance on post-intervention monitoring and follow-up of water and sanitation interventions*. WaterAid, London, UK, which explains how post-intervention surveys should be carried out and how to select statistically representative samples. It also makes recommendations on how data should be collected, stored and presented. To complement existing knowledge and resources, WaterAid will aim to carry out research in the future to further strengthen its work on monitoring and evaluation of hygiene behaviour change.

88   SNV and IRC (2010) *Sustainable sanitation and hygiene for all – Performance monitoring instruction,* p5. Netherlands Development Organisation, SNV and IRC International Water and Sanitation Centre. Available at: www.irc.nl/page/57189 (accessed 3 August 2012)

89   Much of the information in this section has been drawn from the work carried out by Vicky Blackbrough, WaterAid's Hygiene Promotion Adviser from 1997 to 2001.

90   Vicky Blackbrough was WaterAid's full-time Hygiene Adviser from 1997 to 2001 and part-time during 2002 and 2003, until the role ceased in 2004 when it was subsumed in the Programme Learning Facilitator role.

91   These strategic contribution indicators (SCIs) and later bath indicators focused on monitoring hygiene behaviour change and specifically looked at the percentage of improvements in handwashing practices of the target population, sustained for more than three years after a WaterAid funded intervention ended, as well as the percentage of households in which all members continue to use an 'improved' hygienic sanitation facility for defecation more than three years after a WaterAid funded intervention has ended. The SCIs and bath indicators were replaced in 2006 by an annual performance review framework (APRF), which required country programmes to report annually on the number of direct hygiene beneficiaries (ie those who now practised safe hygiene) as a result of a WaterAid funded hygiene promotion campaign or project.

92   Blackbrough V (2006) *History of hygiene promotion in WaterAid*

93   See also the IRC hygiene papers available online at: www.irc.nl/page/51605.

94   WaterAid (2011) *Promoting good hygiene practices: Key elements and practical lessons.* WaterAid, Melbourne, Australia. Available at: www.irc.nl/page/64892 (accessed 3 August 2012)

95   In 2009-2010, the Technical Support Unit (TSU) carried out a quantitative as well as qualitative assessment of technologies and approaches in country programmes (based on 2008-2009 data). These studies differentiate between water, sanitation and hygiene technologies and approaches, and are based on questionnaires as well as interviews with country programme staff (although the studies are not comprehensive and may need further research and verification). Furthermore, consultation was carried out with WaterAid country programmes in May and June 2011, which provided rich information on definitions and approaches, monitoring and evaluation mechanisms, and future needs for hygiene promotion work at global, regional and national levels. Not all of the information obtained from the consultation has been included in this section; it has been documented for purposes of future work.

96   WaterAid Zambia (2011) *Hygiene framework consultation part 1 of 5*. WaterAid, Zambia

97   WaterAid Zambia and WaterAid Ghana (2011) *Hygiene framework consultation part 1 of 5*. WaterAid, Zambia and Ghana

98   However, PHAST carried out by inexperienced and untrained facilitators has a tendency to become didactic rather than truly participatory. Significant skill is needed to use the tools and approaches correctly. But when done well, the approach is very powerful indeed.

99   UNICEF (1999) *Towards better programming. A manual on school sanitation and hygiene.* Water, Environment and Sanitation Technical Guidelines Series – No 5. Available at: www.unicef.org/wash/files/Sch_e.pdf (accessed 3 August 2012)

100   Adapted from WELL (2005) *Social marketing: A consumer-based approach to promoting safe hygiene behaviours* [online]. Available at: www.lboro.ac.uk/well/resources/fact-sheets/fact-sheets-htm/Social%20marketing.htm (accessed 3 August 2012)

101   Adapted from Almedom A M, Blumenthal U and Manderson L (1997) *Hygiene evaluation procedures: Approaches and methods for assessing water- and sanitation-related hygiene practices,* pp49-50. INFDC, IT Publications, London, UK.
      While the presence of a handwashing facility does not necessarily translate into sustained handwashing at critical times, if over the course of time the number of handwashing facilities (especially with soap or a locally available substitute) increases and there is evidence of use, this can indicate an uptake of handwashing behaviour.

102   IRC (2004) *Sustainability of hygiene behaviour and the effectiveness of change interventions*. IRC International Water and Sanitation Centre, The Netherlands. Available at: http://ec.europa.eu/echo/files/evaluation/watsan2005/annex_files/IRCNL/IRCNL.5.Sustainabilityof HP_IRC_Booklet2[1][1].pdf (accessed 3 August 2012)

103   Almedom A M, Blumenthal U and Manderson L (1997) *Hygiene evaluation procedures: Approaches and methods for assessing water- and sanitation-related hygiene practices.* INFDC, IT Publications, London, UK

104   Boot M and Cairncross S (Eds) (1993) Actions speak: The study of hygiene behaviour in water and sanitation projects. IRC/LSHTM, Delft, The Netherlands
      Standard indicators are also being developed as part of WaterAid's *post implementation monitoring (PIM)* processes.

105   Almedom A M, Blumenthal U and Manderson L (1997) *Hygiene evaluation procedures: Approaches and methods for assessing water- and sanitation-related hygiene practices*, p55. INFDC, IT Publications, London, UK

106   For example, government education departments can be encouraged to support child to child hygiene promotion activities in schools. Such an approach contributes to avoiding duplication of efforts and conflicts of interest, maximises use of limited resources, widens WaterAid's sphere of influence, enhances capacity building of partners and communities, and strengthens the long-term sustainability of hygiene promotion programmes.

107   Outcome indicators are different from output indicators – observations on the existence and number of handwashing facilities (although these indicators do not say anything about if or how facilities are used).

WaterAid

WaterAid's mission is to transform lives by improving access to safe water, hygiene and sanitation in the world's poorest communities. We work with partners and influence decision-makers to maximise our impact.

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