

COMING INTO ITS OWN

Hygiene Promotion for Development

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< the past? >





Preamble



The focus of this presentation is hygiene behavior, because health knowledge does not mean good behavior and good behavior does not necessarily require health knowledge. And all health impacts require good behavior first.....



Purpose and Outline

Purpose:

WaterAid Australia invited IRC to contribute a state-of-the-art overview of and lessons on Hygiene Promotion

Outline:

1. Value of HP
2. Key & Contextual Practices
3. Analytical model
4. Selected cases
5. Way forward





1. Value: Beyond health

- MDG1 (poverty): less loss of working days, lower health/death expenses, less diarrhoeas and kitchen gardens for better nutrition, etc.
- MDG2 (education): less diarrhoeas & worms raise attendance and performance, toilets present, presumably clean, and menstruation-friendly improve girls' schooling
- MDG3 (gender): better female education related to better hygiene, smaller families, more income, higher status women, better MCH, HP can empower women and address men on their behavior and support
- MDG4 (child mortality) diarrhoeas 2nd cause of death under fives
HWS/S = 48% reduction, by midwives 25% lower mortality neo-natals, by mothers 60%, safe excreta disposal 36% less diarrhoeas
Etc. etc.

HP contributes to all MDGs either directly or indirectly

2. Key or Contextual Practices?

Key to health benefits are HWWS and ODF, but sometimes other practices count, e.g.:

- In drought areas and where households buy drinking water, other habits may be relevant: face washing (eye infections), bathing (skin infections), teeth brushing and utensils washing with clean water;
- If high arsenic levels, getting / making safe *drinking* water safe may be needed
- If no better infrastructure, HP to recognize gender constraints (time, costs, frugality norms), promote habits with low water amounts, calculate costs & address gender norms, including with mothers-in-laws and husbands;



2. Key or Contextual Practices?



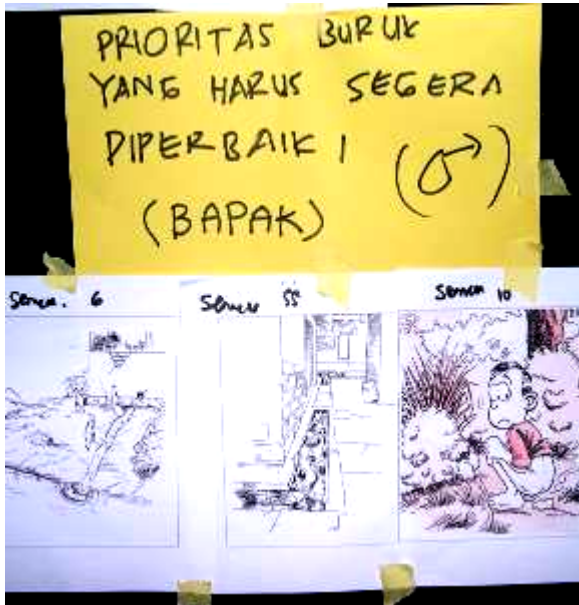


3. Analytical model



To analyze HP programs, a simple theoretical model was used: FOAM (Devine, 2010):

- F:** Focus practices and focus groups
- O:** Opportunities to practice the behavior, e.g. soap and water available, gender relations allow practice
- A:** Ability to practice, e.g. have money, equipment, time, required skills
- M:** Motivation to practice, e.g., cleaner environment, be modern, be like others, better life for children, readiness to try new things, cost savings (Often not better health – may be the program's goal)





4. Cases

a) HWWS/S

(Campaign approach)

- HWWS/S: suitable for social marketing because relatively simple habit allows mass media promotion + inter personal contacts
- Began in Central America. FOAM factors well-defined.
- Preparatory research essential: in Vietnam partially different F (focus groups) and M (motivating messages)
- Best evaluated in Guatemala. Baseline only 3% target group good practice. No clear post behavior data, but diarrhoeas fell over time (3 surveys)
- Costly, but levered commercial sector funds in ratio 1:2 (yr 1). Cost <US\$ 10/case avoided





4.Cases

b) Toilet use & hygiene (Community Approach)



- CLTS programs in Bangladesh (NGOs) and Maharashtra (State):
- FOAM clearly defined: ODF behaviors, low/no cost technology without subsidy, knowledge & skills, disgust & pride
- Reportedly, 70 million and 5 million people stopped open defecation
- Actual toilet use may be less. In Orissa, 40% hhs built toilet, but in 70% all members used consistently.
- No sustained independent verification to account for valid community reward in Maharashtra
- VERC study in Bangladesh: ODF sustained and toilet quality upgraded, but research methodology unrevealed.
- Cost: inconclusive. US\$1,30/pp for VERC, but no representative study at₉ scale (4/100 villages, not random)

b) Toilet use & hygiene (Community Approach)



- Community-managed sanitation program in Kerala: ODF early target (1997)
- NGO build local government capacity
- 17 Panchayats ODF (total pop 850,000)
- Foam: HH using OD (poor), Panchayat's fund for subsidy-with-accountability, knowledge & skills training, social & economic benefits
- HP: 3 session compulsory, husband + wife
- Use toilets 96%, water near 75%, soap rare
- Monitoring: 3-visit community monitoring system on toilet operation, use, hygiene
- Cost Rs 2.000, ½ of state-subsidized toilet incl. sanitation & hygiene promotion costs
- Scaled district-wide (1>3>5 districts >state) on request of other panchayats & districts



b) Toilet use & hygiene (Community Approach)

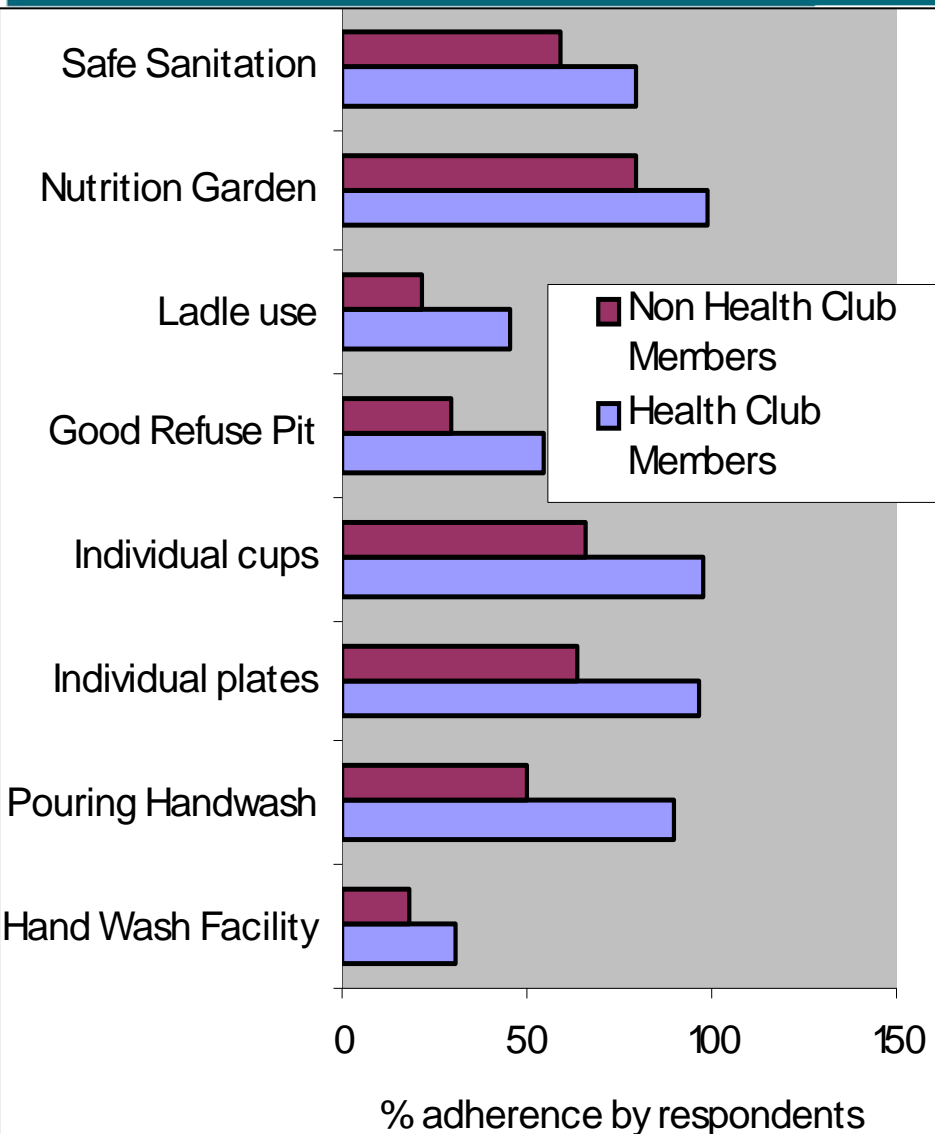


WSLIC-2 Indonesia – HP part of WASH project

- Coverage 2,500 villages (20% extra!)
- HP through PHAST, toilet use & HWWS in schools
- Focus: mothers of <5 & schools; Opportunity: toilet loans, CLTS, local mats & skills; Ability: only knowledge; Motivation: only health;
- Impacts currently under study. Results by December 2010.
- Lessons so far are institutional:
 - After PHAST training no systematic HP program
 - HP workers in practice did all, no focus on HP
 - Project aim was outputs, not behavior change
 - WASH Committees undervalued HP
 - No indicators & monitoring behavioral change

4. Cases

c) Multiple practices (Small Groups Approach)



- Past famous example: radio listening clubs, Tanzania (Similar elsewhere: listening cassettes)
- More recently: Community Health Clubs, AHEAD NGO, Zimbabwe
- In 25 sessions led by trained health staff 50 practices
- Doable focus practices, e.g. safe stool disposal (incl. cat method), hand wash by pouring. Only soap not affordable
- Focus groups self-selected, so readiness to change higher?
- Motivation included influence from peers
- Cost-effective: significant and evidence-based (mostly observable!) improvements at US\$ 0,60/pp



4. Cases:

d) Sustained practice



- Only one study so far on whether practices are sustained
- Comparisons of 25 practices between more recent and earlier ended HP programs showed only 2 of 25 differed significantly
- Fading was studied by surveys in 2001 and one year later
- Only 1 of 17 practices faded
- Access to water made no difference
- Better educated women practiced hygiene better
- HP in India did not change HWWS and toilet use men



5. Conclusions & way forward

- Social marketing suitable for single practice
- More comprehensive changes through group and community approaches
- NGOs may practice social marketing cheaper
- Adjust target practices and groups to local conditions, e.g. drought, availability of soap, gender
- Preparatory study (e.g. FGDs) on FOAM is important
- Social and economic reasons motivate change as much or more than health
- (Participatory) baselines, monitoring behavioral change (including over time!) and cost data still too rare





Thank you