Water, Sanitation and Hygiene (WASH)

Social and Behavior Change Communication (SBCC)

Participants' Manual

May 2020

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Acronyms

BCC	Behavior Change Communication
CLTSH	Community-Led Total Sanitation and Hygiene
CSA	Central Statistical Agency
EDHS	Ethiopia Demographic and Health Survey
IPC	Interpersonal Communication
KAP	Knowledge, Attitudes and Practices
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NGO	Non-Governmental Organization
OD	Open Defecation
OWNP	One WASH National Program
RWSSH	Rural Water Supply, Sanitation and Hygiene
SBCC	Social and Behavioral Change Communication
SEM	Socio-Ecological Model of SBCC
SMART	specific, measureable, attainable, realistic, time bound
SDA	Small Doable Actions
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WSP	Water and Sanitation Program of the World Bank
WVE	World Vision Ethiopia

ABOUT THE TRAINING MANUAL

The demand creation for low cost and high quality WASH products and services within USAID Transform WASH project is implemented on two different approaches namely commercial marketing and community based interventions.

The community based demand creation activity is underway through the existing government health system mainly through health extension workers as a major frontline actors to conduct regular household counseling visit, improve WASH behaviors and create demand for improved WASH products and services in the project implementation areas.

Building the capacity of health extension workers on the implementation of WASH program using appropriate WASH social behavior change communication strategies and tools as well as improving the knowledge on WASH concepts and skill of counseling techniques have a significant impact on the success of interventions implemented at community level.

This training, therefore, is developed to capacitate health professionals mainly health extension workers working with communities to understand Social Behavior Change (SBC) and apply the principles of SBCC in changing community's behaviors on WASH behaviors such as Sanitation (safe disposal of human faeces) Hygiene (proper hand washing) and Water (safe handling of drinking water).

The manual comprises four major units; the first unit is about Social Behavior Change Communication (SBCC) to give an insight to participants on the concepts of SBC and basic elements they need to consider in reaching out households in particular and the community in general to bring the desired change on various health behaviors in addition to WASH.

The second unit has basic elements of WASH concepts, importance of interventions, WASH doable actions or key messages and introduction of optional WASH products and services with a focus on those low cost and high quality products that USAID TWASH promotes.

The third unit is about practical WASH household counseling visit on which participants will be familiarized with communication materials (flipchart) they will be using while conducting household visit, and application of household visit which is the most important part of the session with the aim of developing counseling skill of participants. Participants will make a pair and practice counseling target groups with the use of the flip chart.

The fourth and the final unit is explaining about the monitoring and evaluation activities with a focus on monitoring tools such as proper documentation and reporting, supervision and review meetings. In this unit standard data collection and reporting formats will be introduced and distributed to participants.

Finally participants will prepare a kebele level plan and submit to facilitators on which their subsequent community mobilization and other activities would be monitored.

DEFINITION OF TERMS

- **Attitude:** is a cross cutting factor. Personal dispositions towards a particular subject or situation; how we generally feel about a situation. **Barrier: i**s a difficulty or obstacle that can stop people from performing desired behaviors to the identified problem.
- **Behavior change communication (BCC):** is a consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group, and mass media channels including participatory methods.
- **Campaign:** is goal oriented recognizable attempt to inform, persuade or motivate change within the intended audiences; linked series of activities using different media with mutually supportive messages.
- **Channel:** is the medium used for communication. The three categories of communication channels are interpersonal, mid-media, and mass media.
- **Community:** is a group united around a shared characteristic or concern or a group of people located in a specific area.
- **Ecological:** refers to the relationships between individuals and their environments.
- **Hygiene**: the word hygiene originates from the name of the Greek goddess of health, Hygieia. It is commonly defined as a set of practices performed for the preservation of health and healthy living. Hand washing with soap or ash is the most important element, but it also includes personal cleanliness of the face, hair, body, feet, clothing, and for women and girls, menstrual hygiene. (Ethiopia's OWNP learning resource)
- **Interpersonal communication:** is a face to face exchange of e.g.; information, education, motivation, or counseling.
- **Intervention:** is a set of complementary program activities designed to achieve program goals.
- **Message:** is a brief, value based statement aimed at an audience that captures a concept. Messages must be personally appealing and discuss only one/two key points. The information in the message should be new, clear, accurate, and complete, culturally appropriate, and include specific suggestions of what people can do.
- **Model:** it draws upon multiple theories to try to explain a given phenomenon.
- **Sanitation:** generally refers to the prevention of human contact with wastes, but is also used to mean the provision of facilities and services for the safe disposal of human urine and faeces. Sanitation can be further classified as basic or improved sanitation (Ethiopia's OWNP learning resource)
- **Social and behavior change communication (SBCC):** is an evidence -based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory methods.
- **Theory:** is a systematic and organized explanation of events or situations.
- **Trend:** is a pattern in frequencies of disease incidents or prevalence over time, within or across various subgroups.
- **WASH:** is an abbreviation that stands for water, sanitation and hygiene

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INTRODUCTION

Water, sanitation and hygiene (WASH) related problems are among the major contributing factors for the various health risks and childhood mortality and morbidity in Ethiopia. Water sources that are likely to provide water suitable for drinking such as a piped source within the dwelling, yard, or plot; a public tap or standpipe; tube well/borehole; a protected well or spring; and rain water or bottled water are identified as improved sources (WHO and UNICEF, 2014)..

In Ethiopia, only 24% of the population use latrines that meet basic standards, and worse still, about 37% of the population practices open defecation (JMP, 2014). This lack of adequate sanitation obviously makes fecal contamination of the environment and the spread of disease more likely. In addressing the aforementioned problems of water, sanitation and hygiene, Social Mobilization and Behavior Change Communication activities have a vital role for planners, implementers and other stakeholders on the sector.

Government of Ethiopia and its partners are implementing various programs and projects and registered promising achievements though the existing problem significantly affects the community resulting adverse consequences on the health and other socio-economic parameters.

BACKGROUND

The USAID Transform WASH program is implemented by a consortium of four partners: Population Services International (PSI), Plan International, SNV Netherlands Development Organization, and IRC. The program is designed to reduce preventable deaths and illness in Ethiopia due to diarrheal disease, particularly among children under five. This will be done through the development and testing of scalable and replicable market-based models. The program supports the Government of Ethiopia (GoE) and the One WASH National Program (OWNP) to increase use of improved WASH products and services among women and their families.

The Transform WASH consortium implement a holistic market development strategy to Strengthen the WASH enabling environment through GoE engagement and capacity building, collaboration among market players, and use of evidence-based decision making; to build sustained demand for low-cost quality WASH products and services; to link the public and private sector to more efficiently provide WASH products, services, and financing; and to implement user-centered marketing techniques to identify business models and technologies for the market to meet the needs and desires of low-income consumers.

The Social Behavior Change (SBC) strategy designed for USAID Transform WASH project primarily suggests the implementation of WASH household counseling as a central approach to change existing WASH behaviors and create demand for products and services and improve uptake by target households.

As a subset of the social behavior change strategy, household counseling for WASH behaviors would be undertaken by the existing health system mainly by health extension workers working at kebele level.

USAD Transform WASH project gives a due emphasis to build the capacity of government health structure at woreda and kebele level so that they will be involved in the community mobilization and behavioral change interventions in rural and peri-urban areas towards generating demand for WASH products and services, purchasing and proper utilization of improved WASH products (with a focus on sanitation) and contribute to improved health status of the community as a whole.

This two days training on WASH SBCC mainly focuses on familiarizing participants with USAID Transform WASH project, increase knowledge of participants on Social behavior change approaches, refresh them on WASH concepts, introduction of improved sanitation products, introduction of counseling tools and conduct practical counseling which aims on skill building among participants.

Training Schedule

Duration: Two days

S/No.	Units/Sessions	Facilitation methods	Time allocated	Materials required
Day one				
	Registration of participants			
	Welcome and opening speech			
	Introduction of participants. training schedule and setting rules			
	Introducing USAID TWASH Project			
1	**Unit 1: Social behavior change communication (SBCC)**		**5 ½ Hrs**	Note books, pens, Flipcharts, marker, plasters
1.1	**Session one:** Concepts and principles of Social behavior change communication	Brainstorming	1 Hr	
1.2	**Session two:** Situation analysis technique (Problem identification and causality analysis)	Group work	1 Hr	
1.3	**Session three**: Behavior change theories and models • Stages of change to behavior change • Socio-ecological model	Brainstorming	1 ½ Hrs	
1.4	**Session four:** Interpersonal and group communication	Group work	1 Hr	
1.5	**Session five**: Social/Community mobilization	Brainstorming	1 Hr	
2	**Unit 2: Water, Sanitation and Hygiene (WASH)**		**2 ½ Hrs**	Flipcharts, marker, plasters, sample sanitation products
2.1	**Session one:** Refreshing basic concepts of WASH	Brainstorming	1 Hr	
2.2	**Session two:** WASH small doable actions/key messages	Group work	1 Hr	
2.3	**Session three**: Introduction of WASH products	Demonstration	30 minutes	
Day two				
3	**Unit 3: Household counseling visit for WASH**		**6 Hrs**	Flipcharts, marker, plasters, USAID TWASH HEWs Flipchart
	Recapping Day one		30 minutes	
3.1	**Session one:** Household visit and counseling skills	Brainstorming	1 ½ Hrs	
3.2	**Session two:** Introduction of communication tool (USAID TWASH HEWs Flip chart)	Orientation	1 Hr	
3.3	**Session three**: Application of practical household counseling visit	Pair-to-pair counseling	3 Hrs	
4	**Unit 4: Monitoring and evaluation**		**2 Hrs**	Flipcharts, marker, plasters, M & E tools
4.1	**Session one:** description and discussion of monitoring and evaluation activities	Brainstorming	1 Hr	
4.2	**Session two:** Introduction of data collection and reporting formats	Orientation	30 minutes	
	Planning session		30 minutes	Planning template
	Final Q & A			
	Way forward and closing			

UNIT 1: SOCIAL AND BEHAVIOR CHANGE

Unit Objectives: At the end of the unit, participants will be able to

- Explain the concept and principle of social behavioral change and communication
- Understand the problem and causative analysis on SBCC process
- Explain how behavior change theories and models can be applied to support individuals improve their health status
- Understand interpersonal communication and group facilitation concepts and skills
- Explain social and community mobilization and the process of conducting community mobilization

Allocated time: 5 ½ Hrs

Training materials: Note books, pens, flipcharts, marker, plasters

Session 1.1: Concepts and principles of social behavior change communication

Session objectives

- Explain the concept of social behavior change communication
- Describe the principles of social behavior change communication

Allocated time: 1 Hr

Training method: Brainstorming

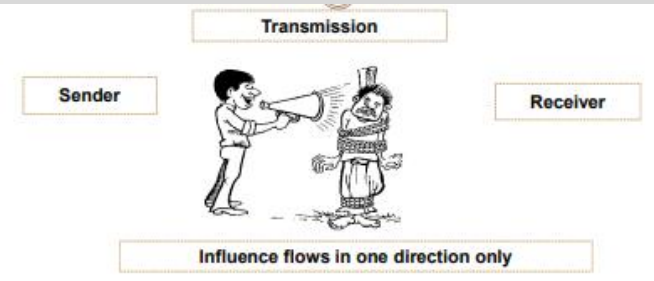
Brainstorming questions: As Health Extension Professionals;

- From your previous knowledge and experience, how do you define SBCC?
- What makes it different from health education, IEC, BCC?
- What are the principles of SBCC and what do you think the principles are useful to apply?

Participants Note

Simply delivering a message does not bring behavioral change.

- **Health communication:** is a broad term that describes a number of strategies to share information that can lead to better health outcomes. Health communication activities can vary widely, depending on the objectives, audience, and communication channels.
- **Health education:** defined as any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes.
- **Information, Education and Communication (IEC)**: range from didactic one-way communication to entertaining methods. It can utilize a wide range of media channels and materials. Fundamentally, the IEC approach assumes that people will follow health advice when they provided with the 'right' information.



- **Behavior Change Communication (BCC):** intends to foster necessary actions in the home, community, health facility or society that improve health outcomes at individual level by promoting healthy lifestyles or preventing and limiting the impact of health problems using an appropriate mix of interpersonal, group and mass-media channels.
- **Social and Behavior Change Communication (SBCC):** is a research-based, consultative process that uses communication to promote and facilitate behavior change and support the requisite social change for the purpose of improving health outcomes.
- SBCC is guided by a comprehensive ecological theory that incorporates both individual level change and change at broader environmental and structural levels. Thus, it works at one or more levels: the behavior or action of individual, collective actions taken by groups, social and cultural structures, and the enabling environment."
- As noted here, the addition of an "S" to BCC intends to signify that individuals and their immediate social relationships are dependent on the larger structural and environmental systems: gender, power, culture, and community, and organization, political and economic environments. Unlike other terms, SBCC explicitly encompasses social change perspectives that foster processes of community dialogue

and action.

- Human behavior is not only a result of individual knowledge, skill, ability, perception, etc… but also resulted from the influences of community norms, social/traditional and political structures on which individual is surrounded. Thus, SBCC should also focus on addressing these external influences in order to bring behavioral change on individuals.

SBCC uses three key strategies

- ***Advocacy*** *occurs when an organization, group, or person gathers to argue for, recommend, or support a cause or policy change.*
- ***Social mobilization*** *brings together various people, groups, and organizations to raise awareness or demand change on certain issues.*
- ***Behavior change communication*** *uses interpersonal, small group, print, and other materials to promote behavior change at the individual level.*

Principles of SBCC	
Follow a systematic approach	It drive the program it tells you how the communication objectives work together to create change or is a platform holding together your different channels and activities (e.g. P-process)
Use research, not assumptions to drive your program	The design and implementation of SBCC interventions needs understanding of behavior related problem on the existing profile of the audience
Consider the social context	Stated and unstated approval of ones behavior by the society or peer groups in which one operates.
Keep the focus on your audience(s)	Understand the intended audience from the perspectives of individual, family, community, and society levels
Use theories and models to guide decisions	Systematic and organized explanation of events or situations.
Involve partners and communities throughout	SBCC interventions demand coordination of different sectors and community engagement including but not limited to, generating local resources (Idirs, Woman associations, Religious institutions etc).
Set realistic objectives and consider cost-effectiveness	Specific, operationalized statement detailing the desired accomplishments (includes communication and program objectives). Specific, operationalized statement detailing the desired result. A properly stated objective is action oriented.
Use mutually reinforcing materials and activities at many levels	SBCC interventions should use a mix of reinforcing and complementary communication tools, and approaches
Choose strategies that are motivational and action-oriented	Factors influencing individuals to act upon information and knowledge. People require motivation often represented by attitudes, beliefs, or perceptions of benefits, risk or seriousness of the issues they are trying to change.
Ensure quality at every step	One mistake make all work fail, so ensure quality at each step

Session 1.2: Situation analysis (Problem identification and causality analysis)

Session objectives

- Explain the reasons for conducting situation analysis
- Apply situation analysis technique (problem tree tool and causality analysis)

Allocated time: 1 Hr

Training method: Brainstorming and group work

Brainstorming questions:

- How do explain understanding the situation or situational analysis?
- What is the importance of undertaking situational analysis?

Participants Note

Understanding the Situation: Helps to :

- gain insight into the issue the program is addressing from many perspectives
- organize and summarize what is known about the situation
- check assumptions by looking at existing research
- identify gaps and plan
- focus energies and resources and make decisions
- focus a program effectively on different groups of people (those affected and those who influence them)
- address a problem and its context through complementary SBCC strategies (BCC, community mobilization, and advocacy)

As Key Summary:

- ✓ Understanding the situation is the first step in an SBCC process.
- ✓ Understanding the situation strengthens program development because it allows practitioners to gain greater insight into the problem, check assumptions, identify gaps, and tailor a program to a variety of audiences, among others.

Group work activities

1. Divide training participants in four small groups and ask them identify one common WASH related health problems in their kebele
2. Discuss and list root cause analysis exhaustively for the identified WASH related health problem
3. Select a cause which can be addressed through communication intervention
4. Allow group representatives present what the group discussed
5. Summarize the session based on the below notes.

Participants Note

Root Cause Analysis: is a method of problem solving that aims at identifying the root causes of WASH problems or incidents. Root Cause Analysis is based on the principle that problems can best be solved by correcting their root causes as opposed to other methods that focus on addressing the symptoms of problems. Through corrective actions, the underlying causes are addressed so that recurrence of the problem can be minimized. It is utopian to think that a single corrective action will completely prevent recurrence of the problem. This is why root cause analysis is often considered an iterative process.

The basic process

- The basic process consists of a number of basic steps. These corrective measures will lead to the true cause of the problem.

1. **Define the problem** or the factual description of the incident. Use both qualitative and quantitative information (nature, size, locations and timing) of the results in question.
2. **Collect data** and evidence and classify them along a time line of incidents until the eventual problem or incident is found. Each special deviation in the form of behavior, condition, action and passivity must be recorded in the time line.
3. **Always ask 'why'** to identify the effects and record the causes associated with each step in the sequence toward the defined problem or incident.
4. **Classify the causes** within the causal factors (socioeconomic model) that relate to a crucial moment in the sequence including the underlying causes.
5. If there are multiple causes, which is often the case, document these, preferably in order of sequence for a future selection. Identify all other harmful factors.

6. Think of corrective actions or improvement measures that will ensure prevention of recurrence with a sufficient degree of certainty. Explore whether corrective actions or improvement measures can be simulated in advance so that the possible effects become noticeable, also with respect to the other underlying causes.
7. **Think of effective solutions** that can prevent recurrence of the causes and to which all involved colleagues can agree. These solutions must comply with the intended goals and objectives and must not cause any new and unforeseen problems.
8. **Implement the solutions** (corrective actions) that have been made by consensus.

Please note: steps three, four and five are the most critical part of the corrective measures because these have proved to be successful in practice.

Causality analysis is A process used to identify the primary source of a problem to examine why the problem exists; may occur in different domains of the social ecological model.

Causality analysis is used to:

- Identify the challenges a program should address to reach its vision
- Address the obvious or most visible aspects of a problem is not likely to succeed
- Help programs develop a more effective strategy to overcome the actual problems

An immediate cause is something that contributes to a problem, but is not necessarily a root cause; Just ask 'why'

- Identify as many immediate causes as possible
- Start with the immediate causes identified and keep asking why

It is important to dig deeper and continue to ask "why?" until nearly all responses have been exhausted

Construct a root cause tree

Steps of Causality analysis

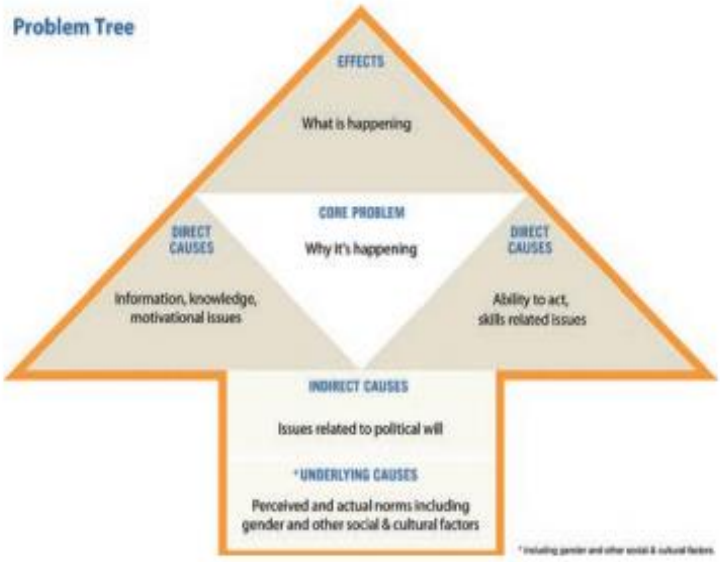
Step 1: Identify possible immediate causes (for the prioritized problems)

Step 2: Identify the root causes

Step 3: Identify behavioral challenges

Step 4: Categorize behavioral challenges as per the social ecological model

Problem Tree



Session 1.3: Behavior change theories and models

Session objectives

- Describe SBCC theories and models and its importance for SBCC intervention
- Apply socio-ecological model to map out the causality analysis

Allocated time: 1 ½ Hrs

Training method: Brainstorming

Brainstorming questions:

- What are theories and models?
- Which theories and models you have heard of before?
- What is stages of change theory and explain the stages?
- What is socio-ecological model of SBCC and its importance to implement SBCC interventions?

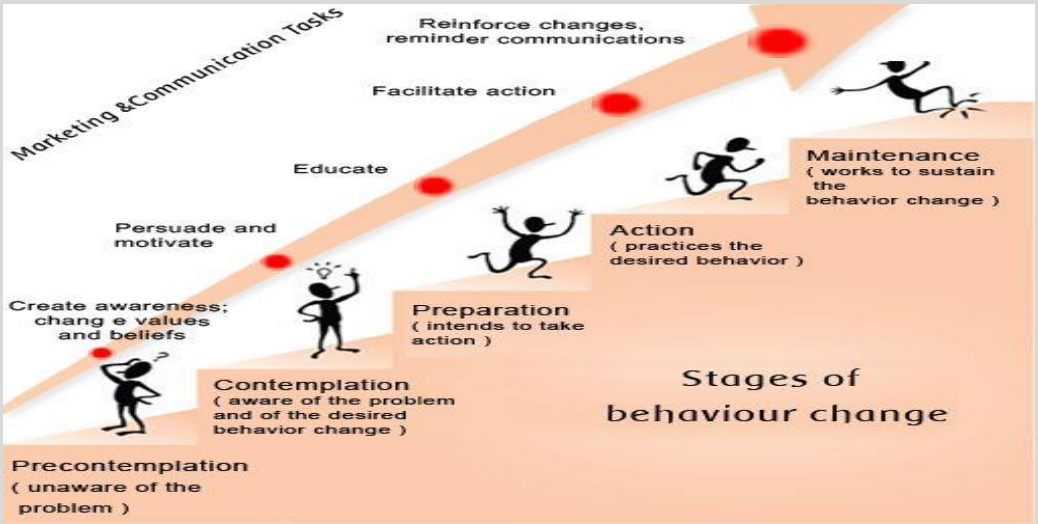
Participants Note

Theory/Model: is systematic and organized explanation of events or situations.

Theories are developed from a set of concepts or constructs that explain and predict events/situations, and provide explanations about the relationship between different variables.

There are many theories and models at individual, interpersonal and community level explaining human behavior. However, we will focus on two major theories and models for this WASH SBCC training. **Stage of change theory** and **Socio-ecological model**.

The Stages of Change theory: focuses on individual level behavioral change and has been applied to a broad range of behaviors at such as weight loss, stop smoking and drug problems, etc… we can consider this theory on WASH behaviors as well. The idea behind this theory is that behavior change cannot be achieved over night. Rather, people tend to progress through different stages on their way to successful change. Also, each of us progresses through the stages at our own rate.



Stage One: Pre - contemplation: at this stage, people are not thinking seriously about to change and are not interested in any kind of help. People tend to defend their current bad habit(s) and do not feel it is a problem. *Example: People unaware of the importance of improved latrine and risk of open defecation.*

Stage Two: Contemplation: at this stage, people are aware of the consequences of their bad habit/behaviors and they spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it. On this stage, people are often weighing the pros and cons of quitting or modifying their behavior. *Example: aware and thinking to construct and use a latrine in the compound instead of defecating on open fields.*

Stage Three: Preparation/Determination: at this stage, people have made a commitment to make a change. Their motivation for changing is reflected by statements such as: "I've got to do something about this - this is serious. Something has to change. What can I do?" *Example: Committed and get prepared to construct a latrine, consulting health workers on where to find improved products, etc…*

Stage Four: Action: This is the stage where people believe they have the ability to change their behavior and are actively involved in taking steps to change their bad behavior by using a variety of different techniques. The amount of time people spend in action varies. It generally lasts about 6 months, but it can literally be as short as one hour! This is a stage when people most depend on their own willpower. *Example: People constructed and started using a latrine.*

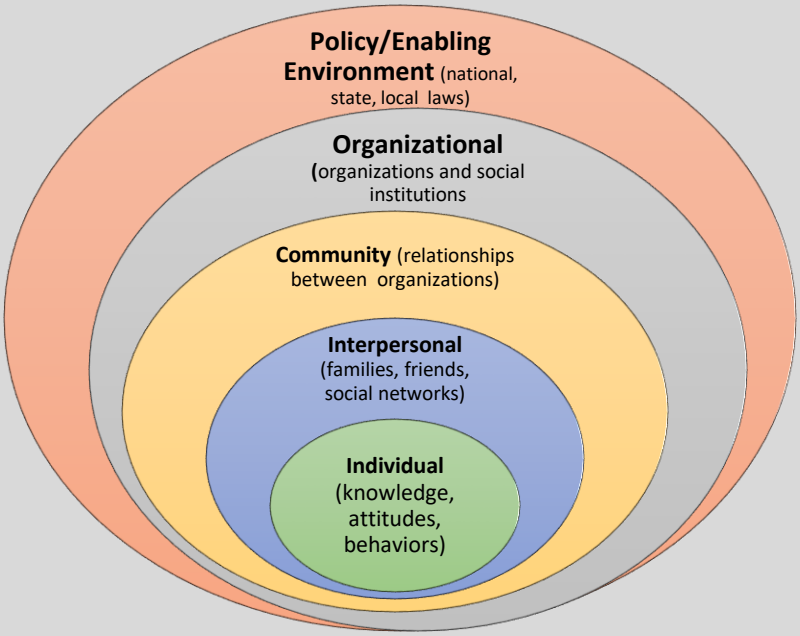
Stage Five: Maintenance: It involves being able to successfully avoid any temptations to return to the bad habit. The goal of the maintenance stage is to maintain the new status quo. People in this stage tend to remind themselves of how much progress they have made. People in maintenance constantly reformulate the rules of their lives and are acquiring new skills to deal with life and avoid relapse. *Example: exclusive use of latrine at all the time for longer period.*

Participants Note

Social Ecological Model (SEM)

The Social Ecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational advantage points and intermediaries for health promotion within organizations.

There are five nested, hierarchical levels of the SEM: ***Individual, interpersonal, community, organizational, and policy/enabling environment***. It considers the individual's (attitude, knowledge and skill); his/ her community (partners, family, peers); services (health facility and level IV HEPs), and the environmental and societal/ structural levels that shape policymaking. The model illuminates the dynamic roles of each level and the need to act in all domains of influence to improve healthy behavior and sustain service uptake



Levels of influence on socio-ecological model for WASH with specific to sanitation;

Individual level (knowledge, attitude and skill, etc…):- for example individuals may not be aware of the adverse health consequences of open defecation, may not have the skill to construct improved latrine, may not be able to pay for construction inputs (improved products, etc…)

Interpersonal level (Family, peers, etc…):- for instance family members put a pressure on other priorities of the household instead of constructing improved latrines, their interest to defecate on open fields rather than in locked latrine due to the long standing community trend, etc…

Community level (social norms, trends, culture, etc…):- the community may not consider open defecation as disgraceful behavior and lacks social penalty to avoid the behavior, people enjoys defecating on outskirts of the village and feel refreshed, etc…

Organizational level (services, institutions, etc…):- availability of strong institutions to educate the community, access to financial services, well developed markets to supply products, etc…also determine human behavior.

Environmental level (policy, religion, etc…):- law enforcements to support healthy behavior, government priority and attention, involvement of influential faith based organization against open defecation, etc…

In addition to levels of influences, there are CROSS-CUTTING FACTORS that should be dealt with across all levels mentioned above to achieve best in bringing the desired behavioral change.

Information, Motivation, Ability to act and Norms

1. **People need information** that is timely, accessible, and relevant. When looking at information, SBCC practitioners consider the level of knowledge held by a person or group. E.g., about improved latrine construction and utilization such as people may not actually understand the adverse health consequences of open defecation and contamination. With such information, some individuals, groups, or communities may be empowered to act. For most people, information is not enough to prompt change.
2. **People require motivation**, which is often determined by their attitudes, beliefs, or perceptions of the benefits, risks, or seriousness of the issues that programs are trying to change—e.g., attitudes toward latrine use that some people may not feel comfortable of using latrines (bad smell, costly, etc...). Identifying what motivates people to practice recommended WASH behaviors really matters most and critical.
    - What is the key motivation for household heads to construct improved latrine?
        - Fear of health risks on family members
        - Restoring pride and dignity
        - Privacy, freedom to use particularly for women to use any time they want
        - Etc…

    Motivation can be affected by SBCC methods or strategies, such as effective counseling, peer education, entertaining radio broadcasts, or TV programs. If done well, such communication can foster individual attitude and behavior change, as well as social norm change.
3. **Ability to act,** motivation may not be enough in some conditions. For instance, women and girls may have the desire to have improved latrine in the compound but they may not have the ability to pay for products or labor intensive works, etc… thus, they need the ability to act in particular circumstances.

Practitioners should look at the ***actual skills***, ***self-efficacy*** (or collective efficacy), and ***access***.

- **Skills** include psychosocial life skills: problem-solving; decision-making; negotiation; critical and creative thinking; interpersonal communication; and other relationship skills, such as empathy.
- **Self-efficacy** is concerned with the confidence of individuals and groups (collective-efficacy) in their own skills to affect change.
- **Access** includes financial, geographical, or transport issues that affect access to services and ability to buy products.

4. Finally, **norms** — socio-cultural, and/or gender norms have considerable influence on behavior. Norms reflect the values of the group and/or society at large and social expectations about behavior. Socio-cultural norms are those that the community as a whole follows because of social status or cultural conventions. Gender norms shape the social views of expected behaviors of males and females.

Session 1.4: Interpersonal and group communication

Session objectives

- Understand and apply interpersonal communication skills for effective interpersonal communication
- Understand and apply facilitation skills for group discussion

Allocated time: 1 Hr

Training method: Small group work

Group work activities

- Divide participants in to four small groups different than the previous small groups
- Give all groups the following questions to discuss very thoroughly
    - What is interpersonal communication
    - What are the key elements and skills required for effective interpersonal communication?
    - What is group communication?
    - What is group discussion facilitation/
    - What are the key skills to facilitate group discussion?
- Allow all group present their discussion points shortly through their representatives

Participants Note

Interpersonal Communication is face-to-face verbal or non-verbal exchange of information and feelings between two or more people. Each time a service provider has contact with a client, communication is taking place.

Key Elements of Effective IPC: there are three main types of communication interactions that occur within a provider-client relationship:

1. **Caring:** The goal is to establish and maintain a positive rapport with the patient.
2. **Problem solving:** The goal is for the patient and provider to share all necessary information for accurate diagnoses and appropriate treatment.
3. **Counseling:** The goal is to for clients to understand their condition and adhere to their treatment.

While they occur throughout an interaction, these types of communication often happen sequentially, with

caring communication to establish a positive tone, then problem solving to diagnose, and finally counseling to provide relevant health education. To communicate effectively through these different interactions, it can help to keep in mind some key elements of effective IPC. These are

- Using Non-Verbal Communication Effectively
- Using Verbal Communication Effectively
- Providing Opportunities for Patients to Speak About Their Illness
- Fostering Two-way Dialogue
- Bridging of Social Distance
- Building Partnerships with Clients
- Creating a Caring Atmosphere

Group Discussion Facilitation

- ***Facilitation*** is developmental educational method, which focuses on development of the whole student, not just the development of intellectual competence.
- Facilitation is different from teaching as it encourages participation of the individuals. A facilitator is different from teacher because he/she puts himself/herself in almost equal position with the group and beliefs that he/she can bring out what is already there in individuals to benefit the individual as well as the group.
- In facilitation, the process is as equal as the goal defined, as it is believed that the process is also major way to reach the end.

Adult learning principles

- Adult learning is participatory – participation in the learning process active
- Adult learning is experiential – The most effective learning is from shared experience
- Adult learning uses case studies or role play- learners can draw previous experience to connect new information to previous knowledge
- shows respect for participants - mutual respect and trust b/n trainers and learner helps the learning process
- Is reflective – maximum learning occurs a when a person takes the time to reflect back up on the experience , draw conclusion and plan for feature use
- provide feedback- effective learning requires feedback that is corrective but supportive

Facilitation Skills

- Communication – verbal and non-verbal, actively listening
- Motivating
- Simplification of content into manageable parts

- Conflict management
- Facilitating discussions and participatory activities
- Effective questioning
- Leadership/team player balance and Inclusive nature that makes participants feel safe
- Time management

Session 1.5: Social and Community Mobilization

Session objectives: - participants will be able to:

- Understand social and community mobilization
- Understand and describe the importance of community mobilization on WASH
- Identify community groups to work with to achieve effective community mobilization

Allocated time: 1 Hr

Training method: Brainstorming

Brainstorming questions:

1. How do you understand community mobilization?
2. What benefits does community mobilization serve for your activities and to the community?
3. How do you identify the community groups that can work with you?
4. Which community groups/stakeholders do you engage for community mobilization in your community? What is their contribution regarding health activities?

Participants Note

- **Social mobilization** is a process of gaining and sustaining the involvement of all stakeholders in order to take action to attain a common goal.
- It involves enlisting all actors including institutions, groups, networks and communities in identifying, raising and managing resources and thereby increasing and strengthening self-reliance and sustainability of achievements made.

- **Community Mobilization** is part of the social mobilization applicable in community members with relatively similar backgrounds, norm, culture etc.
- Community mobilization enables the health extension workers to involve different stakeholders in their kebeles so that the community engages in the overall health activities in a sustainable manner starting from planning.
- The stakeholders that could exist at kebele level includes but not limited to: government sector offices (education, agriculture), various community structures and associations (women association, youth association, and religious institutions).
- The participants identify WASH problems, existing behaviors and practices and prepare village and kebele level plan to improve WASH behaviors at HH and community level.
- The participants can use the list of individuals/groups that have been identified in the socio ecological model identified above to influence the behaviors of the intended audiences as a reference in identifying the intended audience to be reached by community mobilization.

The following table, for instance, depicts the kinds of activities that needs to be done specific to WASH

Institutions/associations	Activities undertaken jointly
Youth association	Environmental health, sanitation, development of safe water sources, resource mobilization, etc…
Religious institution	Influence HHs to construction of improved latrines, construct communal latrine, awareness creation on proper hand washing and overall hygiene, etc…
Women association	Influence construction of improved latrine at HH level and ensure women health, safe handling of drinking water, awareness creation on women about hygiene, MHM, etc…
Idir, Iqub, etc… (social institutions)	Create access to loans for members to buy improved WASH products, awareness creation on WASH behaviors, etc…
School	Role models to implement environmental health and hygiene practices and educate children, provide safe WASH services, influence community on recommended WASH behaviors, construct communal latrines and water points, etc…

UNIT 2: WATER, SANITATION AND HYGIENE (WaSH)

Unit Objectives: At the end of the unit, participants will be able to

- Explain the basic concepts of water, sanitation and hygiene
- Understand and describe the small doable actions of water, sanitation and hygiene practices
- Be familiarized with improved WASH products so that they will introduce to the community at large.

Allocated time: **2 ½ Hrs**

Training materials: Note books, Pens, Flipcharts, marker, plasters, sample improved WASH products

Session 2.1: Basic concepts of water, sanitation and hygiene

Session objectives

- Explain the concepts and importance of water, sanitation and hygiene practices
- Understand and mention the elements to be considered on improved WASH practices

Allocated time: 1 Hr

Training method: Brainstorming

Brainstorming questions: Raise the following questions one by one and make detail discussions based on real experiences of participants?

- From your previous knowledge and experience, what are basic and improved sanitation and its importance?
- What are the elements in the sanitation ladder?
- How do you define hygiene and its elements?
- How to ensure safe handling and treatment drinking water?

- What are the elements in the water supply ladder?
- What are the major problems in the community to practice recommended WASH behaviors particularly to use improved WASH products and services?
- What do you think are the solutions mostly from community based intervention and communication perspective?

Participants Note

1. Sanitation: according to Ethiopia's OWNP learning resource, it generally refers to the prevention of human contact with wastes, but is also used to mean the provision of facilities and services for the safe disposal of human urine and faeces. Sanitation also encompasses management of solid and liquid wastes. For our purpose, the training focuses on latrine construction and utilization.

- Sanitation can be further classified as basic and improved sanitation.
- Latrines can be constructed with the use of locally available materials just to avoid open defecation as it is the case in most of the rural areas of the country. However, there are standards that should be taken in to consideration to construct improved latrines and make use of it exclusively by all family members at all times and contribute to the realization of open defecation free villages and kebeles.
- However, low cost and high quality sanitation technologies/products should be promoted for sustained benefits.
- The following are the major components of improved latrine
    - Strong and well lined slab which doesn't cause any harm for the user
    - Washable slab to keep the latrine clean to make the users like it to use
    - Latrine hole cover to avoid smells and flies
    - Roof
    - Proper wall protecting outsider and ensure privacy and freedom to the user
    - Availability of hand washing point
    - Well ventilated

Sanitation ladder

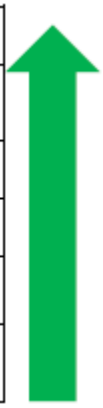
A ***ladder*** is equipment for climbing from one level to a higher level by a sequence of rungs or steps. The use of 'ladder' in describing WASH behaviors particularly ***sanitation*** and ***water supply*** indicates that there is a progression from the basic unimproved provision in a sequence of steps up to improved services at the top of the ladder.

When we see the sanitation ladder as explained in Ethiopia's OWNP learning resource, it starts from

Open defecation upward to , **Unimproved facility**, **Shared facility** and then to **Improved latrine.**

It is with a notion that poor household may not afford to construct improved latrine once and can avoid open defecation through the use of unimproved latrine and go up the ladder to reach the ideal improved latrine as last achievement.

SERVICE LEVEL	DEFINITION
Safely Managed	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite
Basic	Use of improved facilities that are not shared with other households
Limited	Use of improved facilities shared between two or more households
Unimproved	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
Open Defecation	Disposal of human feces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste.



2. **Hygiene**: It is commonly defined as a set of practices performed for the preservation of health and healthy living. Hand washing with soap or ash is the most important element, but it also includes personal cleanliness of the hand, face, hair, body, feet, clothing, and menstrual hygiene for women and girls.

This training mainly focus on hand washing among other elements of hygiene.

According to a study report by Huang DB, Zhou J., in 2007, many diseases and conditions are spread by not washing hands with soap and clean, running water. Keeping hands clean is one of the most important steps we can take to avoid getting sick and spreading germs to others.

Hand washing education in the community:

- Reduces the number of people who get sick with diarrhea by 23-40%
- Reduces diarrheal illness in people with weakened immune systems by 58%
- Reduces respiratory illnesses, like colds, in the general population by 16-21%
- Reduces absenteeism due to gastrointestinal illness in schoolchildren by 29-57%

Huang DB, Zhou J. Effect of intensive hand washing in the prevention of diarrheal illness among patients with AIDS: a randomized controlled study, 2007

HOW: Washing our hands is one of the simplest ways we can protect ourselves and others from illnesses. The most ideal and recommended hand washing practice is washing with running water and soap or locally available soap substitute (ash, 'endod', etc…) for a minimum of twenty seconds to avoid dirt and/or disease causing organisms.

WHEN: there are times which are considered as critical moments of hand washing;

- Before cooking
- Before eating
- Before feeding a child (breast/food)
- After using latrine
- After cleaning child feaces
- After handling wastes of any kind

Now a days, it becomes a primary preventive measure against COVID-19 to wash our hands more frequently than what we usually did. Touching eyes, nose and mouth with unwashed hand increases exposure to the fatal COVID-19.

3. **Water supply** is the provision of water by public utilities, commercial organizations, communities or individuals. Public supply is usually via a system of pipes and pumps. In order to sustain human life satisfactorily, a water supply should be safe, adequate and accessible to all.

Safe water supply means water is free from any form of disease-causing agents. The main criteria are:

- *Biological aspects*: the water supply should be free from disease-causing microbes and parasites.
- *Chemical aspects*: the water supply should be free from dissolved chemicals at the level that would damage health.
- *Radiological aspects:* the water supply should be free from any naturally occurring radioactive substances.

In addition to being safe, the water must also be acceptable to consumers by being odorless, colorless and without objectionable taste.

- Since the rural community of Ethiopia get drinking water from unimproved water sources such as surface waters (river, pond, stream, etc…) and unprotected dug wells and springs, the issue of safe water supply is in question and hence people are exposed to various water born/related diseases.

There are certain activities to address the problem of the biological and chemical aspects described above to improve safety of drinking water at household level through safe handling and treatment and hence reduce/avoid health risks.

The use different low cost and high quality water purification and treatment methods can be applicable in rural households. The following are some options to consider;

- Boiling water
- Different water purification technologies (P&G, Wuha Agar, Bishangari, …)
- Use of water filter technologies (buckets with filtering tools)

Session 2.2: WASH small, doable actions

Session objectives – participants will be able to:

- Understand concepts of small, doable actions
- Develop, be familiarized with and apply small, doable actions for WASH practices

Allocated time: 1 Hr

Training method: Small group work

Group work activities

- Divide participants in to four small groups different than the previous small groups
- Give all groups the following questions to discuss very thoroughly
    - What does small doable actions mean?
    - Discuss in a group and exhaustively list small doable actions separately for sanitation (with a focus on latrine), hygiene (with a focus on hand washing) and water (safe water handling and treatment)
- Allow all group present their discussion points shortly through their representatives

Participants Note

Small, Doable Actions are behaviors that are more likely to be adopted because they are considered feasible by individuals and are effective from a public health perspective when practiced consistently and correctly.

A small doable action is a behavior that, when practiced consistently and correctly, will lead to household and public health improvement. It is considered feasible by the householder, from HIS/HER point of view, considering the current practice, the available resources, and the particular social context. Although the behavior may not be an "ideal practice", a broader number of households will likely adopt it because it is considered 'feasible' within the local context.

There might be a long list of actions identified to address a single behavior and all actions should not be delivered to audiences. Based on certain selection criteria, some key actions should be selected from the list of actions. Actions which have high possibility of implementation, easy to practice and most importantly actions with higher impact to reach the ultimate goal should be selected.

Small, doable actions - sanitation (latrine) but not limited to;

- Construct long lasting, clean and hygienic latrine in the compound
- All family members should exclusively use latrine at all times
- Repair and upgrade existing latrines when necessary
- Dispose of children's feces immediately into the latrine
- Close existing pit when it becomes full and reconstruct a new latrine

Small, doable actions – hygiene (face washing) but not limited to;

- All family members wash their hands with water and soap or soap substitute AFTER handling animal and human feces, even children's feces.
- All family members wash their hands with water and soap or soap substitute BEFORE handling food.
- All family members wash their faces with water whenever they are dirty and use soap when it is available.
- All family members wash their hands for a minimum of 20 seconds
- Avoid touching of eyes, nose and mouth with before washing hands
-

Small, doable actions – water (safe water handling and treatment) but not limited to;

- Use a 20-liter jerry can with a cover to store drinking water. If not possible, use small neck container and cover with best option.
- Attach the cover to the jerry can using a string to keep it off the floor
- Wash water cans and its cover with soap and water every day.
- Separate drinking water from other household water and dedicate the 'best' container to drinking water.
- Treat drinking water in the 20-liter jerry can with water purification technologies (P&G, Water Guard, etc…) or use water filter technologies to keep household water safer.

Session 2.3: Introduction of improved Sanitation products

Session objectives – participants will be able to:

- Understand concepts of small, doable actions
- Develop, be familiarized with and apply small, doable actions for WASH practices

Allocated time: 30 minutes

Training method: Demonstration

Quick reflection questions

- As participants about how many of them are familiarized with improved sanitation products
- What is the importance of introducing new sanitation technologies/products?

Participants Note

Improved sanitation products

Sato products: SATO is a first-of-its-kind line of innovative toilet and sanitation products designed to bring improved sanitation and comfort to rural and peri-urban communities around the world.

SATO toilet pans feature an automatically-closing trap door that blocks odors and insects. This effectively reduces transmission of disease and minimizes odors, making the toilet safer and more pleasant to use. A small amount of water (0.2 to 1 liter) opens the trap door to eliminate waste, which shuts itself tightly after use.

Sato toilet pans are high quality, low cost and safe for users particularly children and elders.

The following are some types of improved sanitation products that have been used in the developing countries to construct improved latrines;

Toilet pan products	
	**Sato pan**
	**Sato Stool**
	**Sato conventional ("zemenay") toilet pan**
	**AIM plastic slab**

<table>
<tr><th colspan="2">INSTALLATIONS</th></tr>
<tr><td>  </td><td>Sato pan on installed on concrete slab</td></tr>
<tr><td> 
  </td><td>Sato pan and Sato Stool installed on existing latrines (upgrading)</td></tr>
<tr><td>  </td><td>Installed AIM plastic slab</td></tr>
</table>

UNIT 3: APPLICATION OF HOUSEHOLD COUNSELING VISIT FOR WASH

Unit Objectives: At the end of the unit, participants will be able to

- Understand and apply counseling skills and negotiation steps to conduct household visit for WASH.
- Be familiarized with USAID TWASH communication tool to conduct effective household counseling

Allocated time: 6 Hrs

Training materials: Note books, Pens, Flipcharts, marker, plasters, sample improved USAID TWASH HEWs flip chart

Session 3.1: Household counseling visit

Session objectives

- To explain what household counseling visit implies
- To describe the counseling skills and steps to follow in the household counseling visit

Allocated time: 1 ½ Hrs

Training method: Brainstorming

Brainstorming questions: Raise the following questions one by one and make detail discussions based on real experiences of participants?

- From your previous knowledge and experience, what is household counseling visit?
- What are the key counseling sills?
- What steps/approach a counselor should follow to conduct household visit.

Participants Note

Household counseling visit is a door-to-door communication intervention with for a specific health or development activity to observe situations/status, identify problem, discuss with target groups, recommend solutions towards positive behavioral outcome.

Household visit mostly involves interpersonal Communication trough face-to-face conversations and activities between frontline workers and audiences (mothers or other family members). It allows frontline workers to personalize messages, demonstrate skills, and provide encouragement.

Counseling doesn't mean just delivering framed messages on hand rather it involves in-depth observation, identification of locally feasible solutions for problems and most importantly negotiation to apply improved practices by the target audience.

Behavioral change through household visit requires repeated contact to the target groups to check status, provide support and appreciate achievements and help them stick to improved behavior.

Communication skill: as it is an interpersonal communication, household visit requires key skills to help practitioners capture the trust of audiences and effectively achieve its objectives.

The following are major skills but not limited to;

▪ Establish good relationship ▪ Ask open-ended questions ▪ Use encouraging prompts ▪ Lean forward and show interest ▪ Listen more talk less	▪ Demonstrate feelings such as empathy, care, and attentiveness ▪ Avoid words that convey judgment ▪ Use appropriate language ▪ Use culturally appropriate gestures

Steps of Household visit: there is a common step during interpersonal communication or counseling visit named **GALIDRAA**, an abbreviation which stands for the major steps;

- **Greeting** - It helps to build good relationship and makes the audience comfortable.

  At this stage, making transect walk in the compound is recommended jointly by the service provider before sitting for counseling to observe sanitation status (the HH has latrine or not, which type, hand washing facilities, cleanliness of the compound, animal and the solid waste, liquid waste management, drinking water handling, etc…). it gives discussion points for

counseling.

- **Ask/Assess** - assessing the situation/status of the HH in terms of practicing the behavior, problems they faced to practice the behavior, etc…
- **Listen** – attentively listen responses for the audience
- **Identify** – identify problems, barriers/difficulties, etc… while the audience explains
- **Discuss** – explaining solutions, show alternatives to solve the problem, describe benefits of recommended behaviors, probe for further discussion, and negotiate actions…
- **Recommend** – when you feel the audience is somewhat convinced, provide recommended doable actions
- **Agree –** make sure that the audience agrees to practice recommended actions and ask the audience to rephrase/repeat what they have agreed to do.
- **Appoint –** ask when to revisit the household and monitor the behavior, provide support, etc…

USAID TWASH household counseling visit

The household counseling visit focuses on behavioral change approach on WASH practices with a focus on sanitation aimed to create demand for sanitation products to construct improved latrine among households in rural and per-urban areas.

The household visit is underway by HEWs and recommended to involve community volunteers such as women development army leaders to ensure frequent household visit and monitoring at village level.

As a direction, the following are key assumptions that should be put in place to achieve the community based demand creation intervention.

- HEWs participate WASH SBCC training and orient community volunteers/women development army leaders as appropriate.
- HEWs provided with communication materials (USAID TWASH HEWs flipchart) to conduct household visit on WASH demand creation.
- HEWs should conduct target households jointly with mason sales agents, local manufacturers, etc… if available in the area to ensure integrated demand creation and enhance link households to product supply when the demand arises.
- HEWs should visit households at least three times to address all sanitation, hygiene and water components of the flip chart and monitor behavior status and negotiate the purchase of sanitation products and proper installation and utilization by the household members.

Session 3.2: Introduction of USAID TWASH communication tool

Session objectives – participants will be able to:

- Understand the communication tool and be familiarized with the messages, illustrations, etc... in the flip chart

Allocated time: 1 Hr

Training method: Orientation of the tool

Activities

- Distribute the flipchart to all participants
- Make sure that all participants receive a flipchart with complete pages and change if there are incomplete or damaged flipcharts
- Give a notice to participants that they should attentively follow the orientation since the success or failure of the household visit is depends on how HEWs understand the messages and illustration representing/explaining the messages.
- Go through the flipchart page by page, reading texts and explaining illustrations/drawings associated with each message.
- Ask them if there have something not clear or concern before proceeding to the other page or thematic point.
- Show participants on how to handle the flip chart during counseling/discussion with the audience.
    - Texts and smaller drawing towards HEW and the same bigger drawing explaining the message faces the audience so that the counselor/HEW can sit straight up and see each other comfortably.

Session 3.3: Practicing household counseling visit

Session objectives – participants will be able to:

- Cover the three components of TWAS flip chart and internalize the tool
- Improve the skill and steps of household counseling visit
- Build confidence to negotiate and convince target households to create demand for WASH.

Allocated time: 3 Hrs

Training method: pair-to-pair practical counseling

Activities

- Inform all participants to sit in a pair
- Inform them to take enough time and conduct the practice very seriously
- Assign one of them as counselor and the other as audience (may be a mother)
- All participants practice counseling visit addressing only sanitation part as it appears on the flipchart and DO NOT CONTINUE THE NEXT UNIT (i.e. hygiene and water)
- Counselors should follow GALIDRAA approach and try to practice the proper counseling skills
- When all participants finish the practice, call them to the larger group and choose two participants randomly to the stage to show practicing to all participants
- After finishing their show, give them a clap, thank and appreciate them and invite participants to give them a comment
- Training facilitators will give them a summary of comments to the pair to improve their skills
- Next, the second part of practice, Hygiene (hand washing) continues and all participants in the previous pair change a role and the one who acted as a counselor will become an audience and the previous audience will act as a counselor.
- Similarly, call the pair to the larger group when all properly finishes counseling practices
- Select other pair to the stage and show their practice
- Thank and appreciate their work
- Allow participants give them a comment

- Training facilitators will give them a summary of comments to the pair to improve their skills
- The third and the final counseling on safe water handling continues but with new pair of participants
- One of them as counselor and the other as audience
- When all participants finish the practice, call them to the larger group and choose two participants randomly to the stage to show practicing to all participants
- After finishing their show, give them a clap, thank and appreciate them and invite participants to give them a comment
- Training facilitators will give them a summary of comments to the pair to improve their skills
- Finally, facilitators will invite any volunteer pairs to show the best of counseling based on the lessons from all the previous practices
- Give them a reward if they perform counseling visit properly and appreciate for their volunteerism

NB: since the ultimate objective of the counseling visit practice is to build their skill and confidence, it should continue until time allows them to do so. Surely, participants will enjoy it and get it interesting.

Finally, training facilitators ask participants on how they get the practice and if they have any question about the practice and make discussions accordingly for the better improvement of household counseling visits.

UNIT 4: MONITORING AND EVALUATION

Unit Objectives: At the end of the unit, participants will be able to

- Understand major monitoring and evaluation activities of USAID TWASH project
- Familiarized with data collection and reporting formats

Allocated time: 2 Hrs

Training materials: Note books, Pens, Flipcharts, marker, plasters, sample data collection and reporting formats

Session 4.1: Monitoring and evaluation activities

Session objectives

- To explain what are monitoring and evaluation means
- To understand and be familiarized with the tools to monitor the community mobilization and demand creation activities on TWASH project

Allocated time: 1 Hr

Training method: Brainstorming

Brainstorming questions: Raise the following questions one by one and make discussions based on real experiences of participants?

- What do you understand by monitoring and evaluation?
- What activities can be considered as a monitoring tool from your experience
- What are the challenges of monitoring community mobilization activities by HEWs at community level?
- What do you suggest to solve monitoring problems?

Participants Note

Monitoring is the collection and analysis of information about a project or program, undertaken while the project/program is ongoing. Monitoring involves regular collection of data to review performance focusing mainly on outputs indicators.

Evaluation is the periodic, retrospective assessment of an organization, project or program that might be conducted internally or by external independent evaluators. Evaluation is conducted periodically in the middle and after the completion of the implementation mainly focuses on outcomes and impacts.

USAID TWASH project put in place some activities to monitor the community mobilization and demand creation activity implemented jointly with government health system since the evaluation on the effectiveness of HEW platform in particular and the demand creation intervention in general will be done by other partner organization.

- **Supportive supervision**: it is one of the major monitoring activity to be done by project staffs, woreda and regional health team at kebele and woreda level to observe the household counseling visit and demand creation activity by HEWs, quality of data and documentation and reporting will also be supervised.

  Woreda health office focal persons, who took ToT and facilitate WASH SBCC training to HEWs are the leading actors to provide close and frequent support to HEWs on the spot.
- **Review meeting:** periodic meeting (may be quarterly) will be conducted at woreda level participating HEWs and kebele WASH committee members mostly kebele administrators to review the performances of health posts/kebeles regarding community mobilization, demand creation for WASH products, integration with suppliers, etc…, to share experiences and discuss challenges and find solutions.
- **Reporting**: HEWs collect data of household counseling visit at the health post properly based on the standard form, compile monthly data, prepare monthly report and send to cluster health center or woreda health office, then the woreda focal person compile the monthly report and send to regional project staff regularly. The project staff enter the data to DHIS2 timely so that all authorized project staff observes performances per woreda to proceed next steps.

Session 4.2: Introduction of Data collection and reporting formats

Session objectives

- To understand the appropriate data collection and reporting tools and improve the quality of data, proper documentation and reporting

Allocated time: 30 minutes

Training method: Orientation

Activities

- Distribute all the necessary data collection tools and reporting formats to all participants
- Make sure that all participants have all the tools for both the orientation as well as to take sufficient copy for future utilization
- Start from start the orientation from the household counseling visit data collection form and clearly read each content until all participants agree that they understand all aspects.
- Continue explaining the indicators/contents of monthly data compiling and reporting form and explain again the report flow as mentioned in the above session.
- Finally, ask them if they have any concern or question to discuss.

Action planning

Allocated time: 30 minutes

Activities

- Distribute a planning template to all participants and make a group based on their kebele/cluster to discuss and prepare action plans they are going to execute after the training
- Ask cluster health center team to support participants under their cluster
- Collect kebele plans and document for future reference

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ANNEXES

Annex -1: Data collection and reporting formats

USAID-TRANSFORM WASH ETHIOPIA PROGRAM

Community Mobilization (Household Visit) activity Register

Registered by HEWs & placed at HP

Kebele:_____

Date of visit	Village	Number of Households reached by sex		
		M	F	T

USAID-TRANSFORM WASH ETHIOPIA PROGRAM

MONTHLY KEBELE PROGRESS REPORT _____ (date/month/year)

Prepared by HEWs & Summarized by Woreda Focals

S/No.	Activity		Quantity
1	Number of households reached by community mobilization to improve household (HH) latrines, hand washing facilities and use household water treatment and safe storage		
2	Number of households constructed improved latrines using improved sanitation products	Sato pans	
		Sato stool	
		Plastic slabs	
		Concrete slabs	
3	Number of households constructed basic/improved latrine with locally available materials and improved products		
4	Number of households placed hand washing facility at the latrine		
5	Number of households used water treatment technologies at HH level	P&G	
		Water guard	
		Other (specify)	

Annex-2: Training participants planning template

Kebele: _____

Activities	Unit of measurement	Quantity of unit	Time table	Responsible person	Support required

Prepared by

Name: _____

Responsibility: _____

Signature: _____

Date: _____


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