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Course unit : **FINAL EXAMINATION**

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**Instructions- attempt all the questions**

1) What is Sanitation and Hygiene?

2) Why are water, sanitation, and hygiene important?

3) What is open defecation?

4) What is Sanitation Marketing?

5) What are some of the biggest challenges you face in teaching hygiene and sanitation?

7) What are the steps for planning and implementing a successful WASH behavior change campaign?

8) What are the challenges faced by WASH Projects in Africa

9) You have visited one of the schools in your locality. What part of its surroundings can you see that satisfy the criteria for disease prevention? List the parts of the building and its surroundings, and state why they are important.

10) You have asked the local county government to provide a license for your new hotel in town. The *inspector* asks you to assist him to describe the basic hygiene for your business before licensing. Kindly describe.

11) You have to make a plan of action for the promotion of WASH in your town. Briefly describe the activities that need to be included in your plan.

**Answers to question one**

Sanitation is the effective use of tools and actions that keep our environment healthy. These include latrines or toilets to manage waste, food preparation, washing stations, effective drainage and other such mechanisms.

Hygiene is a set of personal practices that contribute to good health. It includes things like hand-washing, bathing and cutting hair/nails. Hand-washing is the single most important activity we can all do to encourage the stop of disease.

**Answers to question two.**

Adequate drinking water, sanitation, and hygiene are all essential ingredients to ensure human health. The same is true for proper wastewater management, which is a basic prerequisite for environmental health. Improving upon these services will bring economic gains while also helping to build resilience given increasing climate variability.

Many developing countries are already today struggling to cope with chronic water shortages and the inadequacies of their existing water infrastructure. They are also facing unprecedented population growth, rapid urbanization, and increased economic activity. Basic needs remain unmet, and the human right to water and sanitation remains unrealized for billions of people worldwide. Against this background, global water security has risen on the international agenda. In fact, in 2012, a US Intelligence Community Assessment identified water-related problems in developing countries, such as increased risk of disease from unsafe drinking water and poor sanitation, as a threat to American interests. Just last year, the World Economic Forum identified water crises as the global systemic risk of third highest concern. Policies, institutions and infrastructure to improve drinking water sanitation, hygiene and wastewater management must be put in place today. Such actions will also build resilience to cope with the future impacts of climate change.

The world’s drinking water situation is improving. However, there is still cause for concern. In 2012, it was reported that the international community had reached the Millennium Development Goal (MDG) target, to halve the proportion of people lacking access to safe drinking water, three years before the 2015 deadline. While this is a welcome achievement, there is an important caveat. The proxy indicator used to measure progress towards this target is “access to an ‘improved’ drinking water source.” This indicator has limited meaning, since it does not represent a reliable measure of drinking water safety. In fact, a recent study commissioned by the World Health Organization (WHO) and UNICEF estimates that at minimum [1.8 billion people](http://www.ncbi.nlm.nih.gov/pubmed/24811893) around the globe use fecal-contaminated drinking water. This is more than twice the official figure from the [WHO/UNICEF Joint Monitoring Programme](http://www.wssinfo.org/fileadmin/user_upload/resources/JMP_report_2014_webEng.pdf) of 748 million lacking access to an improved drinking water source.

The global sanitation problem requires urgent attention. The MDG sanitation target, to halve the proportion of people lacking access to improved sanitation by 2015, is seriously off-track. Today, [2.5 billion people](http://http/www.wssinfo.org/fileadmin/user_upload/resources/JMP_report_2014_webEng.pdf) still lack access to basic sanitation. In many parts of sub-Saharan Africa, less than half of the population uses a toilet fit for human beings. One billion people do not use a toilet at all. In South-East Asia almost 40% of the population defecates in the open. In cases where toilets exist, it is important that they hygienically separate human excreta from human contact. But this step by itself is not sufficient to protect health. There are other key factors. For example, excreta are often captured in unlined latrine pits from where excreta freely leach into the ground water. Also, when latrines are emptied, the fecal sludge is frequently dumped into surrounding water bodies. Both features cause major negative health impacts on communities and the environment at large. Approximately [ninety percent](http://www.unep.org/pdf/SickWater_screen.pdf) of wastewater in developing countries is discharged directly into rivers, lakes, and seas. To realize sanitation’s health benefits, the full sanitation chain, including wastewater management, must be considered. Currently, there is no global monitoring to track progress in wastewater management.

Hygiene poses another global health challenge. However, thus far, hygiene has not been prioritized on the international development agenda, despite the fact that hand washing with soap could save [300,000 people](http://onlinelibrary.wiley.com/doi/10.1111/tmi.12329/abstract) annually. Safe drinking water and sanitation in the absence of hygienic behavior will not prevent feco-oral infections. Many households, for example, have no other option than to store water before use. Even if the original source of the water is safe, the water is frequently contaminated by unhygienic conditions and practices in the home. Across the developing world, hand washing and menstrual hygiene facilities along with toilets are often not available in schools, thereby deterring attendance, particularly for adolescent girls. A recent study by Freeman et al., published in the Journal of Epidemiology and Infection, estimates that inadequate hand hygiene practices affects 80% of the global population. Even though hygiene’s health benefits are well documented, there is no global development target or monitoring framework to track the uptake of improved hygiene practices.

There are tremendous economic gains that can be realized with improved drinking water, sanitation and hygiene. The WHO estimates that for every US dollar invested in improved drinking water and sanitation there is an economic return of four US dollars resulting from health and productivity gains. It is estimated that the benefits of achieving universal access to improved sanitation would outweigh costs at least five-fold, and for improved drinking water at least two-fold, with a minimum combined economic benefit of over [220 billion US Dollars](http://www.who.int/water_sanitation_health/publications/2012/global_costs/en/) annually.

The WHO estimates the total global economic loss per annum resulting from poor water supply and sanitation at 260 billion US Dollars. Per World Bank studies, countries in sub-Saharan Africa, as well as Bangladesh and India, on average lose more than 4% and 6% of their Gross Domestic Product (GDP), respectively, due to inadequate sanitation. The evidence is clear: poor sanitation and inadequate water supply play a role in keeping countries poor.

The burden of water-related diseases curtails efforts to improve public health in the developing world. Diarrhea – most often related to unsafe drinking water, poor sanitation and inadequate hygiene – is one of the [leading causes of death](http://www.who.int/maternal_child_adolescent/topics/child/mortality/en/) among children under the age of five. It kills more children than Malaria or HIV/AIDS. The WHO estimates that exposure to inadequate drinking water, sanitation and hand hygiene was responsible for [58% of deaths from diarrhea](http://onlinelibrary.wiley.com/doi/10.1111/tmi.12329/abstract), adding up to 840,000 deaths in low and middle-income countries, in 2012. This translates into 1.5% of the global disease burden, even 5.5% for children under five. There is growing evidence that repeated exposure to unsafe drinking water; poor sanitation and inadequate hygiene have a significant impact on stunting. This comes about as a result of intestinal worm infections, diarrheal diseases and environmental enteropathy which lead to a poor nutritional status. Cholera is also transmitted via contaminated water. The cholera epidemic in Haiti has killed more than [8,500 people](http://www.worldbank.org/content/dam/Worldbank/document/book_haiti_6oct_print.pdf) since 2010.

Taking all of the above into account, water, sanitation (including wastewater) and hygiene must be given greater priority in the health community, which presently puts too much focus on curative approaches. In their paper “Hygiene, Sanitation and Water: Forgotten Foundations of Health,” published in 2010, Bartram and Cairn cross conclude that the “active involvement of health professionals in hygiene, sanitation and water supply is crucial to accelerating and consolidating progress for health”. To translate this recommendation into practice, the WHO along with other key actors in the health sector, should streamline drinking water, sanitation and hygiene as preventative medicine. Through a push for more funding allocation and better policy design, tangible health benefits could be realized. And, most importantly, improvements will be made in the lives of billions of people.

**Answers to question three**

**Open defecation refers to the practice whereby people go out in fields, bushes, forests, open bodies of water, or other open spaces rather than using the toilet to defecate.** Open defecation exposes women to the danger of physical attacks and encounters such as snake bites.  Poor sanitation also cripples national development: workers produce less, live shorter lives, save and invest less, and are less able to send their children to school.

The following actions should be taken into consideration in order to overcome the high risks associated with open defecation.

Establishment of WASH in Health Centers with the Health ministry to map WASH compliance in health facilities in the most deprived areas of the community and making recommendations to address non-compliance.

Institution Strengthening; The WASH section should works with state governments to identify where institutions need capacity-building. For example, it is helping reform State Water and Sanitation Missions to become responsive when they are in mission mode through training   
  
Efforts should be put to address mechanisms to ensure that supply chains can be activated as demand for toilets within communities’ increases. It also works to identify toilet technologies suited to different climatic and geographic zones and is supporting efforts to improve the skills of masons to build better quality toilets.

Communication support; In terms of communication campaigns, the WASH should provide technical support to the Government to develop the national Sanitation and Hygiene, Advocacy and Communication Strategy (SHACS).

This strategy should be contextualized by all states that have a UNICEF presence and create implementation plans to be developed in all states ready for rollout and to plan its programme of strategies including outreach to create demand for toilets.

Advocacy support ; Creation and development of campaign to address the population of young people who have a toilet at home, in order to sensitize them to the plight of those who do not have toilets, and create a youth social movement to stand up and advocate for the need for everyone to have a toilet.

**Answers to question four**

Sanitation marketing is an emerging field that applies social and commercial marketing approaches to scale up the supply and demand for improved sanitation facilities. While formative research is the foundation of any sanitation marketing program, essential to understanding what products the target population desires and what price they’re willing to pay for them, components such as the marketing mix, communications campaign, and implementation are also critical to the design and implementation of effective program.

**Answers to question five**

The poor bear the brunt of the burden of inadequate water, sanitation and hygiene (WASH) and the link between WASH and health is undeniable. An estimated 842,000 people die each year due to diarrheal disease that could have been prevented by WASH interventions; 361,000 are children under the age of five years old. Health impacts go beyond diarrheal disease: half of global malnutrition and one quarter of stunting in children are due to waterborne diseases like chronic diarrhea and intestinal worms, and diarrhea is responsible for 17% of global disability (PMNC

Therefore the biggest challenges faced in teaching sanitation and hygiene is as discussed below.

The Scale of the Need – Water, Sanitation and Hygiene to Half the World’s Population

The sheer scale of the issue is a challenge in itself. It will be no small feat for half the world’s population to gain sustained access to safe water, basic sanitation and good hygiene practices (and to do so in 15 years).

The scale of the need will increase, particularly as populations grow, available freshwater is used and contaminated at increasing rates, and the climate changes.

To date, solutions have tended toward infrastructure, implemented by a few organizations. This approach alone has not been successful in reaching everyone, and there aren’t enough local people with the required knowledge and skills to deliver universal, safely-managed WASH by 2030. The current formal systems for training, such as university and vocational programs, are important but will not produce enough WASH practitioners to meet the demand by 2030.

The Variability of the Problem and Therefore the Solutions

Water and sanitation issues are highly variable from location to location, from season to season and community to community; and people who lack WASH are often living in the most challenging geography and climate.

One-size-fits-all solutions have not worked and cannot be the strategy to scale-up reach. For example, water quality, rainfall and hydrology are site-specific and have important implications on technology selection and siting. Incorrect choices can exacerbate an already poor condition (e.g. digging a simple pit latrine that further contaminates groundwater).

Sustaining Water, Sanitation and Hygiene Services for the Long-Term

Focus over the past decades has been on water and sanitation infrastructure. This approach is costly in up-front capital, operations and ongoing maintenance. It requires a highly educated, skilled workforce and often doesn’t reach the most marginalized communities, nor address specific contextual challenges.

Sustained operation and maintenance of this infrastructure has been challenging. For example, 30% of water hand-pumps in Africa are not working (RWSN, 2009). The failure of community water and sanitation systems is often a failure of operation and maintenance, rather than a failure of the basic technology.

Reaching People Most in Need

Overwhelmingly, it is the poorest that lack better water and sanitation. Virtually the entire poorest 25% of the world’s population does not have piped water and the inequality in coverage between rich and poor is even greater for sanitation than for water (JMP, 2014).

Integrating Water, Sanitation and Hygiene (WASH) for Health

Many of the water and sanitation approaches employed to date in international development focus on providing either improved water or improved sanitation or improved hygiene. Global monitoring programs, such as the Joint Monitoring Program of UNICEF and the WHO count access to each of the three separately. Alternatively, organizations have the vision to implement all three and struggle to do so when faced with the realities on the ground.

**Answers to seven**

In the water, sanitation and hygiene (WASH) sector, it has become evident that providing access to services is not enough to change behavior. Handwashing with soap (HWWS) is one of the most cost effective interventions to end preventable child deaths (Cairncross and Valdmanis, 2006) and can reduce the risk of enteric and respiratory infections (Ejemot et al., 2008, Rabie and Curtis, 2006). However, a systematic review found that this behavior is practiced by fewer than one in five people in the countries where it’s most needed (Freeman et al., 2014).

Traditional approaches to health promotion have relied on educational messages, particularly around the health risks associated with germs. It is now increasingly acknowledged that educating people on health risks won’t necessarily lead to sustained behavior change (Kelly and Barker, 2016). Our understanding of the factors that influence WASH behaviors and the adoption of improved practices is still developing. Researchers and practitioners have begun to explore how a range of factors such as emotions, habits, and settings may drive behavior. Successful WASH behavior change interventions are often underpinned by theories or frameworks from a range of disciplinary backgrounds, including health psychology (Mosler, 2012, Michie et al., 2011), evolutionary and environmental psychology (Aunger and Curtis, 2016) and behavioural economics (Datta and Mullainathan, 2014).

Since 2010, the Sanitation and Hygiene Applied Research for Equity (SHARE) Consortium has prioritized behaviour change in WASH interventions, championing the importance of identifying novel and creative approaches to changing behaviors across many countries (see Fig. 1). This policy brief documents SHARE’s contribution to understanding behavior change and associated health impacts. The structure will follow a practical five-step process for designing and evaluating interventions - Assess Build, Create, Deliver and Evaluate - as outlined in the Behaviour Centred Design (BCD) approach (Aunger and Curtis, 2016).

The first step is Assessment, aims to understand what is already known about target behavior. Researchers or programme designers begin by compiling evidence about the behavior they want to change, the target audience, the context for the intervention and its parameters.

Step two Build Knowledge gaps identified about the target behavior through the Assess stage can be addressed in the Build stage. The Build stage uses formative research, which consists of field-based data collection, to help answer remaining questions and understand the contextually specific drivers of existing and/or target behaviors. Without some immersion in the study setting and with the target population, understanding the context and drivers of current behavioral patterns can be limited or even misguided. Formative research prioritizes methods that engage with the target behavior as it exists in a particular setting, rather than methods that focus solely on what people say about their behavior. The examples that follow highlight how these initial stages are essential for the development of a well-designed intervention.

Step three Creation, The Create stage involves the design of an innovative campaign and associated materials. The BCD approach recommends that the intervention should be surprising and disruptive in order to maximize the effect on the target behavior – otherwise, the old behaviors will simply persist. This stage is an iterative process which is often carried out by a creative team working closely with researchers or programmers.

Step Four: Deliver the deliver stage refers to the implementation of the intervention. There are multiple factors that need to be considered during this phase. These include the exposure to the campaign, length of intervention, coverage, intensity, acceptability, fidelity, interferences, evaluability and sustainability (Aunger and Curtis, 2016). Interventions can be delivered through many different channels, from face-to-face contact to mass media campaigns.

Step Five: Evaluate Evaluating an intervention can provide insights in a number of ways. For example, it may indicate to funders whether they should continue an existing programme, it can provide researchers and implementers with new information on changing or redesigning a programme, or might inform policymakers whether they should replicate a similar programme elsewhere (Aunger and Curtis, 2016). Related knowledge and behavior are prominent (Rabbi and Dey, 2013). To date, all SHARE-supported studies described above have found positive effects on behavior change at different levels, from the household to the community. While each campaign differed, they were all underpinned by a theoretical approach and an engaging campaign to encourage the target population to change their behavior. However, assessing the process of implementation is also important, and process evaluations have been conducted across the SHARE studies to measure different aspects, from fidelity to coverage (Aunger and Curtis, 2016). Results from process and outcome evaluations of the Safe Start, San-Dem, Mikono Safi and Banja la Ukhondo (PACTR201703002084166) behaviour change interventions will be available in late 2018 or early 2019.

**Answers to question eight**

Governments in developing countries are often constrained by poor capacity in technical and financial management as well as ‘soft skills’ including facilitation, behavior change and gender analysis. There is often a lack of engagement with communities in decision–making and weak coordination between stakeholders to ensure that WASH service delivery targets the poor and that programs are based on current evidence of what works on the ground. Development partners often retain an infrastructure focus with limited attention to health, hygiene behavior change and community engagement or accountability.

Lack of strong messages several interviewees commented that latrines have an ‘image problem’. On that basis, a clear targeted message is needed for effective promotion of sanitation and hygiene. Despite the importance of promoting behavior change, there was broad recognition of the difficulties it can present in practice. For example, encouraging adults to adopt hygiene practices with which they are unfamiliar,

Lack of access to credit This cost barrier may, however, be part of the broader issue of people living away from the town and having poor access to its markets (enclavement), which is also a factor impeding purchase of materials for improved hygiene practices – be it bags of cement with which to construct latrine slabs, or vessels for water or soap. Many of the rural poor in Africa are to be found in areas ‘weakly integrated into markets’ so that the location of poverty matters (Farrington and Gill 2002)

Methods/technology ill-suited to context several actors echoed the recommendations of international commentators on the need to understand the way people in different settings do things, e.g. in different regions and under different socio-economic conditions. In a community context, Water Aid reported that its policy is to carry out Behavior, Attitudes and Practices studies before all new projects, through its local partners (who are the implementers of all Water Aid-supported initiatives). One NGO leader pointed to the importance of training community facilitators drawn from the communities with which the given sanitation/hygiene project is intending to work. Another said that messages could be conveyed using drama, with trained ‘animators’.

Lack of service providers the impression is that in past years NGOs whether international or national, have provided much of the innovation relating to sanitation and hygiene projects, in the absence of any dynamism on the part of public institutions in past years. They have been piloting new approaches, in both urban and rural contexts. (such as Water Aid, and local Malagasy associations) have signaled how local communities may be successfully engaged in sanitation and hygiene activities, e.g. via the entry point of water supply and through programmes educating children

Low capacity to absorb funds Donors’ reticence to fund sanitation and hygiene programmes in developing countries may reflect the country’s low capacity to absorb funds. The planning system for development is slow – from communal level, via district and regional levels, to central government. Decentralization of functions to regions and communes (equivalent to municipalities) is only really beginning and, despite the objectives of decentralization and devolution highlighted, major gaps in local government capacity are reported.

Lack of human and technical capacity, the lack of capacity in terms of human resources. The range of skills, including ‘softer’ people-based skills, required for the sanitation and hygiene sector are not sufficiently represented, with engineers outweighing other disciplines. The lack of teaching manuals on sanitation and hygiene for school teacher’s means that sanitation and hygiene are still little or inadequately taught at (primary) schools.

Lack of coordination , there has been very ‘scattered responsibilities’ which had constituted ‘a key stumbling block, hindering strategic solutions and problem-solving’ the Ministry of Decentralization and Spatial Planning (aménagement du territoire) is responsible for sanitation works in medium/large towns, called ‘collective sanitation’ there is uncertainty over the scope of what is meant by ‘collective’, since apparently the ministry interprets its role as applying to large-scale public works, and not therefore sanitation at a community level

Tensions between mindsets the lack of understanding between those who work in the public and private sectors including some skepticism about the role of private providers which are profit-making.

Lack of information, there is a lack of up-to-date information on sanitation and hygiene needs. On the basis of such data as is available, the gap in sanitation coverage is clearly substantial. The empirical studies available point to great needs in terms of improvement of sanitary/hygiene conditions in large sectors of the population

**Answers to question nine**

**Provision of latrines**

The provision of latrines is also extremely important. In addition, separate latrines for girls and boys need to be provided to encourage girls to continue their education. The usual type of latrine at schools is a communal dry pit latrine equipped with a vent.

Pit latrines are the simplest form of dry latrine. They consist of a pit dug in the ground and a cover slab or floor above the hole. Pit latrines must have a cleanable cover slab in order to be considered as improved sanitation systems. The excreta (both faces and urine) drop through the hole to enter the dry pit. Pit latrines should be constructed on a slight mound so they are higher than the surrounding ground and water at the surface will flow away from the hole.

They should also have a lid that can be placed over the hole to reduce problems with flies and odours. They may have a squat pan or a raised footrest to make using the latrine more convenient. The pit is often lined but the bottom remains open, allowing the liquid to drain into the soil and leaving the solids behind.

School latrines should meet the following requirements:

* They must be located away from the classroom in order to avoid interfering with the students’ learning process. They must be reasonably accessible.
* They must be well-maintained and agreeable to use. They should provide privacy and security.
* The dimensions of the latrine must be adequate to accommodate the storage needs for three to five years. You will learn more about this in the waste management sessions later in this Module.
* There must be handwashing facilities near the latrine ,Handwashing with soap after using the latrine and before lunch must be encouraged.
* There should be separate latrines for male and female students. Latrines for teachers must be separated as well.
* There must be a bucket with water and a jug inside female latrines. This is essential for cleaning the bottom for female students during menstruation.
* In primary and secondary schools, there should be one latrine for every 30 students and one urinal for every 50 male students.
* Latrines should be hygienic to use and easy to clean. Students themselves should participate in daily cleaning of the latrine. The hygiene/health club should take the leading role in the maintenance of latrine cleanliness.

**Answers to question ten**

**Premises,** the premises of my hotel include Buliding and rooms involved in food preparation and storage. They are kept clean and in good condition and the design provide suitable working and maintaining hygienic practices, prevent build –up of dirt and mould which provides suitable conditions for handling and storage of food.

The premises has adequate hand washing facilities and toilets for staff, separated from food preparation areas with soap, hot and cold running water and hygienic drying.

The ventilation in the kitchens and toilets is well designed to control condensation, temperatures, odour, humidity or air borne particles and prevent contamination in the food preparation areas. The premises also has well facility for staff to change clothes, where needed and storage of cleaning chemicals, disinfectants and other chemicals to prevent contamination of food.

**Design of food preparation area,**

The design of rooms allows good hygiene practices and processes, including protection from contamination during food preparation processes and prevention of food contamination following food safety legislation requirements for the food preparation

Floor; floors are constructed of material that is easy to clean and safe to walk on and maintained in sound condition.

**Ceiling:** ceilings and overhead fittings (lighting, piping, and cabling) should be designed to prevent accumulation of dirt, mould, condensation and risk of contamination.

Walls are made of durable impervious materials that are washable, non-toxic, easy to clean and maintain

Windows; must be constructed to prevent dirt accumulation and have insect screens where necessary.

Doors easy to clean and constructed of non-absorbent material, surfaces are made of smooth, washable, non-toxic, corrosion resistant material, and maintained in a good condition, washing facilities **for equipment and food:** these must be adequate for washing food and utensils and have hot and cold water.

All equipment’s that comes into contact with food must be made of appropriate materials, kept in good condition, cleaned effectively, and fitted appropriately to allow cleaning around it

**Water supply**

* Water that is used as a food ingredient or comes into contact with food for cleaning, heating, steaming, cooling is of drinking quality
* Ice that may come into contact with food or drink, must be made with potable water and must be produced, handled and stored hygienically
* Steam that comes into contact with food must not contain any contaminants that could affect food safety
* Water that is used for non-food purposes, such as fire control, heating, refrigeration, must be kept in systems so that it cannot contaminate food, drink, surfaces or equipment

Personal hygiene

Staff working in food handling areas is ensured to keep good personal hygiene and be aware of practices and factors that can cause contamination of food and cross contamination. Equipped with all the legal requirement for staff training, such as Food Safety Act

Personal hygiene factors to prevent the contamination of food with bacteria, viruses or parasites passed on by staff include:

* Wearing suitable hygienic clothing, including gloves, hair covering, footwear, where necessary
* Prevent contamination of ready-to-eat foods from cutting boards, utensils, clothing, raw meat or eggs
* Not touching raedy –to-eat foods with bare hands.
* Do not work in a food handling area if ill with diarrhoea, vomiting, infectious disease or have open wounds or skin infections.

Food

All raw storage processing and distribution systems must protect food from contamination that makes it harmful to health or make it become un fit to be eaten. This includes pest control and having processes and procedures that limit bacterial levels to within specified criteria.

**Answers to question 11**

Hygiene Promotion is a planned approach to preventing diarrhoeal diseases through the widespread adoption of safe hygiene practices. It begins with, and is built on what local people know, do and want.

There are six Steps to Hygiene Promotion and in designing a hygiene promotion programme. In step one action with the target communities and the team is initiated. In step two a detailed work-plan for the formative research is made. In step three the formative research is carried out. Step four is to analyze and report on your results. In steps five and six the results are fed back and discussed with key stakeholders and used to make the hygiene promotion plan as discussed below.

INITIATE ACTION Define the target area. Find out what you can about it (maps, population, administration, health services, (etc). Make an outline plan, arrange for funding if you are planning a sanitation/ hygiene programme you should set aside funds for the formative research separate from the main programme.

Many donors are keen to fund well thought out hygiene initiatives at present. Set up the team. Borrow or employ staff, include women and men who live in or come from the target area. You might need 4-5 fieldworkers and a team leader. Project managers, staff and partners can all participate. If you don’t have experiences with research ask a local university or an agency if they can provide advice.

Hold a planning workshop. Discuss what you already know about hygiene in your target zone with the whole team. Share this manual; decide how to adapt the approach to your circumstances. Health workers often think that they already know all about hygiene practices, but don’t jump to conclusions at this stage. Remember, the aim is to listen to, and learn from the targeted groups, not to design your programme in your office. Choose a number of sites that are representative of your target area and make a detailed work plan together. Contact the communities: where you plan to start work, meet with leaders, administrators, women’s groups, use local media to let people know what is happening. Propose the setting up of a community liaison committee to advise you and to inform local people. Build a network: Inform any other organizations working in the area, invite them to join the programme. They may be reluctant at first, but when they see the results they will probably want to join in.

. MAKE A DETAILED FORMATIVE RESEARCH PLAN The objective of step two is to make a detailed research plan like the one shown on the previous page. It includes the four key questions of page 4 and some others. This table is at the heart of formative research for hygiene promotion. It sets out the questions and identifies suitable methods for answering them. To produce your own version, you need to decide on your research questions, and then find methods which are suited to answering them. . You may know other methods you can use to answer your questions reliably. Make a list of questions you want to answer.

This is best carried out as a team exercise. Together cut the list down to only those that are really important for the hygiene promotion. You will probably need to answer all the key questions in the facing table and you may have others. But do not make the list too long or your formative research will become unmanageable. Choose methods to answer each question. When you have your key questions, choose a suitable method for answering each question. Questionnaires may be a good way of finding out about channels of communication employed by the population, for example, but they cannot tell you about the frequency of risk practices.

Your own plan may differ in a number of ways; however, the principles remain the same. Putting it all together. With the research activities listed out, you can now work out the sample sizes. In some cases you can answer several questions in one go. For example, you could ask family members about their radio and TV listening and market-going habits after the morning structured observations. Make a detailed research plan and assign responsibility to team members to carry it out. Training the team. The formative research team will learn much of what they need to know by participating fully in the development of the research. Some formal training will be needed, especially in practicing observing, interviewing and running focus groups. Hygiene Evaluation Procedures (Almedom) has an excellent chapter on training.

CARRY OUT YOUR FORMATIVE RESEARCH Identify risk practices, select practices for intervention. You can work out which practices are posing a problem in your area if you start from the idea that most diarrhoea pathogens come from stools. Any practices that allow faecal material into the child’s environment, especially stools on the ground and poor hand-washing after stool contact are likely to be a priority for action. The risk practices that occur most frequently are a priority for intervention. Behaviour trials allow you to work with target communities to choose suitable replacement practices.

Define message positioning., it means finding out from your primary target audience what they like about the target practices. This can be done by interviewing people who already use the safe practices, and in focus groups and interviews after people have tried out the practices for a few weeks. Communication strategies are then built around these positive values. For example: ‘hand-washing with soap makes your hands smell good.’ Define the target audiences. These are the groups you want to contact. Primary target audiences are those who carry out risk practices (for example, mothers, school children). Secondary target audiences are the immediate society of the primary audience who influence them (eg fathers, school children, mothers-in-law). There is a third target audience which is very important: opinion leaders such as religious, political, traditional leaders and elders. They can have a major influence on the success of your programme, as can partner and collaborating agencies.

ANALYSE RESULTS, REPORT AND FEEDBACK Summaries the data that you have gathered in tables. Go back to your preliminary set of questions and try to answer them from your data. Then write a short, attractive report describing:

* Your objectives
* The methods that you used
* The results that you got
* Your interpretation of the results
* Your recommendations for hygiene promotion You can get a local artist to do some simple illustrations and give it an attractive cover. If you use only black and white text and illustrations the report can be photocopied easily. Many of your readers will be administrators who have too little time to read, so make sure that your report is short and clear and that it stands out! Distribute the report widely. Ensure that all potential partners have copies. Translate the report into local languages and give plenty of copies to the participating communities. It is worth making several hundred copies as this is an important part of the consultation process. Hold public consultations and workshops with partners

MAKE THE COMMUNICATION PLAN Involve people from the community and partners who had good ideas during the consultation process. Get together for several days to work on the full-scale plan for the hygiene promotion programme. Make a plan with the following elements:

* Behaviour change objectives: for example ‘Hand-washing with soap after cleaning a child’s bottom will go from 5% of occasions to 35% in two years’.
* Target practices: the key hygiene practices that replace the risk practices
* Target audiences: age, sex, number in each group
* Positioning: Motivation for behaviour change (why do target audiences want the new practices?)
* Channels of communication: for example, street theatre, house visits, radio, schools.
* Communication materials: the supports you develop for your communications activities like theatre scenarios or flash cards.
* Monitoring: methods for following progress in programme activities, indicators, programme outputs, and in behaviour change
* Project management and budget.

SET UP AND RUN THE HYGIENE PROMOTION PROGRAMME Pilot, test and revise everything. Your hygiene promotion programme will start off best with a few months of testing of messages, strategies and communication materials on a small scale, so that they can be refined and improved, before you begin a large-scale operation. Hold focus groups to review radio spots or theatre scripts.

Ask women visiting clinics to tell you what they see in any images or visual supports you produce. If you decide to work in schools, try out your schools programme in one school first. Ask teachers and children what they liked and what they didn’t like about the programme and then modify it accordingly.

Any materials you produce such as posters or radio scripts will certainly need to be tested and revised, probably several times, before you adopt them. Carry out a baseline survey of target behaviours. Using the same structured observation technique that was used in the formative research to identify risk practices, take a sample to represent of the target group and observe the target behaviors.

Duplicate surveys are then used later to monitor progress towards project objectives. Set up supervision and monitoring. In common with all development programmes, health promotion activities need to be carefully supervised and monitored. Periodic reviews will allow you to ensure that your activities are being carried out; that they are reaching people and that they are effective. The results will allow you to modify the programme to make it more effective Evaluate.

Evaluation will allow the experience to be improved upon, extended and transferred elsewhere. Example: Look carefully at the table on the next page; it shows the research questions, the methods that were used to answer them, the answers that were found, and how these translated into programme decisions in a town in India. Whilst your formative research may ask different questions and will get different answers, the logical process is the same. Formative research guides the programme design