“State of the Art” Hygiene and Sanitation Promotion Component Design of Large-Scale Rural Water Supply and Sanitation Programs – Report on Lessons Learned

PREPARED FOR THE WORLD BANK BY W.S.ATKINS INTERNATIONAL Ltd.

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### GLOSSARY OF TERMS

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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>DFID</td>
<td>UK Department for International Development</td>
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<td>ESAs</td>
<td>External Support Agencies</td>
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<td>GND</td>
<td><em>grama niladhari</em> (rural community organisation in Sri Lanka)</td>
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<td>HSP</td>
<td>Hygiene and Sanitation Promotion</td>
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<td>LSHTM</td>
<td>London School of Hygiene and Tropical Medicine</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>PHAST</td>
<td>Participatory Hygiene and Sanitation Transformation</td>
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<td>PS</td>
<td><em>pradesiya sabha</em> (local government division in Sri Lanka)</td>
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<td>RWSSP</td>
<td>Rural Water Supply and Sanitation Project</td>
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<td>WB</td>
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Executive Summary

The general objective of the State of the Art project is to foster effective implementation of the sanitation and hygiene promotion components of large scale rural water supply and sanitation investment projects. The immediate objectives of the project are:

To learn from global best practice and develop a strategy for hygiene and sanitation promotion in large scale World Bank assisted RWSS projects in three countries;

- To integrate these strategies into the projects, and support implementation;
- To design a methodology for evaluating the success of the strategies, and to support monitoring by government in order to be able to draw lessons from each case; and
- To document the lessons learned, and develop a guidance manual which will guide future World Bank assisted projects as well as being generally disseminated.

This paper provides some general and some specific lessons learned during the project period; as such they relate primarily to the establishment, design and planning phases rather than implementation, which unfortunately did not figure largely in any of the three case studies due to external factors.

The general lessons learned include:

- Commitment by all parties involved and a strong and flexible policy environment are key enablers for successful intervention. Advocacy and discussion are needed at all stakeholder levels to create the acceptance of need and to take account of different responsibilities and attitudes in project design. Effective advocacy is currently weakened by the lack of a strong economic case for intervention at project level.

- Effective baseline data-gathering plays an essential role in meeting intervention goals. The M&E process needs to be integral to programme design to help improve future interventions and build an economic case. There are still instances of poor data-gathering where head of household is expected to provide all information for the survey; in such cases clearly women's input in WSH may be being systematically missed.

- There is no single blueprint for HSP and it is important to develop a thorough understanding of the target group and where most effective influence can be brought to bear before designing an intervention. Design relates not just to the way in which messages are delivered but also to the type of message, its relevance to the baseline situation and the duration of the intervention. The design of HSP is often “lifted” from other contexts and used with little attempt made to focus it. This lack of focus is also clear in the next lesson.

- Design of hygiene and sanitation interventions should be carried out to the same level of detail as the water supply component. Where HSP is “buried” in RWSSP it may not be planned or resourced sufficiently as loan funds may be directed towards capital works. Options for improving the design and implementation of HSP may exist: these include grant or other concessionary funding, establishing HSP as a separate project, coordination with related initiatives (including hardware improvements), linking into existing institutions such as schools to achieve a longer duration of intervention, targeting groups most amenable to behaviour change (such as new mothers) and carrying out pilot work in-country.

Specific country lessons learned are included in Sections 4, 5 and 6 of this document.
1 Introduction

W.S.Atkins International Ltd, in association with Abt Associates Inc., CARE International and London School of Hygiene and Tropical Medicine (LSHTM), were commissioned by the World Bank/Bank Netherlands Water Partnership to undertake research into how to design and implement effective hygiene and sanitation promotion campaigns for large scale rural water supply and sanitation projects (RWSSP).

The research was to be centred on case studies in:

- Uzbekistan;
- Sri Lanka; and
- Ethiopia.

In these countries WB-funded large scale RWSSP were at different stages of development at the start of the research project and it was expected that during the study lessons learned from one context might usefully be tested in other contexts. The research was divided into:

- assessment of global best practice;
- development of generic strategy for hygiene and sanitation promotion;
- situation analysis in each country;
- development of project/country specific strategies for hygiene and sanitation promotion;
- integration of the strategies into the projects;
- supporting implementation of the strategies in the projects;
- evaluation and assessment of the strategies; and
- documenting the lessons learned.

The assessment of global best practice was undertaken by London School of Hygiene and Tropical Medicine (LSHTM) in 2004 and updated in 2005 (ref 1). A generic strategy was developed at a relatively high level as shown on Figure 1.1 overleaf.

1.1 Situation Analysis

A situation analysis was undertaken in each country which may be summarised as follows:

**Uzbekistan Situation Analysis**

The Water Supply, Sanitation and Health Project (WSSHP) collapsed prior to this current project starting work in country. The project team therefore concentrated on understanding how the project had been set up, what obstacles had been met, what work had been carried out prior to the collapse and why stakeholders believed the project failed.

The principal findings were that there was little institutional interest at the highest levels in the “softer” issues such as sanitation and hygiene promotion and a commensurately small
investment was planned in this area, with the bulk of the effort and the investment targeted towards capital infrastructure. In part this lack of enthusiasm at the highest levels appeared to stem from a belief that the documented incidence of diarrhoeal disease would reduce due to the installation of a rural gas network which would allow consumers to boil water and thus avoid illness. Whilst this might sound plausible in principle in practice in many rural communities scarce or expensive resources for heating may be reserved only for cooking.

In addition there was some discussion of the lack of context specific solutions being proposed, with criticism of the HP/SP model, which was based on earlier work done in Nepal, Peru and India. Some of the assumptions, whether institutional, technical or financial were also criticised; for example the assumption that communities could and would afford to pay for facilities had not been tested and little sensitisation was apparently carried out to underpin the sustainability of the approach.

Sri Lanka Situation Analysis

This current study commenced while the 2nd Community Water Supply and Sanitation Programme (2CWSSP) was in the pilot phase, rolling out processes and trialling approaches. The overall approach of 2CWSSP was to establish and institutionalise Community Based Organisations (CBOs) to manage water supply development, hygiene and sanitation promotion and other associated rural development functions.

Whilst hygiene and sanitation promotion were deemed in the design stage to be integral to the design of the programme, with an intended focus on environmental protection and environmental health, the efforts that were expended in these areas during the pilot phase were apparently not carried through to subsequent stages. The different levels of implementing agencies had differing views as to the extent to which hygienic sanitation facilities were to be provided for schools and medical points, with the risk that behaviour changes would not be sustained if children were not able to make use of suitable facilities at school in concert with the hygiene and sanitation education they received.

The pilot phase was also characterised by a selection system based on a priority ranking by the PMU team, with sensitisation, demand creation and awareness raising over a 4-6 month period. During this period CBOs were formed and hygiene education and a baseline survey were carried out to establish the scale of need, the scale of demand, and to help advocate the benefits to the community.

Ethiopia Situation Analysis

At the start of the current study the World Bank was in the early stages of developing a large RWSSP, intended to cover communities in some 40-50 woredas. Administratively, Ethiopia is divided into 11 no. Regions, with 5-10 no. Zones per Region and up to 100 no. woredas per Zone. Below the woreda unit there are village clusters or kebeles, with approximately 12 kebeles per woreda and ultimately the villages themselves are identified as the lowest level of division, although individual villages do not form administrative districts.

The main ministries concerned with rural water supply, sanitation and hygiene education are the Ministry of Water Resources and the Ministry of Health, with the Ministry of Rural Development also involved with co-ordination. Government has been undergoing a decentralization process and so, institutionally, the situation is quite complex. Ethiopia is also in a poor state with respect to water supply and sanitation coverage and hygienic water management. Census data from 2000 suggested that nationally less than 9% of rural households had formal latrines and in some regions this number fell to less than 1%

The GoE acknowledged that the scale of the problem, with a huge underserved population needing large investment and limited financial and human resources at their disposal, was beyond their scope without significant external intervention. However, even external interventions in the past had had limited success and so it was acknowledged that
information on what might work and what has not worked, and why, is essential to improving the success of intervention models. Given the vast range of ethnic groups in Ethiopia, each often with their own language, traditions and religious practices, a pilot ethnographic survey was proposed to try to understand the range of differences and how such differences might translate into different obstacles to behaviour change. With an understanding of such obstacles, it was intended that flexible approaches to hygiene and sanitation promotion might be developed which could support specific areas of behaviour change.

1.2 Strategy development

The next stage of the work, namely project/country specific strategies for hygiene and sanitation promotion, was modified as a result of the varying situations in each of the study countries.

For **Uzbekistan**, given the collapse of the project which compromised the original plan, a short term work plan was developed which comprised:

- further discussion with hygiene and sanitation related implementing agencies to try to get a deeper understanding of reasons for failure of the WB programme, with specific reference to any models that had worked in part or fully;
- development and pilot testing a questionnaire in several communities in the project area, to examine how baseline information might be better collected and used for both project design and M&E work;
- analysis of the pilot survey information and discussion with focus groups to refine the questionnaire; and
- development of a generic project design strategy for future WB funded H&S interventions.

For **Sri Lanka**, a country specific strategy was developed and pilot work was carried out to demonstrate how the baseline data collection could be used as part of the awareness creation campaign. The work plan comprised:

- Development of a draft strategy and M&E indicators and discussions with stakeholders, including PMU and implementing authority;
- Final strategy development with RWSS, health and education officials from Ministry down to lowest administrative levels;
- Planning for strategy implementation, including selection of pilot trial areas, review of strategy following pilots;
- Provide support to provincial council and *pradesiya sabha* (local administration) officers during the pilots and the roll out of the full implementation; and
- Assistance with M&E work, report on effectiveness as far as possible and conduct a lessons learned workshop.

Following the pilot trials the RWSS implementing authority withdrew their support for the full implementation of the work plan. They had prepared budgets for the full RWSSP cycle which included reducing planned expenditure on hygiene and sanitation promotion over the programme, and were unwilling to revise such budgets to make even small additional sums available to strengthen the hygiene aspects of the programme. Any suggestion relating to reduction of the “capital expenditure” was deemed to be politically and institutionally unacceptable.
For **Ethiopia**, where the programme was still in the very early stages of gestation, there was much more willingness to engage, not least because it had been acknowledged by GoE and WB in particular that previous programmes had had little impact, and that therefore something different had to be done. The work plan comprised:

- Identification of existing hygiene and sanitation promotion (HSP) training materials;
- Identification of types and costs of various forms of latrine and their vernacular names;
- Undertaking the ethnographic study in 3-6 selected communities, broadly representative of the range of differences which might be experienced in the developing RWSSP;
- Development of key parameters and indicators for evaluation through the baseline survey and establish and pre-test appropriate survey questionnaires;
- Pilot baseline surveys amongst selected households;
- Preparation of a description of current HSP programmes sponsored by Government and NGOs;
- Assessment of the school and community hygiene education programmes;
- Development of a country strategy based on all the above inputs; and
- Definition of stakeholder responsibilities.

Integration of the strategies into the projects was clearly not appropriate in **Uzbekistan**. It was agreed that after the pilot surveys had been completed and analysed the work should be closed out and any lessons learned documented.

In **Sri Lanka** also, given the reluctance of the PMU to modify hard won infrastructure budgets, it was agreed with the WB that the strategy could not be further integrated without further external funds being made available. The intention of the research project had been to work with the implementing authorities to make the best use of the funds already available and not to provide grant or additional loan sums. Since the implementing authority was unwilling to compromise on funds it was agreed with WB that following the pilot surveys the work should be closed out and lessons learned documented.

In **Ethiopia**, the situation was very much more favourable since the timing allowed much more influence to be brought to bear and the WB and GoE were supportive of the process. However, delays to the RWSSP programme meant that the integration of the strategies became problematic since there would be limited time to observe how the strategy performed and to assess how to modify the process to improve outcomes. The work was re-modelled and re-programmed to provide as much benefit as possible given that the implementation work would be limited in scope.

Supporting implementation of the strategies in the projects was therefore limited to the Ethiopia RWSSP. This RWSSP was delayed and so the support to implementation was limited to one project cycle only.

Evaluation and assessment of the strategies and documenting the lessons learned is the subject of this technical note.
Figure 1.1

Institutional Assessment
- Which Ministry responsible?
- Check existence of national policy on HSP.
- Any evidence of acceptance of policy?
- What are administrative linkages from Ministry to local levels?

Situation Assessment
- Who is responsible for HSP locally?
- What successes/failures to date?
- Who is working in the field, with whom and what linkages with local administrative structures?

Project Planning
- Workshops to help institutionalise the policy.
- Baseline survey development and consultation
- Baseline survey – including KAP, facilities, beliefs etc.
- Project plan and M&E plan development

Feedback

Pilot

Roll Out
2 General Lessons Learned

2.1 Preamble

These lessons learned relate to the work carried out during the research period, the review of best practice and experience gained from projects in other countries. As noted above the three case studies were at different stages of development at the start of the project and the intention at the outset was to try to maximise learning, particularly in respect of intervention and M&E. Due to the events described above after this research project commenced little new information can be gathered and documented for the intervention and M&E stages. The lessons learned may not be radical but they underline some issues particularly during the planning phase. Some of the lessons may be impracticable to put fully into practice in a policy vacuum or where some work is needed to be progressed in advance of the “ideal situation”. Increased preparatory work is likely to increase the chances of success.

2.2 Introduction

Within the water supply, sanitation and hygiene promotion community of professionals it is seen as almost axiomatic that interventions in water management, environmental health and hygienic practices lead to improved health outcomes and improved livelihoods. Whilst this seems a logical conclusion, there are limited data to fully demonstrate this at a project level and thus limited data from studies demonstrating a sound financial/economic argument for the level of input necessary to inspire such improvements. A recent study by the World Health Organisation (WHO), Evaluation of the costs and benefits of water and sanitation improvements at the global level, presents a strong cost benefit case for global level interventions on the assumption that costs and benefits related to avoidance of infectious diarrhoea can be separable from other health impacts. As a tool for advocacy, at Government level, of the utility of undertaking water, hygiene and sanitation interventions this is potentially very useful. In recognition of the need for further evidence WHO is to commission further research in 2006 on cost effectiveness and cost benefit of WSH interventions, with particular emphasis on community level interventions.

Hygiene and sanitation promotion (HSP) is to do with motivating behaviour change. Behaviour change processes are by their nature more difficult to achieve in adults than in small children. Whereas children can be encouraged to behave in certain ways through education and reward for positive behaviour it is a more long term task to modify deep seated behaviours in older children and adults. Evidence from the LSHTM review of practice quite strongly suggests that behaviour change campaigns are most effective when there is a small number of simple consistent promotional messages/activities and where effort is expended on this simple set for an extended period of time.

The LSHTM review of practice and Fewtrell and Colford (2004) also suggest that there are few well documented studies which convincingly demonstrate a causal link between water, sanitation and hygiene interventions and improved health outcomes, although some do. Those that do have been analysed by Fewtrell and Colford and they report that handwashing interventions appear to be more effective at reducing diarrhoeal disease than broader hygiene promotion interventions, but that there are insufficient reliable data to discriminate more fully between the relative impacts of different interventions alone or in combination. Making a quantitative economic argument for such effort, particularly at a project level, therefore remains problematic.
2.3 Enablers

In this context therefore it is by no means certain that implementing authorities for large scale RWSSP will have great commitment to integrating HSP into water supply projects. Evidence from the three case studies shows that: in Uzbekistan the Government had a low level of acceptance of such need; the implementing authority for the Sri Lanka 2CWSSP was clearly not fully convinced of the value to them or the project of spending effort and resources on HSP and their programme therefore included a plan to reduce expenditure and emphasis on HSP; while in Ethiopia CARE reported that “Many key people were not aware of the importance of sanitation and hygiene, nor what they can do to improve the situation”.

The lesson from this underlines the need for advocacy with all levels of stakeholder from central Government, to local government and implementing bodies, all the way down to the grass roots level. This advocacy helps to establish the “enablers” for the necessary activity in HSP. If there is no institutional acceptance of and desire for HSP from the highest level then lower levels of the implementation team will also not exhibit the necessary behaviours.

Following on from this, the policy and legislative framework is a good indicator of the level of institutional acceptance of the need for HSP as an integral part of RWSSP planning, design and implementation. In Uzbekistan for example, we were unable to find any policy in support of rural or urban hygiene promotion or any formal acknowledgement of its role. It was notable to the team in Uzbekistan, during our baseline data gathering, in most of the projects reported on or encountered there was apparently a heavy emphasis on health and hygiene education through schools. The general impression from our team and from other external actors interviewed was that the “top down” approach, whether in respect of mass media campaigns from Government or health education delivered through schools, was one with which the Government felt most comfortable. The attempts by WB and other agencies to work with a “bottom up” approach, whilst appropriate in principle, does rely for success on there being “vertical” pressure and encouragement to lower levels of administration.

In Sri Lanka, the situation was different in many ways, not least in the fact that Government at all levels and a large cadre of project professionals have been exposed to the ways and thought processes of the development community for many years. The concepts behind community engagement and mobilisation are well understood and there is a large pool of NGO and other private practitioners who can lead on or assist with community level work. Interaction with the communities and reception by the communities is therefore facilitated by common languages, both technical/developmental and linguistic. The design of 2CWSSP was based around devolved levels of administration and the use of NGOs to build local capacity in communities to lead on development of the physical works and on the HSP. During our visits to the field our team was impressed at the level of knowledge of the communities, their willingness to debate how best to take the work forward and their desire, generally, to participate in self help. There was even evidence of “peer competition” with some families with latrines upgrading over time to a higher specification, and paying private sector artisans for the work.

So far so good, in principle, but the way in which the programme developed with minimal attention paid, and almost no resources allocated, to HSP for the second round of projects suggested that the implementation authority remained more focussed on infrastructure delivery than on seizing the opportunity to obtain potentially more lasting benefits. This was despite there being a very comprehensive policy in place in Sri Lanka relating to all aspects of water and sanitation, including policy objectives, levels of responsibility, the role and place of hygiene education and promotion, payment modalities and the role of private and public sector organisations.

In Ethiopia there is a recent national policy on sanitation which was the subject of a national review workshop to allow debate on issues and to fix and agree the intent of the strategy at all levels of administration. The CARE team was able to modify the design of
The basic lesson we take from this is that there is still a relatively weak demonstrable foundation for the **economic case for hygiene and sanitation promotion at the project level** and as such many administrations either have not developed any policy in respect of integrating HSP with water supply/sanitation engineering projects and/or do not fully believe in the need to undertake such effort. As a result design of RWSSP frequently has low emphasis on HSP and even when it is included, for example as noted in Sri Lanka, there is a risk that it is more for appearances sake rather than through conviction. In order to provide a sound base for integration of HSP into water supply projects, there is a need to strongly advocate at all levels of beneficiary government, making use of **pilot work in-country** where possible. This kind of **staged approach** can help to prevent the discussion being considered as academic and impractical. When the WHO report into cost benefits and cost effectiveness of WSH interventions for community level projects is available in mid 2006, this may add weight to the economic arguments in favour of such integrated interventions.

A corollary to this is that helping to develop a **strong and flexible policy for water and sanitation provision** should be considered as a precursor to detailed design of RWSSP. At the very least having a policy indicates Government sponsorship of the need, and the debate that is necessary to derive a policy suited to local conditions – administrative structure, capacity, baseline conditions – adds to the weight of advocacy and requires the conceptualisation of the structure and process for delivery.

Development of an effective policy necessarily takes time, in much the same way and probably for many of the same reasons that hygiene promotion itself takes a significant time. Full adoption of the policy so that it informs project design and implementation at all levels may take even longer. CARE have noted in Ethiopia that despite the fact that the Ministry of Health is investing in national and regional workshops with a wide range of stakeholders as part of policy development and advocacy the momentum of policy development is difficult to maintain. **Debate is important** so that all stakeholders can develop their own position on the matter and see how their contribution fits in to the overall process, but even in a country where there is one common tongue, finding a common language in which to deal with the issues clearly may itself take a considerable time. The common language is affected by language itself, tradition, beliefs, hierarchical structures, level of “scientific” understanding, climate, environment and potentially many other parameters. Our work in Sri Lanka suggested to us that the 20-30 years worth of development activity in the field have left a legacy of a common language that was potentially far easier to build upon than in Uzbekistan, where despite a common tongue and a fairly high level of education, the Uzbeks appeared to have little confidence in or comprehension of initiatives which were not government inspired and directed.

While the policy development is on-going it is relevant to assess the activities of **other initiatives** and see how they can fit in with and support the policy debate. For example if the Ministry of Education is improving health/hygiene education at school or the Ministry of Health is training additional field health workers, liaison between the ministries to align the messages and content helps to provide mutual support and a consistent set of messages.

### 2.4 Baseline data collection

Baseline data collection is an essential element of any successful hygiene and sanitation intervention because it helps to identify the local nature of the problem (for advocacy and intervention design) and those most in need (targeting). It is also the foundation for ongoing M&E, allowing an assessment to be made of the outcomes of interventions in order to improve future interventions and build an economic case for intervention.
As noted in the LSHTM review work, and taken as a basic truth in project or programme management, it is first necessary to “define the problem”. This means obtaining a realistic understanding of the actual starting point and the desirable end point. In the case of HSP the desirable end point can be in itself hard to define, particularly given the risk that there may at the outset be limited common ground regarding goals. In effect therefore, before project design can begin, the starting point should first be established, through baseline data gathering.

Baseline data may be gathered in too restrictive a sense, without full reference to the purposes for which they are needed. For example, in the Sri Lanka case study, there was a questionnaire developed for 2CWSSP. This questionnaire was:

- to establish community size, location and numbers of people
- to form the basis of understanding current provision (number and quality) of water and sanitation facilities,
- to establish land ownership
- to assess what levels of water-borne disease occurred
- to ask what were perceived as the priority needs for the community
- to select communities for inclusion in the process.

The questionnaires were administered by NGOs, but household members (specifically head of household) were expected to complete the forms themselves. We noted that the head of household was generally male and thus there was a risk that women were insufficiently engaged in the process. It may therefore be necessary to consider gender-inclusive data gathering by, for example, discussions with gender-specific groups or individuals. This is particularly important for hygiene, sanitation and health matters relating to children and infants as in many cultures these are issues about which women are more knowledgeable than men.

In addition the form was of a tick box nature which did not allow for much qualitative engagement. The NGOs administering the process were often unskilled in baseline data collection, and could not offer much guidance on how best to complete the form, as they were not fully aware of the purposes to which the data could be put. As a result the data obtained was of relatively poor quality, with little information extractable from it to guide the community engagement process, or to understand behaviour baseline, or to be used as the basis for a behavioural M&E system or even to act as the first stage of community engagement and sensitisation. The principal use of the information therefore was as a tool to justify community selection and potentially to monitor physical interventions.

In a similar way, the Uzbek case study demonstrated a very low quality of baseline data collected. How significant a contribution to the overall failure of the Uzbekistan project such poor baseline information made is not quantifiable. However there was a dispute over the delivery model, there was lack of credibility regarding water-borne disease prevalence and there were assumptions made about the availability of materials and resources at community level which proved in many cases to be unfounded. Given these failures of baseline information, it seems probable that any potential benefit to the design of the project was missed.

The lesson from this is that proper design must be based on reasonable background or baseline information. Baseline data are gathered primarily to inform the design through learning about

- current levels of knowledge, belief and practice;
• what obstacles to development exist and how they may be overcome whether in
terms of community hierarchy, traditions or beliefs or lack of resources;

• what capacity there is for undertaking work at community level using CBOs or
NGOs;

• what sound practices are already established and how these might be built upon;

• what motivation to behaviour change may be found and exploited for the general
good;

• what links may readily be made between improved water, sanitation and hygiene
and improved livelihoods; and

• what level of effort might therefore be needed to have a noticeable and sustainable
impact.

The baseline must also start to establish a basis for monitoring and evaluating success in
physical, capacity and behavioural terms. Thus the M&E process must be integral to
the design of the programme – if the programme is incapable of affecting any of the
parameters being monitored then clearly the design of the programme needs modifying;
and vice versa – if the programme can engender changes that the M&E system cannot
detect then one or both need changing.

The baseline survey should be facilitated by NGOs trained to carry out the work, not
least to allow a judgement about the quality of the information gathered, to ensure that the
survey/questionnaire is managed to get the best information possible and to make use of
the opportunity to commence an advocacy process at community level.

2.5 Design

Design of HSP needs to take into account the discussion above about the integration of
HSP into RWSSP design and the discussion earlier about the need for top down pressure
and encouragement to ensure that the community level interventions have sufficient
support and momentum.

The implementation of HSP should be planned to the same level of detail as for physical
infrastructure. There has been much effort spent over many years in the engineering
community to produce systems and processes for planning physical infrastructure design,
procurement, installation and commissioning. As a result it is relatively easy to specify a
great deal of detail for such infrastructure and since inevitably there is a large capital sum
associated with construction it is generally deemed essential to provide detailed plans for
costing and monitoring purposes. Physical assets are consistent in nature – one VIP
latrine in Orissa is similar in nature to one in Zimbabwe in terms of activities – even if local
costs are different from place to place.

Implementation of HSP fits less easily within the engineering planning process as there
may be more iterations and less easily defined success criteria or “stage gates”.
Nonetheless, merely because it is currently less tractable does not make it any less
necessary to undertake the planning on an equal footing – this step will improve the
accuracy of cost and time predictions and over time will make HSP planning more routine
and monitoring of success more visible.

Cost recovery for hygiene and sanitation promotion can be particularly difficult or
impossible because of its strong public good characteristics. This lack of financial
sustainability makes governments (and possibly lenders) more reluctant to prioritise loans.
Until an economic case has been established and accepted, hygiene and sanitation
promotion may need to be financed by external grants or other concessionary sources.
This model was followed in a recent intervention in Kyrgyzstan, where the UK DFID provided grant funding for the implementation of HSP and WB supported the rural water supply project. The HSP team were responsible for planning, implementing and monitoring the promotional activities in co-operation with the RWSP team who were responsible for developing CBOs and projects in target communities. Since the HSP was a separate project the weight given to planning and implementing these activities was clearly significant and on a par with the more engineering based activities of the RWSP.

Design of the programme is not just related to the way in which messages are delivered but also to the type of message and its relevance to the baseline situation. For example in the Sri Lanka context the messages build from a general acceptance of the need for and benefits of hygienic practice. In rural Ethiopia the baseline might indicate the need for a greater effort on advocacy prior to selecting appropriate messages and delivery processes so that the messages can be properly received. It was for this reason that our team proceeded with some pilot ethnographic surveys in Ethiopia to try to elicit any differences between areas, tribes or other segment of population which should bear on the design of the promotion programme from advocacy, sensitisation to message and delivery process.
3 Specific lessons learned as reported in the LSHTM review

3.1 Introduction

The lack of high quality published research and rigorous project evaluations in the field of hygiene promotion adds to the difficulty of drawing general lessons from experience in the sector to date. This problem is also noted in a review by the World Bank (World Bank 2003) which concludes that although many World Bank projects claim a health benefit, few have baseline or monitoring data to support their claims. Nevertheless there are a number of reports that bring together the results of field experience from different projects and locations (e.g. Van Wijk and Murre 1998, Billig and Bendahmane 1999, Favin and Bendahmane 1999, Appleton and van Wijk 2003, Shortd 2003).

3.2 Understanding of the Target Group

The variety of experiences that comes out of these studies suggests that there is no single blueprint for hygiene promotion and that different strategies may be needed depending on the target group, the locality and the behaviour as well as the existing prevalence of the desired practice within the population. Therefore it is always important to begin by developing a thorough understanding of the practices of the target group and of the beliefs and physical, economic and social conditions that underlie them. This is consonant with the Behavior-Centred Programming™ approach described in various EHP publications (Favin, Naimoli and Sherburne, 2004).

3.3 Mass Media Campaigns

Mass media campaigns for hygiene promotion have so far worked best in urban areas (Saadé, et al 2001), possibly because of the combination of a dense population, access to mass media and other facilitating hardware such as soap, water and latrines. Identifying the target audiences is important. These may include groups who are not themselves priority targets for behaviour change. In Guatemala, for example, it was found to be important to target fathers as this group was concerned about the additional cost of using water for improved hygiene practices.

It has also been suggested that particular groups, such as new mothers, may be especially amenable to appropriate behaviour change messages and so may be an effective target audience (Curtis 2002). Curtis (2002) also suggests that for mass media campaigns to achieve results, in addition to identifying the audiences, messages and channels of communication, the campaign should aim for the target audience to receive the campaign message at least six times per month in order to generate the critical mass of stimulus needed for behaviour change. However no evidence is presented to support this lesson, which seems to be based on anecdotal evidence from the commercial sector. Furthermore the optimal duration for such a campaign is not specified.

3.4 Hardware Improvements and Demonstration Projects

Although hardware improvements alone are not sufficient to bring maximum health benefits, hygiene promotion is thought to have the greatest likelihood of success when it is combined with appropriate improvements in water supply and sanitation hardware. The most effective order for these interventions, if there is one, has not been established.
Experience in Zimbabwe with Community Health Clubs has been that **hygiene promotion can be beneficial if introduced even before improvements in hardware are begun** (Appleton and van Wijk, 2003). A supportive legislative and policy framework can be important in achieving hardware improvements (Favin and Bendahmane 1999). To this end, **demonstration projects, though not the most effective way of producing widespread and lasting behaviour change have proved useful advocacy tools** for use with policy makers (Appleton and van Wijk, 2003).

### 3.5 Mixed Activities and Communication Channels

There is no single proven approach to hygiene behaviour change that reigns supreme to the exclusion of others. Nor is there likely to be, given differences that exist even between communities in the same country in terms of education, understanding traditional and/or religious/faith beliefs and constraints. From general health promotion practice it is recognised that good results are only likely to be achieved when:

- The intended changes are based on the body of behavioural theory that underpins health behaviour and change (summarised in Nutbeam and Harris 2000).
- Promotion practices are based on approaches in keeping with sound theory.
- A mixture of carefully selected approaches is used (Ewles and Simnett 1998, Naidoo and Wills 2000).

It follows that the **best results in hygiene promotion are likely to be achieved through using a mixture of activities and communication channels** to reach different groups in numerous ways and that educational, community capacity building and social marketing approaches should be combined (Shordt 2003, Favin and Bendahmane 1999). However there have been few attempts to systematically combine different hygiene promotion approaches, probably resulting from practical or financial constraints in development projects which seek not to be test beds for theory but to promote and monitor an approach. Thus neither the optimal mix of activities nor the additional benefits from additional activities are known (Billig and Bendahmane 1999). DFID (1998) cautions that local partners in intervention programmes may become weary and sceptical if a succession of new approaches is introduced and that for this reason it may be more productive to offer rather than insist on a particular approach and to ensure that local capacity is built to implement it.

### 3.6 Length of Intervention

In addition to the intensity of the activities, duration appears to be a key element in achieving sustainability (Shordt 2003). Evidence suggests that **the length of an intervention is more important than the time elapsed since project activities ended** in determining the sustainability of behaviour change. The optimal duration for intervention activities is not known but little is to be expected from interventions with a time frame of less than one year (Shordt 2003). This implies that projects may benefit from linking into existing institutions such as the education system, primary health care system, health promotion centres and processes and general community development schemes in order to achieve continuing inputs beyond the project cycle.

### 3.7 Outstanding Issues

The drawing together of experiences, ideas and opinions from a number of interventions has thus provided some potentially useful rules of thumb to guide ongoing work in hygiene promotion. However, there is a pressing need for more rigorous evaluations of projects as well as primary research and desk studies to allow us to answer such questions as:
• What is the optimum mix of different activities and approaches?

• What additional benefits can be expected from additional activities?

• What magnitude of behaviour change can reasonably be expected from a mass communication campaign and over what time period?

• What magnitude of behaviour change can reasonably be expected from a community development approach and over what time period?

• What is the reach of different approaches, what sections of the population are missed and what are the public health implications of this, especially for the poorest?

• What useful role can education play and under what circumstances and in what form should it be delivered?

• What is the cost-effectiveness of various hygiene promotion approaches, in terms of cost per number of people adopting a specific behaviour?

Curtis and Cairncross (2003b) underline the lack of progress made in understanding diarrhoeal diseases over the past one and a half centuries, pointing out that the best strategies for promoting hygiene and sanitation are still not known and posing a number of additional important research questions including:

• What is the relative importance of human and animal faeces in disease transmission?

• What is the relative importance of hand, food, flies and other objects as vectors for disease transmission?
4 Specific Lessons Learned: Uzbekistan

4.1 Overview

The Water Supply, Sanitation and Health Project (WSSHP) collapsed prior to this current project starting. We therefore concentrated on understanding how the project had been set up, what obstacles had been met, what work was carried out and why the project failed.

4.2 Organisational/institutional Issues

Our principal findings were that there was little institutional interest in Government in the “softer” issues such as sanitation and hygiene promotion and a commensurately small investment was planned in this area, with the bulk of the effort and the investment targeted towards capital infrastructure. In part this lack of enthusiasm appeared to stem from a belief that the incidence of diarrhoeal disease would reduce after the installation of a rural gas network which would allow consumers to boil water and thus avoid illness. Whilst this might sound plausible in principle in practice in many rural communities scarce or expensive resources for heating may be reserved only for cooking.

The project was intended to be administered in the field at three main levels: hokimiat (rayon level) kolkhoze (village group level) and through CBOs, with support from Ministry of Health officials and from the international consultant. There were difficulties at all levels from the breaching Government of norms by trying to pay sums of money for construction into CBO bank accounts, inability to procure materials in local markets, difficulties in getting community participation, no choice in the type of sanitation to be provided due to lack of enthusiasm by Government in spending foreign currency on HSP.

Health Centres

Although the Health Centres have a remit to carry out health promotion capacity of this organisation is presently lacking. Initiatives through the USAID ‘Health’ project in other areas of Uzbekistan may, in time, provide the organisation with the capacity to develop its hygiene and sanitation work.

Sanitary Epidemiological Services (SES)

SES also has a remit to work within the area of H&S, but as a monitoring and testing agency has struggled to meet the high standards set for monitoring in Uzbekistan. Practical water quality monitoring relevant to the context must be developed. Indicators may include turbidity (measurable at local level) or biological testing (also measurable at local level, but at higher cost). SES lacks the laboratory testing equipment and institutional capacity to carry out such work, and would also require significant capacity building and resources.

Lesson 1: Baseline information about communities’ willingness and ability to pay for facilities, information about materials and capacity of local institutions led to a poor starting point for the project. Lack of advocacy of hygiene and lack of understanding of the local needs and health indicators meant that Government remained not persuaded of the need for HSP.
### 4.3 Summary of lessons learned and actions required to address issues

A summary of lessons learned are as shown in following Table 1, below.

<table>
<thead>
<tr>
<th>Lesson learned</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertainty about ability to repay loan.</td>
<td>More research is required to find the willingness / ability of communities to pay for sanitation facility works in the project area. Such willingness or ability will be related to the level of understanding of the benefits (economic, financial and other) which would accrue. Lack of advocacy at all levels contributed to lack of incentive to change.</td>
</tr>
<tr>
<td>Uncertainty about actual diarrhoeal disease in the Project area.</td>
<td>Research is required to provide evidence that diarrhoeal disease morbidity is at levels that show that a H&amp;S intervention is required. SES is responsible for both monitoring health outcomes and for reducing infections – there is a thus a conflict between the roles and some evidence of under-reporting of disease. Government’s view that new gas supplies would automatically lead to improved health was unproven.</td>
</tr>
<tr>
<td>Externally developed strategy not appropriate to project area.</td>
<td>A strategy developed from widely different contexts (Nepal, Peru and India) was not thought to be appropriate, and at least should have been adjusted to suit the local context.</td>
</tr>
<tr>
<td>Latrine design to be used did not meet communities’ needs.</td>
<td>The Communities involved must be involved in the design process of the sanitation facilities, on a case by case basis, creating a locally relevant design. The design (elevated ventilated pit latrine) was effectively imposed on the project in the project design. This is a costly design and may not have been appropriate.</td>
</tr>
<tr>
<td>A combination of the above.</td>
<td>Uncertainty about project need and ability of project to repay the loan taken led to lack of GoU buy-in and deteriorating relationship</td>
</tr>
</tbody>
</table>

### 4.4 Implications for future strategy

The above lessons learnt and actions recommended to be taken have implications for any future strategy being developed. It appears that there was insufficient reliable baseline data available, and insufficient proof of workability of the project, leading to a doubt in the GoU that the project would be workable and would repay the loan taken from the World Bank for the Project. These lessons should be taken forward to any future strategy developed.

### 4.5 Preconditions to implementation

Various preconditions are considered relevant prior to implementation of a future project as follows:

- This project must be carried out where the beneficiary communities have access to, or will be achieving access to safe water sufficient for drinking, cleaning, cooking and other household activities. Without access to a safe water supply the benefits of this project, through improved hygiene and sanitation practices, may be unrealised.
Prior to implementation there should be a survey determining the actual knowledge of and demand for sanitation facilities improvements within the communities involved, and the communities' capacity/willingness to pay for such improvements.

Before any project starts in Uzbekistan, there must be agreements with all relevant Government departments, at all appropriate levels for the approval for the implementation of the project. With such agreements and support from the Government, the local population will feel protected and safe to be involved with such a project.

4.6 Strategic context and methodology of implementation

Context specific considerations

Uzbekistan is a country where much decision making has been highly centralised. This has led to a general expectation and dependence by many on continued centralised decision making, and indeed responsibility for many aspects of life may be assumed to be passed on to others. Hygiene and sanitation is one such example, where organisations such as SES have taken responsibility for testing and monitoring hygiene and sanitation practices.

In other hygiene and sanitation projects in Central Asia, (pers. comm. from S.Keane of Abt Inc relating to the USAID Zdrav programme), continued centralised approaches such as mass media campaigns are have been found not likely to create significant change in hygiene and sanitation behaviour or create motivation to be involved in and promote ownership of sanitation facility construction projects. It has also been found that mass-media approaches are generally more successful in urban contexts, less successful in rural areas, as in this project. The majority of the project area in Uzbekistan is rural, further underlining that mass media approaches are not appropriate as the principal strategy for this context. A more interactive and participatory approach is therefore suggested.

Methodologies for implementation

As identified previously by the LSHTM Participatory Hygiene and Sanitation Transformation (PHAST) is recommended.

It is considered that hygiene messages heard through the PHAST methodology may be learned and remembered because of the process of discovery through which they are acquired, and that behaviour and infrastructure changes may be sustained because the community will feel a true sense of ownership and control over them and will provide a supportive environment to individuals making these changes. The materials and methods are intended to achieve a balance whereby communities explore and take control over behaviours and facilities that have important health consequences, but do so within a framework and following an agenda that has been defined and driven externally.

4.7 Identification and implications of methodology recommended for the Uzbek context

A key aspect of the PHAST methodology is that the community involved need to be allowed to chose for itself the level of sanitation service appropriate to its own needs. This means that flexibility must be allowed within the project for different levels of sanitation service provision, and therefore allowing for a variety of different designs of sanitation facilities and varying levels of budget input from location to location for the type of facility chosen. Whilst this makes the project harder to design as a whole before the ‘set-up’ phase, the benefits of this approach (the delivery to end beneficiaries of demanded services, which are then much more likely to be used and sustainable) ensure the chances of a successful intervention are greatly increased. A budget review can be held after the ‘set-up’ phase to ensure that the budget allocated to the sanitation facilities construction is
appropriate to the needs. Furthermore, the research recommended to be carried out prior to the implementation of any project would give a guide as to the project budgets that may be considered appropriate. It may be more appropriate for this project therefore to be split into two projects – the set-up phase covered under an initial project (potentially under grant funding) and the remainder of the project implemented under a loan, once the scale of the project is more realistically defined.

Project set-up

The project set-up phase lays the base for the remainder of the project. It involves research and discussions with various organisations to agree and design basic components, such as identification of community level committee structures to be worked with, baseline survey, familiarisation with the specific departments and individuals to be worked with and development of training and other materials for use within the project.

It should be noted that, although some preparatory aspects of following phases may be conducted during the set-up phase, following phases should only commence once the set-up phase has been completed.

Specific details are:

- Baseline survey. Survey carried out to establish existing Knowledge, Attitudes, Beliefs, and Practices. This survey is in addition to the required research identified earlier in this report.

- Formation of community health promotion committees. A previous project in this context identified ‘Kolkhoze Committees’ (see World Bank Staff Appraisal Report, 17 April 1997). This structure may be found to be appropriate for use again in this project. The basic functions of the committee are to:
  - Undertake active participation in the PHAST methodology, as facilitated by the project implementation team.
  - Liaison between the project implementation team and the communities involved.
  - Mobilisation and management of people in the community to provide contributions of cash or labour for the sanitation facility component of the project.
  - Overseeing of long-term management and maintenance of the sanitation facilities (and water supplies, if included in conjunction with the anticipated parallel water project).
  - Overseeing and long-term management of the water-testing procedure, and subsequent contact with the organisation chosen to take follow-up action (specific organisation to be chosen as part of the process outlined in section, ‘Water quality monitoring’, below).

- Identification and training of candidates from each pilot project community for training in hygiene promotion, including PHAST. The candidates should be selected from village teachers, medics (doctors, felchers/nurses, Health Centres), and other respected village figures. The community level hygiene promotion projects should run concurrently with pilot villages for water supply projects (dependant on related projects ongoing at the time). These individuals will be included in the PHAST training with the community health promotion committees.

- Development/adaptation of PHAST for use in the local context. Design, with local counterparts, of culturally appropriate hygiene promotion materials to reinforce
messages on the relevance of good hygiene and sanitation practices. Distribution, making use of local structures, of these hygiene promotion materials across the project areas. This work element takes considerable time.

- Development of post training evaluation tool.

- Familiarisation with any formative research which has outlined hygiene and sanitation practices to be changed and how to effect these changes for the project area.

- Familiarisation with existing and planned Uzbek health promotion structures.

- Identification with stakeholders of the type of latrines most suited to the Uzbek context, which may be put forward as options for project communities.
5 Specific Lessons Learned: Sri Lanka

5.1 Overview

The 2CWSSP followed on from the relatively successful CWSSPI and II with much of the project design carried over directly from one project to the next. The hygiene and sanitation promotion aspects of CWSSPI and II were however apparently not a great success. The budget for HSP was intended to be directed to Ministry of Health but this was not what happened. One reason given, but not corroborated by documentary evidence, was that it was unpalatable to direct finance towards non infrastructure work. The rationale to this is if Government is unconvinced of the long term economic benefits of HSP it may seem more logical to maximise the expenditure on physical assets.

5.2 Organisational issues

Project Implementation for the 2CWSSP was carried out in a decentralized manner. The project sits in the Ministry for Housing and Plantation Infrastructure (MHPI) with overall responsibility resting with the National Rural Water Supply and Sanitation (RWSS) Division and its Project Director, linking with Provincial Councils and Departments of Local Governments in each Province.

The RWSS Division liaises with the Chief Secretary of the Provincial Councils. Each Province has a RWSS Unit, responsible for the work of the CWSSP. This is guided by a Provincial Coordination Committee (PCC), which includes the Chief Secretary, deputy chief secretaries (planning training development etc.) and other relevant officials. The PCC meets quarterly to review the progress of the project. The RWSS unit is responsible for implementation of the project at provincial level, providing support to pradesiya sabha (PS) level and grama niladhari (GND) level where required.

A RWSS cell has been formed in each PS, under the leadership of the PS chairman (who is democratically elected every five years). The RWSS cell supervises the work of the Partner Organisations. At PS level a Divisional Coordination Committee (DCC) oversees the project work. The committee includes the participation of Divisional Director of Health, District Epidemiologist, Divisional Director of Education and other relevant PS level staff.

At GND level, the 2CWSSP is operated by the Community Based Organization with full facilitation by the Partner Organization. In addition a Village Coordination Committee (VCC), incorporating public health officers (family health nurse) government school principal, religious leaders and other voluntary organization leaders at the GND level, is intended to be responsible for guiding the CBO operational activities and project implementation. It is assisted by PO and PS cell staff. However, it is the CBO which has total responsibility for water, sanitation, hygiene education, environment and other social development activities, including budgeting, implementation, monitoring, and producing relevant documentation. In practice the CBOs in the GNDs where we held discussions seem to operate largely with the support only of the Partner Organisations.

The Ministry of Health is responsible for coordinating all health activities at national level. Under the Ministry are the Family health bureau, Health education bureau and the health ministry of each provincial council. These bodies are responsible for improved hygiene and sanitation, including hygiene education. They work with government funding in collaboration with many international development agencies, NGOs, and other funding agencies. Hygiene and sanitation promotion work is usually integrated with other health
related activities such as water supply, general health, mother and child care, immunization, disease prevention, clinics, health education, family planning and other health related programmes, as indicated in Table 1.

Table 1 Current Ministry of Health hygiene and sanitation promotion activities

<table>
<thead>
<tr>
<th>Hygiene &amp; sanitation promotional activities currently operating</th>
<th>Organisations responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health education activities</td>
<td>Family health worker under the Divisional Director of Health. (Family health bureau)</td>
</tr>
<tr>
<td>Community Health education activities</td>
<td>Government Hospitals, clinics and medical institutions</td>
</tr>
<tr>
<td>Conducting health education activities (like training, workshops, video shows, mass media etc)</td>
<td>Health Education Units - health education officers</td>
</tr>
<tr>
<td>Government Health Education activities with regular clinics and places</td>
<td>Medical officers, Doctors, public health sisters, public health Inspectors etc</td>
</tr>
<tr>
<td>• Well baby clinics</td>
<td></td>
</tr>
<tr>
<td>• Maternal Clinic</td>
<td></td>
</tr>
<tr>
<td>• Family planning Clinics</td>
<td></td>
</tr>
<tr>
<td>• Hospitals Out patients</td>
<td></td>
</tr>
<tr>
<td>• Schools &amp; preschools</td>
<td></td>
</tr>
<tr>
<td>• Through community based organizations</td>
<td></td>
</tr>
<tr>
<td>Family planning programme activities</td>
<td>Family Health workers / Family Planning Association</td>
</tr>
<tr>
<td>School health club programme</td>
<td>Provincial health office, district health office and provincial education department and Zonal education office</td>
</tr>
<tr>
<td>Nutrition improvement programme</td>
<td>Conducted by Ministry of Health &amp; Nutrition)</td>
</tr>
<tr>
<td>Early child care, Health &amp; Nutrition improvement programme</td>
<td>ESAs (Unicef, Plan, World Vision etc)</td>
</tr>
<tr>
<td>Health education, sanitation, hygiene education activities</td>
<td>NGOs with community organisations</td>
</tr>
<tr>
<td>Organised special Health clinics</td>
<td>Organised by NGOs in some areas</td>
</tr>
</tbody>
</table>

However, not all the above activities take place to the same extent in all PS areas. It was frequently reported during discussions in villages that family health workers had a fairly tight focus on mother/child health issues and immunization with little effort expended on more general health and hygiene issues. It was apparent that not all of these activities are mutually supportive in terms of the messages they deliver. There was apparently no co-ordination at ministerial level between MoH and MHPI.

**Lesson 1:** Inter-Ministerial co-ordination appeared to be lacking with no apparent input from MoH into the HSP messages. This led to lack of consistent message.

### 5.3 Project Programming

The work in each area was planned to last almost two years, with the first year taken up with community mobilisation, education, project design etc, and the second year being the construction phase, as follows:

- 2 months of pre-project awareness
- 4 months of mobilisation
- 4 months of project design and continued working in communities
- 2 months of pre-construction preparation
- 10 months construction
The first and second batch projects completed the mobilisation and planning phase and started the construction phase. At the close of this study indications were that the mobilisation and training had gone well, but the HSP activities had been curtailed. No resources appeared to have been allocated to any of the second batch projects.

Lesson 2: There was only one period of HSP planned in a 22 month programme at the end of which there would be an improved water supply. Repeat campaigns when water supply is available would be useful. HSP was not regarded as important enough to figure in the planning and indeed no HSP resources were allocated to the second group of project nor probably to subsequent groups.

The failure to explicitly include sanitation provision at schools would tend to undermine the hygiene education being presented at schools under the jurisdiction of the Ministry of Education.

5.4 Information Gathering and Progress Monitoring

A system of information gathering was proposed for 2CWSSP whereby at each PS the results of data gathering and monitoring exercise are input into a computer system. This is supposed to collate data and be able to present results at GND, PS or province level. The first stage of this is the initial household questionnaire, which is gathered from every household in a particular PS. In theory this data is to be entered into the management system, in order to provide a baseline of information, and is used to select the most needy GNDs within a PS. However, the practicality of this is questionable, as there is simply too much data from every house in a PS to enter into the system. During the course of project activities in a particular GND, progress of various key activities is supposed to be monitored and recorded on the computer system. For the first batch of projects not all of the data were entered onto the system.

Information was also gathered in an unconventional way with a tick box questionnaire supplied to each head of household to fill in. There was no cross checking of information supplied and no evidence of any women’s input to the process. These failures are likely to lead to poor quality information.

Lesson 3: Data collection was weak, with no positive attempt to get the women’s view, whereas it is likely that women would be most knowledgeable and most positively affected by good decisions on water, sanitation and hygiene. The information was badly gathered, poorly used and was too late to be used to assist in effective project design or M&E. Good baseline information can be gathered from knowledgeable communities and used for design and effective M&E.

5.5 Strengths and Weaknesses of the Current Strategy

The general impression of the work in Sri Lanka was initially very positive. Various government agencies were all supportive, and the existence of a national policy for water and sanitation, including provision of hygiene education and sanitation promotion, provides a clear focus and legitimacy for the work in the sector. As such many of the so-called “enablers” in a political sense are in place.

The community education appeared to be reasonably successful in the first batch communities. Many environmental improvements were seen in the villages, including household compost piles and rubbish tips, water storage and cleanliness of kitchens. In addition, many communities appeared to be very active in terms of raising funds, with many members already contributing to CBO bank accounts.

However, concerns remain regarding the sustainability of the work. The success seen in the villages all came during or immediately after the training, and before construction of
latrines or water supply schemes. The time lag between the education and the use of the facilities is significant, and raises the possibility that the impact of the training will not last until the schemes are finally constructed.

Although plenty of data has been collected in each PS this data is not thought reliable and does not give much information as to people’s current behaviour. The monitoring of the impact of the project is also questionable, as indicated above. Greater focus is needed on developing a simple methodology for gathering baseline data and for subsequent progress monitoring against this baseline.

**Lesson 4:** Despite the existence of a good water and sanitation policy, the lack of co-ordination between ministries, the lack of financial resources allocated to HSP and the lack of capacity at the local implementation level mean that the 2CWSSP has not been implemented other than to construct water supply hardware. CBOs were effectively formed to meet the needs of the project and were under-trained particularly on the data collection and HSP aspects.

### 5.6 Relative Success of Hygiene and Sanitation Promotion in Sri Lanka

Sri Lanka has shown a tremendous increase in usage of sanitation facilities over the past 10 to 15 years. A study was undertaken to attempt to understand why this might be the case and what key factors make rural communities receptive to HSP messages. The study was carried out by conducting semi-structured interviews/discussions with more than 25 selected practitioners involved in development work throughout the country. The following factors were identified as being key to the relative success of HSP in Sri Lanka:

- National policies;
- Increased literacy rates;
- The education system;
- Use of mass media;
- Public awareness campaigns;
- Community development;
- Government health structure;
- Increased number of hospitals and clinics;
- Compulsory clinic attendance for pregnant and lactating mothers
- Investment in development projects, and
- Long term approach to behaviour change

All participants agreed that the long term raising of public awareness of hygienic behaviour over many years was probably the most important reason for relative success. Simple messages repeated at school, by health workers and through mass media have created a broadly accepting environment.

Although all participants agreed that hygiene and sanitation practice in Sri Lanka has improved during the past 20 years, it was noted that improvement is not the same throughout the country, with the war zone having seen the lowest level of improvement. Amongst the causes of this were lower levels of investment in health, education and utilities, lower importance given to hygiene messages and probably less access to mass media forms of promotion.

**Lesson 5:** Long term effort on hygiene promotion was seen by many Sri Lankan practitioners as the most significant reason for relative success of sanitation in Sri Lanka. There has been some liaison between various ministries responsible for education, health and water supply to allow generally consistent messages to be passed over a long period to create an environment broadly accepting of the need to improve hygienic behaviours.
5.7 Summary

In summary we consider the following to be lessons worthy of note:

- Having a national policy on water supply and sanitation is a good step forward, but implementation and general acceptance of the policy and its implications takes a considerable time and needs all stakeholders to reach some form of consensus.

- Having a strong looking national policy does not necessarily translate into action on the ground if there is inadequate pressure from Government to institutionalise the policy requirements. Again this may be a weakness in Sri Lanka due to the relatively short time since the policy has been published.

- Baseline data collection needs to seek to understand constraints to and opportunities for development in the communities, and should collect information so as to both inform the design of the community level work but also to set M&E parameters that can be measured as the HSP campaign seeks to modify behaviour.

- Baseline collection is also a stage in local advocacy of behaviour change and as such should be facilitated by trained interviewers.

- Timing of HSP campaign is important – the proposed “single shot” method during the design of the water supply systems is unlikely to modify behaviours sustainably. Some longer term intervention, as suggested by some of the participants in the communities, seems more likely to instil long term change.

- Lack of HSP resources means that there was apparently no money available either for follow up visits nor for community level messages such as sign boards, stickers, calendars and the like to reinforce hygienic behaviours.

- The apparent reluctance of Government to commit scarce resources to HSP may be as a result of the view that there is no strong proven case for a specific level of input resulting in an expected improvement in health or economic development. Possibly a grant based approach to HSP may be appropriate until a demonstrable case is available.

- The decentralised approach proposed in Sri Lanka was good in principle but lack of capacity at the lower administrative levels meant that some of the local responsibilities were retained at a higher level. There is nothing wrong with this apart from a lack of clarity early on that such capacity weakness exists.

- The project was rather prescriptive about the type of latrine that was acceptable (VIP) whereas preferences for other types, such as water seal with offset pit, were noted.

- There was no clarity about whether schools would be supported to procure effective sanitation, which could undermine the hygiene messages which were to be delivered through school.
6 Specific Lessons Learned: Ethiopia

6.1 Introduction

The Rural Water Supply, Sanitation and Hygiene Program in Ethiopia is the rural portion of a classic large national World Bank supported ‘WASH’ program, covering many towns and villages in every region in Ethiopia, and managed by the Ministry of Water Resources. Like many other programs of its kind, (the rural portion anyway) had virtually no concept or detailed budget for hygiene and sanitation. This is typical for Ethiopia (and many other countries) where programs are managed by the Ministry of Water Resources.

The State of the Art team has attempted to redress the balance by emphasising the importance of sanitation and hygiene. The team has had some success in this as demonstrated by the comment from a Regional PCU staff member that, “Water is important too!” Despite these efforts, staff of the Ministry and consultants hired show in their behaviour and attitudes a (perhaps unconscious) belief that sanitation and hygiene are too difficult to do and not worth investing resources in.

6.2 Significance of HSP to RWSSP Success

There is a huge economic argument to be made for the provision of safe water, in terms of time and energy savings and for water quality improvements particularly for those suffering from HIV/AIDS. However, there is an even greater economic argument for hygiene and sanitation improvements in terms of health, nutrition and food security as well as physical security and human dignity and academic achievement particularly for girls. Many key people were not aware of the importance of sanitation and hygiene, nor what they can do to improve the situation. The State of the Art team were able to identify data for use in advocacy on sanitation and hygiene for use by the Ministry of Health as well by the Regional Bureaus of Health, and other programme staff (including WSGs, WWTs and CFTs). A draft Advocacy Document was produced and shared in the July 2005 trainings.

Lesson 1: The emphasis of this program is still WATER only. This is not a WASH program where sanitation and hygiene are given equal priority with water. Sanitation and hygiene still need to be elevated to the importance of water.

6.3 Need for more detail regarding HSP Interventions

Typical of many programs and projects, RWSSHP was very specific about water interventions but vague about hygiene and sanitation. The State of the Art team were able to define and achieve agreement on the details of the hygiene and sanitation components, specifically through the:

- Minimum package for sanitation
- WASH Volunteers, two per 14 households, (male and female) to undertake household visits for the promotion and monitoring of sanitation and hygiene at grass-roots level
- WASH Motivator, the household monitoring tool for use by illiterate WASH Volunteers as the basis for monitoring of the whole program, on individual hygiene and sanitation behaviors as well as gender roles for water, sanitation and hygiene related tasks.
The need to be specific about hygiene and sanitation identified a number of gaps in knowledge and practice:

- It remains to be seen whether the traditional latrine options selected for sanitation promotion can be sustained, i.e. whether poor households will be able to construct simple pit latrines out of locally available materials, and whether they last for a year or more.
- A Minimum Sanitation Package for Schools and Health Facilities was developed at the end of the July 2005 mission. This was used in the first CFT training, but was not shared and finalised officially. Similarly, the role of the Regional Bureaus of Health in the program has been discussed but not finalised.
- Other possible opportunities for sanitation and hygiene promotion were identified such as contributions to the school curricula (during revision process), mass media - particularly the use of radio soap opera for promotion of hygiene and sanitation, and links with other partners already involved, e.g. the National WASH Campaigns. Some of which are being followed up. If there had there been a specific budget for hygiene and sanitation, then more could have been done to develop these ideas. Without this budget, the program is not ‘State of the Art’ in hygiene or in sanitation.

### Lesson 2: The hygiene and sanitation component needs to be detailed in the initial design phase at household, community and administrative levels. The household visits, community volunteers (WASH Volunteers) to make the visits, and the mass media follow up that would support this grass-roots activity has not been planned in advance and budgeted. Similarly, the administrative support to make sure that all this happens has not been planned, negotiated, and budgeted.

**All aspects of roles and responsibilities need to be defined and agreed upon; to the same degree as for water supply.**

### 6.4 Cross functional liaison

The Ministry of Health’s Health Extension Worker Program and other initiatives within the Ministry of Health, and positive examples of prioritizing hygiene and sanitation within government (e.g. SNNPR and Amhara) mutually support each other and together provide a climate for positive change in hygiene and sanitation. What is needed is commitment by Government departments at different levels, plus commitment at the grass-roots level. With interest only at the grass-roots level, nothing much happens. With commitment by the government but none at grass-roots level, the result can be coercion, latrines that are not sustainable, and reversion to poor hygiene behaviors in a short time.

**Lesson 3: Hygiene behaviour change does not happen in a vacuum. Mutual support of other related initiatives is important.**

### 6.5 Need for national and regional consultation

The State of the Art team was involved in many consultations in Addis Ababa and in the Regions as part of the development of the State of the Art Hygiene and Sanitation Strategy. The Ministry of Health is currently investing heavily in national consultations with a wide range of stakeholders.

Despite this interest and activity in hygiene and sanitation, the State of the Art team has experienced difficulties in maintaining momentum between visits to Ethiopia. Few Ethiopians are able to critically review documents sent by email, perhaps because they lack the skills or do not have adequate internet or computer facilities or lack incentive.
Lesson 4: Active consultations on a national strategy involving a wide range of stakeholders are an important contribution but communication skills and time to reach consensus are also key elements.

6.6 Training as part of advocacy and the policy debate

The State of the Art team were able to make significant inputs to the training of staff at various levels including WSG, CFT and WASHCO training manuals, guidelines, and training sessions. This included training the groups on the importance of WASH, the Minimum Sanitation Package, WASH Volunteers and the WASH Motivator concept, Advocacy, and the use of a limited number of participatory hygiene tools.

The State of the Art team were able to identify the Women Development Unit within the Ministry of Water Resources and to get them involved in the Program. This started with their participation in the WSG Trainings. This is a first step in institutionalising their involvement in the program.

The imminent timing of the RWSSHP WSG training provided pressure to quickly reach consensus on the minimum sanitation package and other details of the sanitation and hygiene components, and provided an opportunity to get additional stakeholders involved.

Lesson 5: The RWSSHP training workshops provided opportunities to focus attention on hygiene and sanitation, propagate ideas widely, and make decisions quickly.

6.7 Obtaining cooperation requires communication and may require budget support

Inadequate conceptualisation and insufficient detail about the sanitation and hygiene aspects of the program, and no budget allocation for Regional Bureaus of Health has led to a communication problem between Health and Water staff at various levels, most seriously at the regional level where health staff were excluded and excluded themselves from the program despite their responsibilities in the sector. The State of the Art team helped to build relationships between Regional Bureau of Health (RBoH) staff and their counterparts in the Regional Bureaus of Water (RBoWs) through negotiations and invitations to program trainings.

Lesson 6: Involvement of the Ministry of Health/RBoHs at all levels must be identified, defined, agreed and maintained throughout the life of the program. The Ministry of Health/RBoHs must be an equal partner with the Ministry of Water Resources/RBoWs and have an appropriate share of the budget.

6.8 Messages and delivery take time to get right

Many projects say that they use participatory hygiene promotion tools but very few actually do, and the only agency found with experience and a set of tools was the Red Cross. The full set of participatory hygiene promotion tools promoted under PHAST contains too many tools. In addition, many of the pictures and tools that have been developed in Ethiopia and elsewhere are not fully appropriate for Ethiopia. UNICEF Ethiopia is currently developing a set of tools with the Ministry of Health and RBoHs but these are for wider health issues and not just for water, hygiene and sanitation. It is expensive to produce tools in sufficient numbers to reach every household within a national project. A minimum basic package of appropriate pictures is needed.
The State of the Art team identified the following tools as very useful: WASH Walk including feces calculation, Mapping, FGD, Sanitation Ladder, 5-F’s Diagram, 3-Pile sorting, Demonstration (making a Tippy-tap). Using the behavior change objectives developed under the State of the Art Strategy, pictures for the Sanitation ladder, 5-F’s diagram, 3 pile sorting and making a Tippy-tap were selected from a number of pictures developed for other programs and projects (particularly pictures developed by UNICEF Ethiopia, WaterAid, and the Ministry of Health Environmental Hygiene and Sanitation Department). All of the tools were demonstrated and used during the WSG trainings. A **participatory toolkit** including simple instructions and a set of pictures was provided to each WSG and to each RBoH.

**Lesson 7:** A small number of well-selected hygiene promotion tools need to be developed and produced in large numbers for use at scale in a national program. The time it takes to obtain the appropriate pictures and to negotiate and agree the final tools with relevant stakeholders should not be underestimated.
7 References

7.1 Manuals


7.2 Other Useful Materials


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