Guidelines for Urban Hygiene Promotion

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Preface

Infectious diseases claim a lot of lives and cause many serious disabilities, some of which can be permanent, such as blindness. Eighty percent of the incidence of these diseases is related to inadequate water supply, sanitation and poor hygiene. The promotion of better hygiene, alone, or in combination with better water supply and/or sanitation, can have a major impact on reducing disease prevalence and public and private health costs.

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.

This manual presents guidelines which are meant for WASH professionals who intend to implement Hygiene promotion activities in urban areas. It has been noted that various Hygiene promotion strategies are being employed by different organizations using different approaches and this has resulted in compromised quality and standard, mis-coordination and poor linkages of hygiene promotion techniques. This guide comes as an answer to the poor coordination as it provides standards of what issues should be considered during hygiene promotion in an urban set up.

These guidelines are based on the experiences of the various civic organizations, government and local CBOs in hygiene promotion. It is produced for all professionals interested in the area of hygiene promotion.

Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBM	Community Based Management
CBO	Community Based Organisations
CHAST	Children Hygiene and Sanitation Transformation
CHC	Community Health Club
DDF	District Development Fund
DPP	Department of Physical Planning
ICT	Information Communication Technology
IEC	Information Education and Communication Materials
IWSD	Institute of Water and Sanitation Development
MDGs	Millennium Development Goals
NGO	Non-governmental organisation
PHHE	Participatory Health and Hygiene Education
PWD	Public Works Department
SHC	School Health Club
UN	United Nations
UNICEF	United Nations Children's Education Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

1.0 Introduction

Water and sanitation are essential to life, health, livelihood and dignity and are basic human rights. Universal Declaration of Human Rights, 1948, Article 25 states that: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and his family".* Indeed, water is a food in its own right without which humans can survive normally not more than 3 to 5 days. Timely and adequate provision of clean water to communities is of special importance given that they have traditionally faced difficulties in fully exercising their rights and are very prone to exploitation (Shrestha and Cronin, 2006). Of equal importance is the provision of adequate sanitation and this includes excreta disposal, management of solid waste, proper medical waste disposal, control of waste water and drainage and also control of vectors of communicable diseases including mosquitoes, rats, mice and flies. In addition, any water and sanitation program **in isolation of proper hygiene promotion and implementation will not be effective in preventing diseases and deaths, and resulting suffering among the affected population**.

1.1 Why Hygiene promotion?

Hygiene is central to both water and sanitation interventions. It is possible to implement a water programme without a sanitation component and to implement a sanitation programme without a water component but both would require hygiene for maximum benefits. In urban areas, efforts should be made to also address water and sanitation challenges whilst implementing a hygiene promotion intervention.

Zimbabwe is among the countries that agreed to meet the eight international time bound Millennium Development goals by 2015. Among these goals is the goal on environmental sustainability whose targets include:

- *Reducing by half the proportion of people without access to safe sanitation by 2015.*
- *Reducing by half the proportion of people who do not have access to water of sufficient quality and quantity.*

Water, sanitation and hygiene are closely related and one cannot mention safe sanitation without including the issue of hygiene and on the other hand one cannot mention the issue of water quality without mentioning hygiene. During the formulation of the Millennium Development Goals, there was no specific mention of hygiene though it was implied in the safe water and safe sanitation. Because it has not been mentioned explicitly though critical, it has not been given priority by the national governments.

In Zimbabwe, the water and sanitation situation started to deteriorate from the year 2000. The general economic decline buttressed by hyperinflation led to serious challenges in urban local authorities. The water and sanitation infrastructure is now too old and in need of either replacement or extensive rehabilitation.

The urban areas have always had access to safe water and sanitation due to the nature of By-laws that require a connection to the system before a house can be approved as habitable. However there are now some challenges associated with urban areas which call for the need of good hygienic practices. Some of these challenges are as follows;

- Due to frequent water cuts residents are now storing water in containers bringing the aspect of compromised water quality during transportation, storage and final use.
- Due to lack of access to water, residents use other sources of water when their household supply is closed e.g. boreholes, shallow wells[1]
- Those who are Internally displaced and homeless for example street men and women and street kids, often use water from all sorts of sources that may not be safe
- Most of the times latrines are not functional due to consistent water shortages in urban areas thus there is need for hygiene awareness.eg education on Cat sanitation or safe disposal means.
- Again those without access to sanitation such as homeless need better understanding of alternatives[2] so as to avoid open defecation.
- The changed economic situation where there is affordability and imported goods has brought the issue of solid waste to the fore. An example is the use of pampers and their disposal. Solid waste is becoming an eye sore hence the need for improved hygiene and solid waste management.
- Also due to the economic challenges the drainages are often not working and when it rains we have stagnant water which lead to the of creation of breeding sites for parasites such as mosquitoes resulting in water washed diseases such malaria and other diseases.

It is important to note that building latrines in a community and providing access to reliable and safe water supplies is desirable, but will not be sufficient to prevent the occurrence of diarrhoea. Equally, rehabilitating urban water and sanitation infrastructure without combining it with hygiene promotion and the related capacity development will not yield maximum benefits. It must be combined with hygiene promotion which is designed to encourage the changes in people's patterns of personal behaviour which are necessary in order to block the faecal-oral transmission route and reduce the spread of disease.

A combination of the above puts the population at risk of contracting diarrhoeal diseases due to the compromised hygiene. This sad state of affairs culminated in the cholera outbreak of 2008/2009 which resulted in the loss of life of over 4000 people. Also there was an outbreak of Typhoid in some urban areas in Zimbabwe (Harare, Chitungwiza, and Bindura among others). This situation is a reflection of poor hygiene that is now prevalent in urban areas of Zimbabwe.

In an effort to respond to the emerging challenges, stakeholders have embarked on hygiene promotion programmes in urban areas but there are no clear guidelines in place to guide institutions and as a result different approaches and strategies are being used, some them conflicting in some cases. It is against this background that these urban hygiene guidelines were developed in an effort to give direction to the stakeholders spearheading the process.

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[1] Some of these shallow wells are unprotected which is a potential health risk for example those found in peri-urban settlements of Epworth and Hattcliff extension

[2] Better understanding here implies that during those times when the municipality closes access to their toilets after hours, one should be able to resort to safe sanitation practices rather than practicing open defecation.

Urban water must generally take into account the issues of access, quality and quantity and urban sanitation must take into account the issues of excreta disposal, solid waste disposal, vector control, wastewater management, disposal of dead bodies and, crucially, hygiene promotion across all of the Water and Sanitation issues.

After the realisation of the above challenges, some countries have since signed declarations committing themselves to improved sanitation and Hygiene for example the Ethikwini Declaration which was signed in 2008 during the celebrations of the International year of Sanitation.

2.0   Definitions

2.1 Common terms in Hygiene Promotion

Since Water, Sanitation and Hygiene are closely linked and work hand in hand, it is important to define some of the basic terms used in hygiene promotion.

❖ *Hygiene promotion* implies education, awareness participation in identification of risks and in taking action to avert the risks. It can include but is not limited to: community level and mass media hygiene promotion adapted to the local context and culture, focusing on a limited number of key messages to improve health e.g. safe handling and storage of waste, hand washing at key times and the use of latrines. It can also be defined as to raise or advance a cause, raise the profile and status of the cause, further the growth and expansion of the cause and to further its popularity.

❖ *Sanitation*: interventions to reduce people's exposure to diseases by providing a clean environment in which to live; measure to break the cycle of disease. This is usually includes disposing of or hygienic management of human and animal excreta, refuse and wastewater, the control of vectors and the provision of washing facilities for personal and domestic hygiene. Sanitation involved both behavior and facilities which work together to form a hygienic environment

❖ *Improved sanitation*: one that hygienically separates human excreta from human contact. The following Joint Monitoring Programme WHO-UNICEF classification is used to differentiate improved from unimproved sanitation facilities:

Improved sanitation facilities
   ➢ Flush or pour-flush to:
      - piped sewer system
      - septic tank
      - pit latrine
   ➢ Ventilated improved pit latrine
   ➢ Pit latrine with slab
   ➢ Composting toilet

Unimproved sanitation facilities

- Flush or pour-flush to elsewhere (other than piped sewer system, septic tank or pit latrine)
- Pit latrine without slab or open pit
- Bucket
- Hanging toilet or hanging latrine
- No facilities or bush or field (open defecation)

❖ **Improved water sources**: one that accessible and provides safe water supplies.
Improved water sources:
- Piped water in a dwelling, plot or yard
- Public tap or standpipe
- Tube well or borehole
- Protected dug well
- Protected spring
- Rainwater collection

Unimproved drinking water sources:
- Unprotected dug well
- Unprotected spring
- Cart with small tank or drum
- bottled water*
- Tanker truck
- Surface water (river, dam ,pond, stream, canal, irrigation channels)

Participatory approaches:

These are methods designed to enhance participation through meaningful decision making, planning, implementation, and monitoring and evaluation of activities. Participatory approaches are sensitive to existing situations. They draw answers out of communities rather than attempting to impose preconceived solutions. Examples include Participatory Rural Appraisal, Children Hygiene and Sanitation Transformation (CHAST), Participatory Health and Hygiene Education (PHHE).

PHHE

Participatory Health and Hygiene Education (PHHE) is a process that aims to promote conditions and practices that help to prevent water and sanitation related diseases. The PHHE approach seeks to facilitate a change in health and hygiene education approaches from a didactic technical model to a participatory social model. PHHE helps people to develop the outlook, the competence, the self confidence and commitment that will ensure a sustainable and responsible community effort towards their overall development including the control and management of communicable diseases.

Community health club Approach: This is an approach used for hygiene promotion interventions which is divided into four stages; Health Promotion, Water and Sanitation, Sustainable Livelihoods, Social Capital. The underlying concept of CHC is that a lack of "common-unity" within communities causes a deficit of development and by increasing the social capital within these areas and empowering its residents by promoting self-efficacy, sustainable development can be achieved.

School health clubs;
- School Health Clubs (SHC) are groups of school children attending weekly PHHE sessions facilitated by a PHHE trained school teacher at their school.
- This is a club just like any other school clubs like the drama, music, debate to name a few.
- School health Clubs idea was muted on the premise that children can influence each other to adopt positive health seeking behaviour within the school and also that they can influence change in the home as they can help spread health information back home. If they are caught young their behaviour becomes health seeking and their future is secured as they are open to new ideas which they can easily adopt as compared to adults who are a bit difficult to change as they have set habits and attitudes stemming from long experience.

2.2 Defining an Urban Community

It is important to define the characteristics of an urban community as it differs a lot from a rural community. The unique characteristics will influence the strategies that will be used for hygiene promotion. The following are some of the features of an urban community.

Features of an urban society
- An urban society is heterogeneous and well known for its diversity and complexity.
- Formal means of social control such as law, legislation, police, and court are needed in addition to the informal means for regulating the behavior of the people.
- The urban society is mobile and open. It provides more chances for social mobility. The status is achieved than ascribed.
- Occupations are more specialized. There is widespread division of labor and specialization opportunities for pursuing occupations are numerous.
- Family is said to be unstable. More than the family individual is given importance. Joint families are comparatively less in number.
- People are more class -conscious and progressive .They welcome changes. They are exposed to the modern developments in the fields of science and technology.
- Urban community is a complex multi-group society.
- The urban community replaced consensus by dissensus. The social organization is atomistic and ill-defined. Mass education is widespread in the city increasing democratization of the organizations and institutions demand formal education.
- Urbanites prioritize searching for money hence they are always away from the household
- Most of them highly literate being influenced by ICT

3.0   Contextual Factors to consider in implementing Hygiene Promotion
Below are some of the issues to consider when implementing hygiene promotion programmes in urban areas based on the experiences of the Institute of Water and Sanitation Development and other development partners who have or are implementing programmes in urban areas.

Availability of Water and Sanitation Facilities

– The most obvious enabling condition for personal hygiene is the <u>availability of water and sanitation facilities</u>. However, for <u>behavioral change</u> to occur and be sustained there is a need to continue <u>hygiene promotion</u> <u>until the new behavior has become entrenched. Water and sanitation facilities on their own do not result in improved health. Access to improved facilities is crucial, but correct use of water and sanitation facilities is what leads to a reduction in diseases. Correct use requires personal, community and institutional actions and actions depend on behaviors</u>

The UNICEF Hygiene improvement framework is illustrated below:

Target the Five Behavioral Domains
(Boot and Cairncross, 1993)
- Disposal of human faeces
- Use and protection of water sources
- Water and personal hygiene
- Food hygiene
- Domestic and environmental hygiene

Generate political will
Hygiene promotion activities cannot be implemented in urban areas without the full involvement of the local authorities and other relevant political institutions. They need to be fully involved in all phases of the hygiene intervention programs, from initiation, planning, implementation, monitoring and evaluation. It is important to get buy-in from the highest office i.e. the Executive Mayor and the Council Executives. In addition, Councilors who are the politicians need to be involved as these play a very critical role in community mobilization. Communities are more motivated to change when they know political will exits.
There is also need to build political support through;
- Identifying high level allies
- Holding effective national level meetings to legitimize programming work and develop policy.

- Linking hygiene programming to international movements- politicians may feel more comfortable supporting hygiene promotion activities if they feel that it is part of an internationally mandated movement e.g. the MDGs.
- Ring fence some money for hygiene promotion separate from infrastructure development.
- Setting out of targets and expected outcomes so that these can be measured.

Give Hygiene Promotion its Priority
- From an implementation point of view, hygiene promotion should be treated as a priority issue on its own right and not simply as an add-on to more attractive water supply and sanitation programmes.
- Local Authorities who are the custodians of water, sanitation and hygiene in urban areas, should make budgetary promotions for hygiene promotion.
- The gap between curative and preventative should be minimized.
- Hygiene promotion requires its own resources, its timeframe to achieve optimal results.
- Use the rights based approaches to hygiene promotion which are anchored on PANEL principles. These are participation of all stakeholders, accountability of householders and local authorities, non discrimination where sometimes focus is only on women leaving men and children, empowerment and equity where the outcome should be a community able to identify their risks and take action, linkages with other UN and national framework and development agendas.

Recognition of the Government Role
The Government should create an enabling environment by developing WASH policies that facilitate and enhance partnership among the private sector, NGOs, community-based organizations and local authorities in achieving improved hygiene. Hygiene promotion should be viewed as a partnership process that should include all the relevant stakeholders for effectiveness. In this instance there is need to link to the national hygiene and sanitation strategy and policy[3].

Be Gender Sensitive
Hygiene promotion programmes should equally address the needs, preferences and behaviours of children, women and men. The interventions should take a gender sensitive approach but should guard against directing messages only to women or placing the burden of improved hygiene primarily upon women. A one size fits all approach does not work. It is important to device strategies that will separately engage children, women and men in identifying their hygiene related problems and developing appropriate methods to deal with them.

Consider the Marginalized groups

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[3] The policy is still under development but will be an operational document once completed. The Sanitation and Hygiene Strategy puts in place key measures for sustained sanitation and hygiene service delivery in Zimbabwe. The Strategy defines the existing challenges that have impeded on progress and in some instances contributed to reversal of gains. The Strategy is intended for policy makers, practitioners, implementers and development partners in the WASH sector.

There is need to focus on excluded groups that do not have access to services and draw in a range of non-conventional partners who may be better able to serve them than the traditional utilities. Those staying in informal settlements are normally excluded as they are perceived to be illegal. However, diseases do not respect borders and it is these areas which are normally the source of transmission due to shortage of clean water, unsafe sanitation and poor hygiene. Furthermore there are the homeless, internally displaced groups who probably need hygiene awareness more as they leave in environments where they are susceptible to diseases.

Build on existing practices
Hygiene promotion should be addressed incrementally, based on local beliefs and practices and should work towards small lasting improvements that are sustainable at each step, rather than wholesale introduction of new systems.

Involve the Residents
Hygiene promotion in urban areas should involve the residents as individual households, collectively as a community and should also work with residents associations for effectiveness. The hygiene strategies should be targeted at addressing the real problems within a particular residential area. The residents should make decisions on the hygiene standards they want and should be part of the solutions. For effectiveness, local community groups can be formed to spearhead the hygiene interventions (through for example the formation of community health clubs).

Avoid Creating Dependency
In order to avoid creating a dependency syndrome in hygiene promotion programmes, beneficiaries must be involved in planning, consultation, decision making and responsibility sharing. Such early community participation will consequently help to mainstream the hygiene promotion programme during the care and maintenance phase and promote community ownership of the process.

Prioritize high-risk behaviours
Hygiene promotion interventions should target high risk behaviours as these have the greatest impact in minimizing the hygiene challenges being faced by the community/residents.

Start Small
It is important to work in a limited geographical area initially so as to develop new ideas and build local capacity before scaling up to a national level programme. The key idea is to keep the process as simple as possible while at the same time ensuring the real participation of the key actors at the lowest (most local) level possible.

Develop the Capacity of Stakeholders
Capacity development is central to any hygiene promotion interventions. The stakeholders ranging from government, local authority, NGOs, civil society organizations, residents associations, households and the community at large require to be capacitated so that they can understand the problems better, understand their roles and responsibilities and understand the delivery strategies.

Choose the right communication Channels
Communities are not homogenous. They differ from one area to another within same city and from one city to another. It is therefore important to select the most effective media that is appropriate to the area in question. The media can be a very effective vehicle for hygiene promotion. Efforts should be made to get the media interested in hygiene activities and motivate journalists and reporters to write about it in newspapers, talk about it on radio and television.

Use Participatory Techniques for Hygiene promotion
Strategies for hygiene promotion should be participatory to enable the intended beneficiaries to identify their problems and the related causes, and to recommend appropriate actions. It is therefore necessary to develop appropriate participatory tools suitable for use within an urban context.

Use a mixture of promotional techniques and methods
These may include the use of indigenous media (such as employing dance/drama), use of more traditional communication channels (lectures, activities at church and voluntary level, poster campaigns, radio/television broadcasts. Other innovative methods may include distribution of T-shirts, caps and other promotional clothing to publicize the programme.

Technical and cultural issues
This has two dimensions; the physical conditions which determine what technologies might work and the expectations of consumers. Technology choice may be constrained by factors such as availability of water and congestions which determine the availability and location of space for treatment facilities. Consumer expectations affect technology choice in countries which already have high levels of coverage with flush toilets and sewers, households may aspire to advance systems and be willing to cover some at least of the cost. The probable technological choice to be made will influence decisions about how to organize the hygiene promotion programme processes because it will determine what types of organizations which need to be heavily involved.

Resources
The availability and structure of finances is important because it determines who should be involved in decision making. In localities without adequate financial resources of their own potential funding partners need to be involved as early as possible to ensure that they too have ownership of the ideas and approaches in the programme.

The need to set standards and Benchmarks
Set hygiene standards that you wish to attain and also set a monitoring, benchmarking framework. In some cases, it is recommended to start with a baseline survey which should reveal all the critical water, sanitation and hygiene related challenges. This will form the basis for monitoring and evaluating efficiency and effectiveness of the hygiene promotion programme.

Private Sector Involvement

- Most of the solid waste generated in urban areas comes from the private sector. It is therefore critical to work with the private sector for example on reuse, banning of plastics, banning of cans etc which will help improve environmental hygiene. It is generally accepted that the private sector is part of the problem and they should be part of the solution. Private Industry is very successful at changing behavior and its survival may depend on it. Soap manufacturing companies have got soap into almost every household in the world. They can thus be useful partners in promoting hand washing.

4.0   Practical Tips on Urban Hygiene Promotion

4.1   Getting the balance right

An important factor in your choice of sample size is the scale of your proposed programme. There would be little point in spending so much time and using up so many resources in formative research that nothing was left for the intervention. But skimping the formative research could lead to costly mistakes, wasted effort and demoralization for all concerned. What is the proper balance between the two? Spending around 15% of programme resources on getting the programme set up properly at the beginning is well worth while.

4.2   Tips for team building

- Involve the whole team in planning and decision-making and make it clear that their contributions are valued.
- Hold regular team meetings to air problems, share solutions and hold social events to boost morale.
- Choose staff with experience of extension work, who are interested in hygiene, and who speak the local language(s).
- Ensure that contracts and financial arrangements are clear, understood and agreed by all parties from the beginning. Review any problems promptly.
- Stick a weekly planning calendar on the wall, so that everybody knows what everybody else is doing, including team leaders.
- Involve the whole team in piloting the formative research and revising the formats and guides that you will use.
- Allow a long lead-in period to train staff and pilot and develop the formats and guides.
- Harmonize approaches by pairing up staff so they can learn from each other. Settle on an agreed introduction in households, so that everybody explains what they are doing in the same way.
- Regular, frequent supervision assures quality and punctuality. Even one field worker who cheats can ruin the whole investigation, so tackle any suspected problems rapidly and seriously.
- Review data as it comes in from the field. Don't make corrections in the office, but go back to households.
- If you are using a computer to enter data, check on the quality of data entry regularly.
- Hold team think-tank sessions to review findings and develop ideas about the key questions.
- Early results guide the later work.

5.0   Myths on Hygiene education

1. *People are empty vessels into which new ideas can simply be poured*-Hygiene Education rarely starts with what people already know. Every society already has coherent explanations for disease (which may or may not include microbes). If we try to pour new wine into these already full vessels then, the new wine will just spill over. The new ideas create confusion and incomprehension. Some people even reject the new teachings saying: "these doctors just don't understand what makes my child sick!"

2. *People will listen to me because I'm medically trained*- Hygiene Education often assumes that health personnel are automatically believed and respected. This is often untrue in both developed and developing countries. There is no reason why the outsider with the foreign ideas should be given higher credence than tried and tested local explanations of disease. And a health worker who is thought to be saying "it's your fault your kids get sick and die, it's because you are dirty" will gain little respect from the community (Nations).

3. *People learn germ theory in a few health centre sessions*- Everybody likes to learn, but how responsive would you be if you were worrying about a sick child in a clinic waiting room? Even in the best of circumstances, replacing old ideas about disease with new ones is a long, slow process.

4. *Health education can reach large populations* - Major improvements in public health require interventions that cover large populations, like vaccination or AIDS prevention programmes. But is it practical to give health education classes about the germ theory of disease to all the child carers in a region? Let's take an example; say we want to educate the mothers of one province about the role of microbes in diarrhoeal diseases. The population is 800,000 people, there are 200,000 mothers, each of whom need to attend a minimum of three group sessions. If one educator can carry out three sessions per day, 100 educators will be required working flat out for a year. Few health programmes would find this practicable.

5. *New ideas replace old ideas*- Most people hold a variety of ideas about the origins of disease in their heads at the same time. Folk models of illness co-exist with medical models in all countries of the world, and few people anywhere explain child diarrhoea by lapses in stool hygiene. Hygiene education often just adds one more idea about disease without erasing the old ones.

6. *Knowing means doing*- Even if we could convince large populations that germs spread by poor hygiene cause disease, would this mean that they would change their practices overnight? Though knowing about disease may help, new practices may be too difficult, too expensive, take too much time, or be opposed by other people. Fear of disease is not a constant preoccupation and is often not a good motivator of behaviour change.
(These myths are adapted from the useful booklet by Van Wijk & Murre.) The best health education practice does not make all these mistakes.

6.0   Legislative Framework

The principal legislation governing the water and sanitation sector includes the following;
1. The Water Act.
2. The Communal Lands Act.
3. The Public Health Act
4. The Provincial Councils and Administration Act.
5. The Environmental Management Act.
6. The local authorities acts (Urban Councils Act, Rural District Councils Act)
7. The Regional, Town and Country Planning Acts;
8. The Traditional Leaders Act.
9. The Burial Act.
10. The District Development Fund Act

The Water Act (Chap 20:24) vests water in the President as read in conjunction with the legislation governing the existence and work of local authorities in Zimbabwe. No person owns any water and no water can be stored, abstracted, apportioned, controlled, and/or diverted except in accordance with these pieces of legislation.

The **Water Act** obliges the Minister responsible for water as the national water services authority to:
▪ Develop policies for guiding the orderly and integrated planning of the resource i.e. facilitating optimum development, utilization and protection of the country's water resources in the national interest.
▪ Ensure the availability of water to all citizens for primary purposes.
▪ Ensure the equitable and efficient allocation of the available water resources in the national interest for the development of the rural, urban, industrial, mining and agricultural sectors.

The District Development Fund (DDF), established in terms of section 3 of the repealed African Development Fund Act (Chapter 232) has the responsibility for the development of Communal and development areas.

The Act obliges the Minister responsible for local government to:
▪ Declare, in consultation with the Minister responsible for Agriculture, any rural area as in need of development by the Fund.

In this regard, DDF has the mandate to provide and maintain such services as water, roads, bridges etc to such development areas as defined by the Act.

The local government legislation accords local water services authority and water provider status to urban and rural district councils. Further information on water provider status is presented in paragraph 4.5. The Minister responsible for local government is obligated to ensure that:
▪ Local Authorities fulfill their functions in respect of matters listed in the Schedules of each Act that is, ensuring that the public has access to potable water supply systems as well as domestic wastewater and sewage disposal systems.
▪ Local Authorities have the necessary capacity to fulfill these roles/functions.

The country's **Sanitation** provision and standards are managed through the Public Health Act. The operations of the Public Health Act are also read in conjunction with the relevant local government acts. However, sanitation standards have not been effectively enforced in both rural and rural areas.

The provision of access to water and sanitation services is thus a functional area of **concurrent national and local authority legislative competence.** The Ministries responsible for Water, Health and Local Government thus have the roles of supporting and strengthening local government capacity to deliver the services, and of regulating such performance. The two levels (national and local government), with the support of the provincial administration, have a real responsibility and obligation to see to the progressive realisation of citizen rights to basic water supply and sanitation.

6.1 The role of Local Government

The **primary responsibility** for water and sanitation services provision rests with local authorities. This is provided for in terms of the Urban and Rural District Councils Acts, not the Water Act or the Public Health Act.

The local authorities in terms of the Urban and Rural District Councils Acts have the following primary responsibilities;

*1. **Ensuring the progressive realization of the right to access** to basic water and sanitation services. Local authorities will do this through providing financial, informational, technical and other forms of support to communities and other agencies to facilitate affordable, acceptable and sustainable service provision. Local government shall also be directly responsible for actual service provision in addition to facilitating provision by other agencies (public, private or voluntary).*

*2. **Preparing development plans** that integrate water and sanitation service provision as a key priority woven into other activities/priorities. The local authority has an added responsibility of enabling other agencies to develop and execute plans reflecting people's needs.*

*3. **Regulating** service provision in the public interest and pursuant to maintenance of minimum standards. Regulation covers local authority provided services and those facilitated by service providers.*

*4. **Communication and capacity building** as it relates to consumer awareness, information provision, CBM, health and hygiene education including ensuring that agencies working within its local area develop and adhere to client charters.*

6.2 The role of Central Government;

Ministry responsible for Local Government;

The Ministry has overall responsibility for the affairs of local authorities. This includes policy, promotion, legislation, capacity building, grant allocation and regulation in relation to service provision.

With regard to water supply and sanitation, the role of the Ministry is to ensure that relevant policy, legislation, capacity building processes, regulatory responsibilities as well as co-ordination are integrated into the core local government institutional processes. This implies oversight of the relationships between individual Ministries and local authorities.

The specific responsibilities of the Ministry particularly important with regard to water services and sanitation include;
- *Legislation relating to local authority systems which includes provisions for establishing public-private- sector partnerships and for approving development plans.*
- *Regulation of local authority affairs with provisions for intervention in the case of non-performing local authorities.*
- *Capacity Building of local authorities*
- *Facilitating the co-ordination of sector activities on the ground.*

The Ministry of Local Government also hosts the Departments of Physical Planning (DPP) and the Public Works Department (PWD). The former is responsible for broader land-use planning in terms of location of services as well as the control and management of development while the latter acts as the implementing agent on behalf of Ministries when government buildings or facilities are constructed or rented. PWD's activities include the planning of projects to construct facilities (usually buildings), administering projects and managing facilities for client departments. The Department thus has an important responsibility in ensuring that adequate provision is made for water and sanitation facilities in all development programmes and areas in line with national policy.

The Ministry of Local Government is also responsible for implementing public works programmes as well as the promotion of community based planning and should therefore coordinate with water services and health authorities to align priorities and approaches in this respect.

Ministry responsible for Water Development
The Ministry responsible for Water Development has a central role to play in four key areas;
*1. The Ministry has **overall responsibility for the water sector.** The Ministry's specific functions in this regard include sector leadership, promotion of good practice, development and revision of national policies, oversight of all legislation impacting on the water sector, coordination with other Ministries on policy, legislation and other sector issues, national communication, and the development of strategies to achieve water sector goals.*

*2. **Support** to local authorities and other water related institutions to achieve the goals of the water sector. In particular, support to local. The nature of the support depends on the specific needs and requirements of local authorities and other water related institutions. It includes capacity building, the development of guidelines and practical tools, and technical support with respect to water services issues.*

*3. **Monitoring sector performance** to improve performance and to ensure compliance with policy and other regulations. The Ministry is responsible for putting in place mechanisms for*

facilitating, listening to and responding to consumer feedback on the quality of services provided and receiving regular reports from water services authorities and providers.

*4. **Allocation of finance** and local authority infrastructure grants and advice to Treasury on other grants to local government for water and sanitation service provision.*

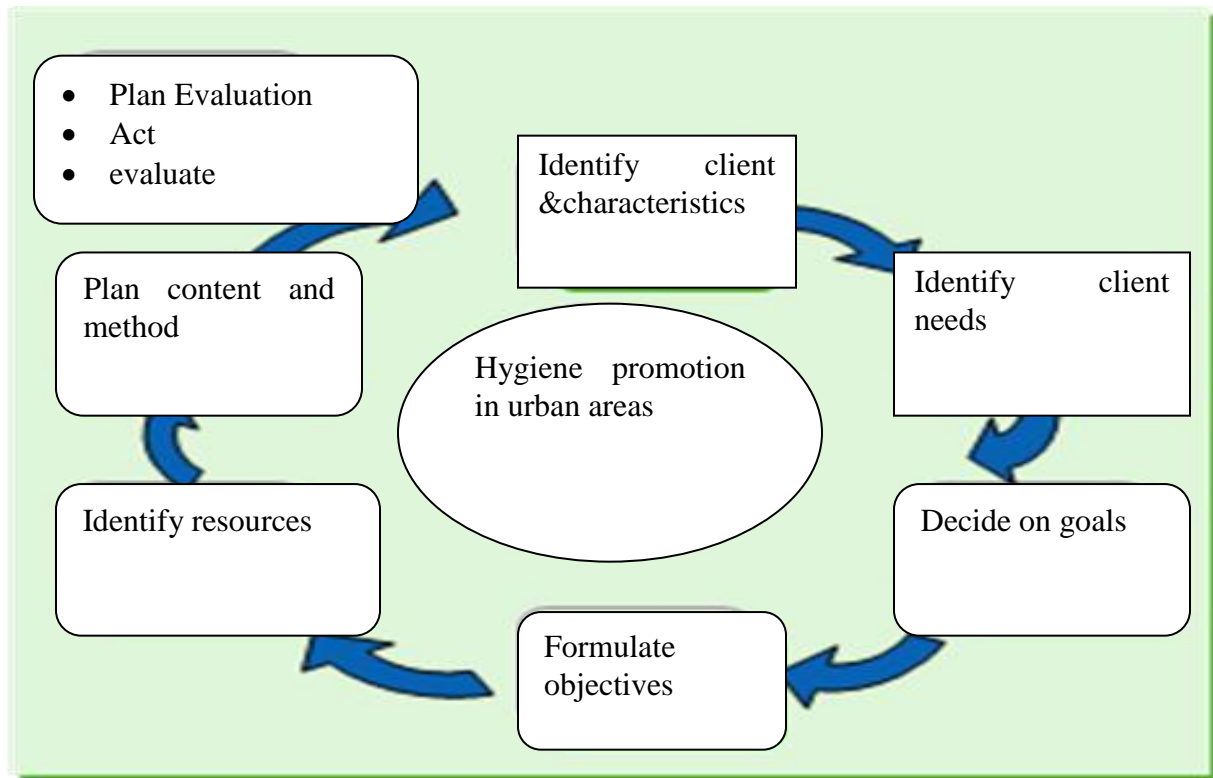## 7.0   Key steps in Designing a Hygiene Promotion Programme

Figure 1: Key Steps in designing a hygiene promotion programme

Step 1: Identify Client Characteristics
There is need to know;
- Experience and knowledge of the community concerning hygiene issues
- Their attitude and level of motivation
- Their experience in educational methods
- Their level of receptiveness
- Their problems, limitations, strengths and skills

Step 2: Identify Client Needs
Communicator needs
1. to ask the sort of need for the community i.e. is it
   - Imposed need (need defined by experts)
   - Felt need (what people want)
   - Expressed need (felt need turned into an expressed demand)
2. To ask who decided there was need for a hygiene promotion e.g. the people? The local authority? The provincial authority? The head office?
3. Collect data from reliable sources for needs identification

Step 3: Decide on the communication goals
Do you want to;
- Raise awareness
- Explore attitudes
- Share information
- Assist communities to make decisions
- Help people change behaviour

There is need to broadly define what you intend to do.

Step 4: Formulate Objectives
Once goals are identified there is need to define objectives which are more specific.

Step 5: Identify Resources
There is need to identify the;
- Human resources
- Financial resources
- Material resources

Step 6: Plan the content and method in detail
It is important to ask these questions:
- Which communication methods are the most appropriate for the set objectives?
- Which communication methods will be most acceptable to the community?
- Which communication method do you feel most comfortable to use given your training, your skills and the human and other available resources?

Step 7: Plan evaluation methods
- Evaluation is about making a judgment about an activity. Be sure of what you want to evaluate; the effectiveness or the outcome or the process.
- Make use also of the community to evaluate the programme

Step 8: Action stage in a communications programme
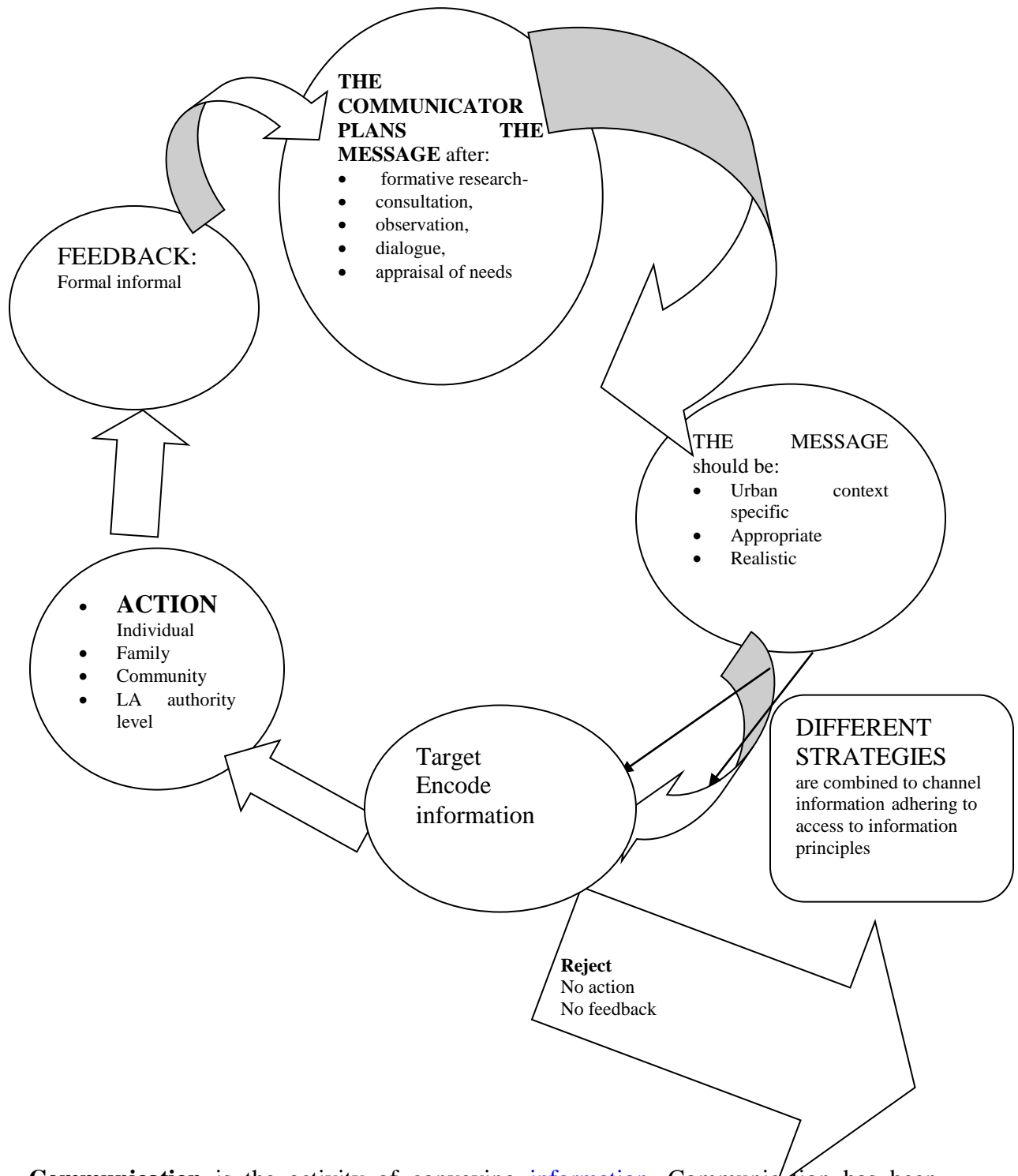This is the implementation stage.

Step 9: Evaluate
The evaluation is carried out and the results are fed back to the community so that they too are kept well informed about progress.

8.0   Communication Process in Hygiene Promotion

After the evaluation stage, there is need then to communicate with relevant stakeholders. The communication process can be diagrammatically shown as follows:

THE COMMUNICATOR PLANS THE MESSAGE after:

- formative research-
- consultation,
- observation,
- dialogue,
- appraisal of needs

FEEDBACK:
Formal informal

THE MESSAGE should be:

- Urban context specific
- Appropriate
- Realistic

ACTION

- **ACTION**
  Individual
- Family
- Community
- LA authority level

Target
Encode
information

DIFFERENT STRATEGIES
are combined to channel information adhering to access to information principles

Reject
No action
No feedback

- **Communication** is the activity of conveying information. Communication has been derived from the Latin word "communis", meaning to share. Communication requires a sender, a message, and an intended recipient, although the receiver need not be present or

aware of the sender's intent to communicate at the time of communication; thus communication can occur across vast distances in time and space.

Communication is usually described along a few major dimensions:
- Message (what type of things are communicated)
- source / emisor / sender / encoder (by whom)
- form (in which form)
- channel (through which medium)
- destination / receiver / target / decoder (to whom), and Receiver.

8.1   The Seven (7) Cs of Good Communication

Hygiene promotion is about communicating information through various types of strategies and channels. When communicating Hygiene messages/information, it is important to ensure that the message is:

Clear
- Is your hygiene message clear?

Concise
- Is the message concise? (stick to the point and keep it brief.)

Concrete
- When your message is concrete, then your audience has a clear picture of what you're telling them. There are details (but not too many!) and vivid facts, and there's laser like focus. Your message is solid.

Correct
- Must suit your audience. (Language used is understood by your audience)

Coherent
- When your communication is coherent, it's logical. All points are connected and relevant to the main topic and the tone and flow of the text is consistent.

Complete
- The audience has everything they need to be informed

Courteous

Courteous communication is friendly, open, and honest. There are no hidden insults or passive-aggressive tones. You keep your reader's viewpoint in mind, and you're empathetic to their needs.

8.2   Possible Communication Strategies for Urban Hygiene Promotion

Table below shows some strategies which may be used for hygiene promotion in urban areas and the objectives and possible target group of each approach.

Strategy	Target group	Approach which can be used	Objectives of such communication
Mass Media	General population i.e. adults	Radio, TV,	Inform, create awareness

	and children	newspapers	
Interpersonal communication	Residents in urban and rural areas	Door-to-door campaigns, road shows, dramas	Inform, sensitize and educate
Traditional Media	The elderly, especially women.	Social and religious gatherings, song and dance, poetry, theatre	Addresses community needs through the locally existing communication channels.
Participatory Approaches	Community members. Various approaches for different interest groups (elderly, chronically ill, school children). Community health workers.	PHHE, Community/School Health Clubs, CHAST, Household exchange visits	Facilitate community members to unpack existing knowledge and develop further from there. Participation promotes probing and dialogue.
New media	Urban residents and field based health personnel	Cell phones (SMS), Internet, Telephone hotlines, hailers	To disseminate information very fast and regularly. Ensures two way communication even where distance is a barrier to other communication approaches.
IEC	General population adults and children	Stickers, posters, videos, key rings, pens, t-shirts, badges, posters, leaflets, advertisements on vehicles etc	To supplement to dialogue oriented and participatory approaches.

However some tips have to be considered when selecting a method to use for hygiene promotion and table 3 below outlines some methods and tips which can be considered;

Table 3: Hygiene promotion methods and Tips(SPHERE, 2004)

	Suggested Method	Suggested Tips
Knowledge	Chalk and talk sessions	
	Question and answer sessions	
	Seminars	Use Brills for the blind people in the community
	Workshops	Target very influential people in the community
	Print media	Target the Sunday Mail
Awareness and attitude change	Newsletter articles	Should be attractive, brief and in simple language, avoid jargons
	Newspapers	Target the most read newspaper and also the Sunday Mail
	Exhibitions	Target the most popular events such as during the Agriculture Shows were many activities are taking place
	Visual displays	Aim for attractive spots or sites which will draw the attention of people
	Stop and study posters	Place them in institutions were there is interest
	Single glance posters	Place them in areas where there is traffic and mass movements of people
	Programmes on local radio and tv	Target to broadcast during family times hours and weekends
	Discussions	Separate men and women and also ensure people of the same age groups to avoid dominance of other people
Behaviour change/decision making	Group discussions	Separate men and women and also ensure people of the same age groups to avoid dominance of other people
	Role-play	Emphasize on practicability rather than imagination or fiction
	Drama	Emphasize on the need for day-today lifestyles
	Participatory methods which use stories, visual aids	Let them be clear and coloured (for visual aids)
	CHCs	Link with livelihoods activities so as to attract those financially deprived
	SHCs	Train more than 1 health master at any school and also link the health club with the Environmental club. Use the private sector to provide incentives to SHC such as tooth brushes, soap etc
Acquisition of skills	Demonstrations	Work with the private sector and research institutions for sustainability
	On-Job training	
Social change	Work with influential leaders groups. Eminent persons	Link with popular sports such as soccer, and make use of short breaks to promote hygiene using the sports people
	Lobby policy makers	
	Workshops	Target the most influential people in the society. Also include the politicians
	Fliers	Should contain relevant information that is easy to understand and to read
	Briefing notes	Vocabulary should be related to the target group
	Sanitation days	Declare a day to observe sanitation e.g. in Nigeria every last Saturday of the month for 2 hours nothing operates in the country, everyone will be busy cleaning the cities

9.0   Roles and Responsibilities

It is important to clearly define all the stakeholders to be involved in a hygiene promotion programme. Their roles and responsibilities should be clearly defined to avoid duplication, friction, conflict and confusion among them. The following are some of the important institutions but it varies from place to place. What is important is to fully involve all the critical partners throughout the hygiene promotion exercise.

9.1 Role of the National government
- Facilitation of programming policy development
- Creation of facilitative laws and regulations
- Publication of verified national data on coverage and progress
- Governments must prioritise hygiene education and awareness rising through media, schools, and partnerships with the private sector.
- Adequate funding must be allocated by the government so that more money goes to sanitation and hygiene promotion.
- Financing for technical assistance to small scale providers, community groups, etc.

9.2 Role of the Regional/local government
- Management of hygiene promotion and community development activities
- Monitoring of technical issues
- Licensing of small scale providers
- Certification of community support organizations
- Coordination of local monitoring and collation of data for planning purposes

9.3 Role of the urban government
- Provision and management of trunk services and facilities in some cases
- Management of wastes
- Licensing of small scale providers
- Oversight of credit providers
- Technical assistance to communities

9.4 Role of NGOs
- Technical support to communities
- Delivery of hygiene promotion and community development support
- Provision of credit services, oversight of progress through participatory monitoring and evaluation

9.5 Role of the Small Scale Private Providers
- Sale and delivery of sanitation goods and services
- Contribution to planning and programming activities may also provide credit directly or through dedicated credit providers etc.

9.6 Role of the Urban Communities
- Participatory planning
- Identification of appropriate local institutions for management of resources and facilities
- Assessment and negotiation of local demands
- Management of internal cross subsidies if needed

9.7 Role of Households
- Key investment decision making
- Financing and management of facilities

- Hygiene behaviours and outcomes

10.0 Monitoring and Evaluation

10.1 Importance of Monitoring

- It is important to monitor the impact of hygiene promotion including the change in community hygiene practices which can contribute to the reduction of WASH related diseases. Information provided by monitoring can usefully feedback into future evaluation and planning of hygiene promotion projects so the objectives can be adjusted where necessary.
- During the initial stages of hygiene promotion programme planning, objectives are set and accompanying indicators of achievement defined. A logical framework can be used as an active tool to guide monitoring.
- Monitoring can include measuring impact and assessing whether the project purpose has been achieved and significant change has occurred. This includes reviewing the projects appropriateness, outcomes and outputs (facilities provided or systems set in place) and activities (toilets or water points constructed).
- It is also important to monitor participation of communities and whether all those affected are adequately represented e.g. women, men, the poorest and disabled people. Monitoring can be used to measure progress against the baseline data gathered during the initial stages of an emergency, as well as faults in project design and unrealistic objectives.

10.2 Monitoring systems

These provide a rapid and continuous assessment of what is happening. Monitoring is primarily at the implementation level to show whether;

- Inputs are being used as planned
- Inputs are leading to expected outputs
- Inputs are being made within the agreed vision and rules

10.3 Importance of Evaluation

This provides a more systematic assessment of whether visions and objectives are being achieved in the long run in the most effective manner possible. Formative evaluation aims to diagnose problems and is best done internally for maximum learning and capacity building. Summative evaluation is aimed at deciding which outcomes have been achieved and is an important tool in generating confidence in the programme. It's usually best done externally to increase credibility.

10.4 Uses of Monitoring and Evaluation

	Monitoring	Evaluation
Programme planning, development and design	❖ Measure of crude inputs and outputs ❖ Track processes and instruments	o Assess needs, problems and assets o Establish a baseline reference point o Explore programming options and identify solutions
Project level	❖ Assess whether programme is on	o Check whether implementation is resulting

implementation	track, delivering services, conforming to standards and targeting the right people ❖ Motivate communities to solve problems ❖ Quality assurance through supervision	in the delivery of the programme vision and objectives o Assess whether projects resulted in the desired impact and outcomes o Solve technical or programmatic problems through operations research

10.5 Possible tools for monitoring and Evaluation

	Monitoring	**Evaluation**
Tools	• Surveillance questionnaires • Network/system operations and maintenance checklists • Supervision checklists • Financial summary audits • Participatory monitoring tools	Situation analysis, technical, social and institutional reviews Participatory impact assessments/ participatory rapid appraisals Sanitation and hygiene model questionnaire Qualitative studies, midterm and final evaluation
Responsibility	• Ministry of Health, Ministry of Water, • Utilities • Local government • Communities	Use should be made of independent public or private sector organizations with skills in evaluation techniques Non-governmental organizations Universities National statistics or census bureaus
Dissemination of results	• Public score cards and report cards • Publish in newspapers/radio.tv • Provide flyers • Annual institutional reports • Internet	Journal articles Conference papers TV/Radio profiles

10.6 Monitoring Indicators

Indicators are identified in order to be able to monitor and evaluate. Indicators are how
you measure whether you have achieved your objective and how this has been done. Indicators can be qualitative or quantitative and are identified when the project plan is initially written.
They are either impact indicators or process indicators and direct and proxy indicators.

❖ Process indicators are found in the Logical Framework at (activity & result level), compared to impact indicators which are found at (purpose or specific objective level). It is also important to measure participation of people and gather health clinic data where possible. Hygiene promotion can be difficult to measure and this process is helped if indicators are simple, few in number and suitable for use at community level where possible.

❖ Direct and Proxy (indirect or substitute) Indicators can be easily measured e.g. numbers of toilets. Whilst the ultimate aim of hygiene promotion projects is to reduce the mortality and morbidity of WASH related diseases, it is widely recognised that it can be difficult to establish a direct relationship as the incidence of disease is affected by many factors. For this reason indirect or 'proxy' indicators are considered an acceptable alternative to monitor project impact e.g. hand washing with soap has been proven to have a significant impact on the reduction of diarrhoeal diseases.

10.6.1 Essential indicators for monitoring Hygiene Promotion

The five essential indicators which should always be monitored as a priority include:
- X% of the population uses safe water for drinking
- environment free from all faecal matter
- X% of the population wash their hands with soap or ash at least after contact with faecal matter and before handling food
- Women are enabled to deal with menstrual hygiene issues in privacy and with dignity
- All sectors of the community, including vulnerable groups, are enabled to practise the target hygiene behaviours
  X%=depends on the situation)

10.6.2 Example of Proxy Indicators for Monitoring the Effectiveness of Hygiene Promotion Interventions

Hygiene Behaviour	Indicators
Safe drinking water	adequate water handling practices to minimize contamination practised by x% of the population
Safe excreta disposal	• x% of children's and babies' faeces are safely disposed of • toilets are used by the majority of men, women and children
Hygiene practices	• soap or ash for hand washing is available in all households • hand washing facilities are available at 100 % of communal latrines or in the majority of homes and in use
Women privacy and dignity around menstrual hygiene	• appropriate sanitary materials and underwear for all women and girls are available
Community participation and representation	• all sections of the community, including vulnerable groups, are consulted and represented at all stages of the project • the majority of community members are satisfied5 with the provision of facilities • users take responsibility for the management and maintenance of water supply and sanitation facilities

10.6.3 Suggestions of ways to monitor some of the essential indicators:

Indicator	Means of Monitoring
Safe drinking water	• Water testing at source and household level • Inspection of water containers at water points • Household visits to look at water storage containers for signs of possible contamination e.g. not covered, open necked, hands come in contact with water etc.
Safe excreta disposal	• Exploratory walks to look for signs of open defecation Observation of maintenance and use of toilets/potties provided • Reports from members of affected community expressing use and satisfaction with toilets provided
Hygiene practices	• Observation of soap at household level • Observation of hand washing at communal latrines • Self reported increase in hand washing by affected community
Menstrual hygiene	• Reports of satisfaction with provision of menstrual materials from women
Community participation	• Observation and discussion with community committees • Observation and reports of response to vulnerable groups e.g. latrine provision for disabled people • Reports from men, women and children of satisfaction with facilities and improvements in hygiene

Source: (IRC, 2005)(Walden, 2007). *A guide for field staff.*

10.6.4 Indicators for Hygiene Monitoring and relevant Sphere Indicators

Hygiene behaviour	Indicators	Relevant Sphere Factors
Safe drinking water	• adequate water handling practices to minimize contamination practised by x% of the population	• Each household has at least two clean water collecting containers of 10-20 litres, plus enough clean water storage containers to ensure there is always water in the household. • Water collection and storage containers have narrow necks and/or covers, or other safe means of storage, drawing and handling, and are demonstrably used

Safe excreta disposal	• x% of children's and babies' faeces are safely disposed of
	
	• toilets are used by the majority of men, women and children
		• Use of toilets is arranged by household(s) and/or segregated by Sex
		• Toilets are designed, built and located with the following features:
		  ☐ used by all sections of the population
		  ☐ sited to minimise threats to users, especially women
		  ☐ sufficiently easy to keep clean to provide a degree of privacy
		• Users (especially women) have been consulted and approve of the siting and design of the toilet Separate toilets for women and men are available in public places (markets, distribution centres, health centres, etc.).
		• Shared or public toilets are cleaned and maintained in such a way that they are used by all intended users
		• Toilets are used in the most hygienic way and children's faeces are disposed of immediately and hygienically
		• Infants and children up to two years old have 12 washable nappies or diapers where these are typically used.
		• People are provided with tools and materials for constructing, maintaining and cleaning their own toilets if appropriate

Hygiene practices	• Soap or ash for hand washing is available in all households • Hand washing facilities are available at 100 % of communal latrines or in the majority of homes and in use	• People wash their hands after defecation and before eating and food preparation • There is at least 250g of soap available for personal hygiene per person per month. • Each person has access to 200g of laundry soap per month • Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day (water quantity)
Women's privacy and dignity around menstrual hygiene	• Appropriate sanitary materials and underwear for all women and girls are available	Women and girls have sanitary materials for menstruation
Community participation & Representation	• All sections of the community, including vulnerable groups, are consulted and represented at all stages of the project • The majority of community members are satisfied6 with the provision of facilities.	• Women and men of all ages and wider local populations, including vulnerable groups, receive information about the assistance programme, and are given the opportunity to comment to the assistance agency during all stages of the project cycle • Written assistance programme objectives and plans should reflect the needs, concerns and values of disaster-affected people, particularly those belonging to vulnerable groups, and contribute to their protection. • Programming is designed to maximize the use of local

	• Users take responsibility for the management and maintenance of water supply and sanitation facilities	skills and capacities.

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