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## Hygiene promotion of NAP in the international context

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### Introduction

Internationally, interest in hygiene promotion is increasing. Its relevance is recognized for bringing better health behaviour, both as part of water and sanitation projects and in the absence of technical interventions. In this introduction I shall present a number of general developments in hygiene promotion and raise how these relate to what is currently being done in the NAP, as far as is possible with the sometimes not fully complete information makes this possible. In the subsequent discussion you may wish to give more information on innovative work done in the NAP and it can be decided what elements in general developments are most relevant for the NAP.

After introducing the concept and its actors I shall touch briefly on some key developments. These concern:

- \* making change measurable;
- \* collecting baseline data;
- \* deciding on scope of programme and strategies for change;
- \* determining achieved changes.

### Concept and actors

Hygiene promotion as a term and concept has come about for two reasons. The first is the dissatisfaction with the term 'hygiene education', which assumes that hygiene behaviour can improve by merely widening people's knowledge on health, which is seldom the case. The second is the insight that people themselves decide to change a particular condition or practice, often for other reasons than health, and that others such as project staff can only assist them in this process. Hence the concept of promotion, which means 'to help forward, encourage', but also 'publicize and sell'.

The latter meaning lies close to social marketing strategies, which are used to encourage one particular type of behaviour, such as making ORT mixtures or getting vaccinated. In water supply and sanitation projects we deal with over 28 different ways of transmitting disease, which can be cut off at many different places in the transmission cycle and it will take a long time to address them all. Neither are all risks equally serious or a priority of the people themselves. In his presentation, Peter Flik has therefore stressed the selection of key objectives.

Being new, there is not yet a generally accepted definition of 'hygiene promotion'. WHO-SEARO has defined it as "all activities that promote, step by step, hygiene behaviour and related facilities".<sup>1</sup> In the discussion paper, it is defined as "all activities that promote measurable reduction of risky hygiene conditions and practices, through programmes that include engineering and social activities". By including engineering

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activities it is indicated that also engineers have a role to play in hygiene promotion, by making general and safe use of facilities the ultimate aim of the programme. In the NAP, in all states, engineers and social staff already promote such general use, by involving male and especially female villagers in decisions on the design and location of water points and latrines. However, the main engineering targets are construction and maintenance. Whether also engineers should make better hygienic conditions and behaviours the ultimate targets of their work is still a point for discussion.

#### Making change measurable

Water and sanitation projects have as ultimate aims to improve living conditions and reduce mortality and morbidity from water and sanitation related diseases. These diseases account for 74% of the life years lost in the South through an unhealthy environment (World Development Report, 1993). Because of the many intervening variables it is difficult and costly to measure impact of water and sanitation projects on health. The emerging international consensus is therefore to measure the objectively verifiable reduction in conditions and behaviours by which these diseases are transmitted. If measurement shows that most transmission risks have been eliminated, disease reduction will follow and can be measured where circumstances and funds make epidemiological research possible. If the risk reductions have not yet taken place, it is clear that the programmes which promote safe behaviours have not yet been successful and that it is still too early for a health impact study.

In the NAP, identifying local conditions and practices and measuring change has started. In Uttar Pradesh and Kerala, for example, the programmes monitor such aspects as hygiene at taps, waste water disposal at homes and hygienic use of latrines. One experience which emerged was that for proper measurement, objectively verifiable indicators are needed. The concept 'clean' for example was found to be subjective: what one observer scored as clean, another scored as not clean and opinions also changed over time. Besides defining key objectives for hygiene promotion, it will thus also be important to define the indicators which will be used to measure change and to have a consensus on programme indicators among all involved.

#### Collecting baseline data

To measure change it is necessary to know what the conditions are at the start of the promotion activities. In the NAP, some baseline studies have been made, but not in all states. Also some baselines have not included behavioural and environmental data. The survey in Gujarat-I is an example of a baseline with behavioural data collected through observations and interviews. Internationally, this type of KAP survey is now increasing replaced by more participatory forms of data collection, such as Participatory Rural Appraisal. In the NAP, PRAs, which are more suitable to start group action than the usual passive interviews, have been used in Karnataka and AP-III. Because men and women differ, baseline research should be gender specific. DGIS has recently published a manual. An abstract can be found on the

documentation table.

Collecting the same baseline data in matched villages outside NAP makes it possible to prove that reductions in transmission risks have been the result of the programme, and not of other factors. This type of research is at present not done in NAP.

#### Deciding on scope and strategies

Research has shown that behavioural change requires person-to-person contacts. This is why all NAP programmes work with NGOs or own programme staff and in the villages with trained volunteers or programme-paid village women. In this way, the programmes together reach some 10% of the 4000 villages in the NAP at the end of the second generation projects.

The first strategy which NAP uses to expand coverage of hygiene promotion to all project villages is a greater involvement of Indian staff working in related Indian programmes, such as PHC, ICD and DWCRA. Problems are that these programmes have their own activities and targets and are not always sufficiently staffed and motivated to cooperate in a water supply and sanitation programme. Moreover, the staff of these programmes have had little or no training on planning and implementing hygiene promotion programmes as part of integrated water and sanitation projects and are not familiar with participatory learning tools. The shift towards district level projects makes their involvement easier, but commitment to a programme other than that of their own is likely to remain a problem.

In parts of the NAP, programmes already include special measures to foster involvement of district health and social staff. For their cooperation in NAP in AP-III, for example, ICD and PHC programmes will get support for Angawadi and PHC buildings in return for inputs in NAP. Other options, which as far as known are presently not included are to give programme managers of ICD, PHC and DWCRA programmes the opportunity to determine for themselves how relevant hygiene promotion work is for their own programme goals, and to give their fieldstaff opportunities to take part in training in new skills, such as PRA and participatory learning techniques.

A second strategy to widen coverage is under way in UP. This concerns the use of local radio broadcasts with programmes on water use and hygiene. For the person-to-person communication needed for behaviour change, the NAP staff will help to form radio listening groups and train the group's discussion leaders. After listening to the broadcasts together, the discussion leaders will help the participants discuss how the broadcasted items relate to their own condition and practices, and what changes they intend to make and how. In the light of earlier experiences with this strategy, two aspects are of particular interest. The first is how the programme will enable people to make the physical changes needed to reduce some of the transmission risks, and where they can get materials and skills for these changes. The second is how the impact of the broadcasts on actual hygiene conditions and practices will be measured.

## Determining achieved change

What local transmission risks are eliminated in the NAP is an area for more concrete data. Several programmes, e.g. in Kerala and Uttar Pradesh monitor the local hygiene conditions and practices resulting from the programme, such as conditions at standposts, use and conditions of latrines and waste water disposal at homes. As far as known, summary overviews of NAP hygiene promotion results do not yet exist. In other areas, such as GU-I, baseline data exist, but what the effect of the technical programme and hygiene sessions has been on local conditions and practices, and if these differ from those in non-NAP villages in the area has still to be determined.

Water use studies have also been carried out. They were held mainly in villages where at the time hygiene promotion was not yet generally included. Where integrated NAP programmes have been running for several years, it would be useful when technical and social staff within the programme itself assessed the actual use and hygiene practices which have followed from technical and social hygiene promotion inputs, if possible together with male and female community members in the villages concerned.