

Asia workshop “Performance Monitoring and Hygiene Behaviour Change”



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Organised by:
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TABLE OF CONTENTS:

<u>I.</u>	<u>INTRODUCTION</u>	<u>3</u>
<u>II.</u>	<u>WORKSHOP SESSIONS:.....</u>	<u>4</u>
1.	Field Visit: practical aspects of measurement of hygiene behaviour.....	4
A.	Group 1: Excreta disposal babies and young children (in village Ban Phonsavan Nua).....	5
B.	Group 2: Toilets and handwashing at public toilets (in village Ban Nongdouang Thong).....	5
C.	Group 3: Handwashing in households (in village Ban Thatlouang Nua)	5
D.	Group 4: Toilet conditions and use in households (in village Ban Thongkhankham).....	5
E.	Group 5: Monitoring practice (in village Ban Hatsadi Tai)	5
2.	Core aspects of performance monitoring of sanitation & hygiene	9
A.	Presentation on the outcomes of the HH sanitation assessment in Laos	9
B.	Presentation on Monitoring Hygiene: Lessons from Case Studies	9
C.	Country presentation on current Government Monitoring System for Rural Sanitation and Hygiene	9
D.	Introduction to Qualitative Information System (QIS).....	9
E.	Introduction to cost monitoring	9
3.	Learning from current BCC practices	15
A.	Motivators for hand washing with soap: Approach and lessons from Vietnam ..	15
B.	Reflection of BCC materials by each country	15
<u>III.</u>	<u>Conclusion.....</u>	<u>16</u>
A.	Country Reflection	16
B.	Summary of overall conclusions	18
<u>I.</u>	<u>Annex:.....</u>	<u>20</u>
	Annex 1: List of participants.....	20
	Annex 2: Summary of D group discussion on performance monitoring	22
	Annex 3: Presentation of the HH sanitation assessment in Laos	32
	Annex 4: Presentation on Monitoring Hygiene: Lessons from Case Studies	36
	Annex 5: Introduction to Qualitative Information System (QIS)	38
	Annex 6: Introduction to cost monitoring	40
	Annex 7: Motivators for hand washing with soap: Approach and lessons from Vietnam.....	41

I. INTRODUCTION

As a part of the “Sustainable Sanitation and Hygiene for All” Programme, currently being implemented in Nepal, Bhutan, Laos, Cambodia and Vietnam with funding from DGIS and AusAID, a three days Asia workshop “Performance monitoring and Hygiene Behaviour Change” was organised by IRC International Water and Sanitation Centre and SNV Netherlands Development Organisation Asia from 22nd – 24th August 2010, in Vientiane Laos.

This report presents the first part of the workshop in which performance monitoring of hygiene behaviour change was discussed in general and in the context of existing government monitoring systems. Government and implementing partners participated in this block of the meeting. Afterwards, the outcomes of the first part were used to develop the specific performance monitoring framework for the above mentioned SNV/IRC programme. This second part of the workshop is captured in the performance monitoring instructions which will be shared separately.

The Sustainable Sanitation and Hygiene for All programme has 4 components, which are:

- 1) Sanitation demand triggering and follow-up
- 2) Strengthening sanitation supply chain development
- 3) Developing behavioural change communication for hygiene and sanitation marketing
- 4) Improving WASH governance and multi-stakeholder sector development

In addition to the above, there is a fifth component for analysis, dissemination, and learning in collaboration with IRC. This workshop was a part of the analysis, dissemination and learning activities and also aimed to contribute to the development of the fourth component: Improving WASH governance and multi-stakeholder sector development in the countries. The expectation was that participants and in particular government partners could learn from the exchange with other countries on monitoring of hygiene behaviour and from other inputs.

The objectives of the workshop were to:

- ❖ Exchange experiences and share information on monitoring of Rural Sanitation and Hygiene programmes in Nepal, Bhutan, Laos, Vietnam and Cambodia; and
- ❖ Jointly develop knowledge on how to measure performance for Rural Sanitation and Hygiene programmes

A total of 34 participants representing SNV advisors, Local Capacity Builders (LCB), government partners (from ministries, health department etc) , other partners (Water Aid Australia, Plan International, WSP) and WASH professionals from countries like Nepal, Bhutan, Laos, Vietnam, Cambodia, Australia, Netherlands and UK participated in the workshop. List can participants can be found in annex 1.

Prior to the workshop, a D group discussion¹ about the measurement of hygiene behaviour change at both household and school level was held among the SNV advisors, clients and partners in Asia, which was facilitated by SNV and IRC. The major objective of the D group discussion was to exchange ideas, knowledge and current practices in performance measuring in three different topics as given below.

1. Measuring ODF and technical and hygienic quality of toilets in households and schools
2. Measuring toilet hygiene and ability and actual and consistent use by all (household members/girl and boy students , M/F teachers)
3. Measuring provisions and practices on hand washing with soap

Discussion on each topic ran for a week, on the basis of which a summary paper was developed and shared among the participants of the workshop to further discuss and develop the monitoring indicators. Summary of the D group discussion can be found in the annex 2.

II. WORKSHOP SESSIONS:

The workshop sessions were conducted around three different themes:

- 1. Field Visit: practical aspects of measurement of hygiene behaviour**
- 2. Core aspects of performance monitoring of sanitation & hygiene**
- 3. Learning from current BCC practices**

1. Field Visit: practical aspects of measurement of hygiene behaviour

On the first day of the workshop, 22nd August, a field visit to the surrounding slum areas of Vientiane was organised for all participants. The major objective of the field visit was to:

- ❖ Allow people to test and reflect on the practicalities of measurement of hygiene behaviour changes in the Laos setting and
- ❖ Allow people to get to know each other in an informal, active setting and

Five different groups visited different villages and interacted with the community members, local authorities and the inhabitants to talk about different hygiene behavior issues as below:

¹ D group discussion is an electronic email discussion to exchange and share ideas and learning from cross country and multi professional's experiences in water, sanitation and hygiene sector in Asia. Participants of this D group discussion were 92 people from 17 countries, 37% clients and partners, 63% SNV and IRC staff). A d-group on Water, Sanitation and Hygiene can be joined at: <http://dgroups.org/Community.aspx?c=2be28e06-a3c3-4c6d-bf56-cf98339a06b8>

- A. **Group 1: Excreta disposal babies and young children (in village Ban Phonsavan Nua)**
- B. **Group 2: Toilets and handwashing at public toilets (in village Ban Nongdouang Thong)**
- C. **Group 3: Handwashing in households (in village Ban Thatlouang Nua)**
- D. **Group 4: Toilet conditions and use in households (in village Ban Thongkhankham)**
- E. **Group 5: Monitoring practice (in village Ban Hatsadi Tai)**

After the field visit, each group made a presentation about their findings and recommendations regarding the group topic and the complexities in measuring that hygiene behaviour. Discussion on the group presentation was also based on the use and reliability of the method being adapted to measure the behaviour change. A brief overview of the topic, complexities and the conclusion of each group is given below:

A. Group 1: Excreta disposal babies and young children (in village *Ban Phonsavan Nua*)

The group visited three households and found out that in each household the mothers clean the babies and dispose their excreta, mostly in the toilets. Mothers said that they usually washed their hands with soap after cleaning the baby and disposing the excreta but one mother said that she cleaned her hands with soap, only if the faeces had bad smell

The methods used were:

- semi structured interview
- demonstration with tools and
- direct observation

Advantages of these methods were that it did not take much time for information collection and that people were also quite open. However regarding the reliability of the method, it was questionable whether the correct information was obtained as most people knew the right answers from hygiene education in the past. To verify the presence of soap, a check should have been done in the toilets. A baby doll was used for demonstration, which worked well in one household but not in the other. But in future a more realistic doll (one with a better bottom- the one being currently used had a flat bottom) could be used. The demonstration methods could also be tested in each country.

To conclude 90% participants thought that it should be a part of hygiene promotion, but not in a RWSS monitoring system. The reason is that while everybody knows it is important and studies have revealed that the child faeces is more harmful than that of adults, it is very difficult to measure it objectively. Also not every household could be monitored and surveyed thoroughly. For example in Indonesia, child excreta are monitored through mother and child care groups and not through the district monitoring system.

B. Group 2: Toilets and handwashing at public toilets (in village *Ban Nongdouang Thong*)

The group found out that there were three public toilets densely located in the village with separate toilets and bathroom for male and female (2 toilets each) with availability of running water in each toilet. Although plenty of water was available no soap was seen in any toilets for hand washing. The respondents said that they sometimes bring soap from home and sometimes wash hand at home. The toilet was not so friendly for disabled people and had no provision for light. The design and construction of those public toilets were done by the project with labour contributions from the village people.

The methods used were:

- interview
- demonstration
- observation

The major advantage of demonstrating the handwashing knowledge tool (cards with drawings indicating critical times of hand washing) indicated the people's priority for handwashing and also their perception about the hygiene behaviour. The drawings were displayed in front of the people and asked what it indicated for them and which one would they prioritise as the most critical ones for handwashing. However it was questionable if the tool could be readily applied in the given context as many different and new meanings were depicted for the same picture. In such case, the drawings should be adjusted or made by people themselves. For correct use of the tool it is essential that the people really know what exactly each picture means.

In application of the tool, it was found that people could easily point out all the critical time of handwashing but then again knowledge of hand washing do not automatically translate into practice. Also there are hygiene aspects in how people wash their hands, for example in Laos, same bowl/basin is used several times by many people to dip their hand for handwashing.

As a conclusion, it was agreed that though the tool looks good, it will need country wise adaptation for more effective results. Similar tools could be developed in alignment with the local context (could even ask the people to draw themselves or pocket voting could also be done if people are shy to draw) and field test to verify its effectiveness.

To the question whether the public or shared toilets should be included in the monitoring system, many said that it should be included as in many cases, there are no other alternatives and shared toilets are the only option. For example when there are clustered houses in Bhutan, there is no space for individual toilets. A checklist as that of Bhutan could be useful to measure hygiene quality of such toilets.

C. Group 3: Handwashing in households (in village *Ban Thatlouang Nua*)

The group visited the handwashing facilities in toilets and kitchen area of 4 households and interviewed two school children. The design and construction of the toilets were done by the project through labour contribution by the village people.

The methods used were:

- interview
- demonstration
- observation

Similar to group two, handwashing knowledge tool was demonstrated to determine awareness and knowledge about handwashing at the household level. The group found that the major advantage of using the tool was that it gave an opportunity to involve all people of the household in discussion. However, the role of the facilitator plays an important role in this. Similarly, it is important for the facilitator to be a good listener and non judgemental. This group also felt that the pictures need to be improved as per the local context. In case of schools, it was questionable if the practice of HHWS actually existed. There has been no evidence of soap in rural school and even if there is soap it does not guarantee that people actually wash their hands with soap.

On asking whether it is practical to monitor handwashing at district level, it was decided and concluded that yes it is desirable to monitor it at the district level but the major question is whether it could be done. Perhaps the best proxy indicator to monitor it would be presence of soap.

D. Group 4: Toilet conditions and use in households (in village *Ban Thongkhankham*)

The group visited toilets of four households and found out that all toilets had access to pipe water for hand washing while only two toilets had soap. Though no evidence of open defecation was observed, there were no hygiene promotion programs and no health issues were yet reported. However, all wanted to improve the hygienic standard of the toilets and were willing to invest in different terms (tiles, concrete etc). Private sector is involved in emptying pits, through the payment of the household which is considered expensive. In case of communal septic tanks, there are problems of operation and maintenance.

Red stickers are being given by the government to say that the household meets the hygienic standard; however it was being misused as all households were given stickers and people themselves agreed that they do not qualify for those stickers.

The methods used were:

- interview
- observation
- sampling

During the observation, certain aspects such as: toilet location, type, construction, cleanliness, water availability, privacy, safety, presence of bucket, soap, etc were considered for information collection. Likewise certain indicators such as privacy, visible faeces, smell, access to water, etc were defined to determine the toilet

condition at the household level. Advantages of doing so was that it acted as a kind of a checklist which helped in to gather information easily (in every toilets visited). However, questions of individual observation difference came into light as the definition of hygiene could differ from individual to individual. While taking an interview, user's satisfaction, usages, access including history of sanitation services, people's willingness to improve sanitation, and their perception on cost and affordability were taken into consideration.

Thus it was concluded that though rating of toilets as hygienic or unhygienic is crucial, there could be observation difference and the data generated will vary accordingly. To overcome this, clear criteria could be developed and used by all (possibly in a participatory way).

E. Group 5: Monitoring practice (in village *Ban Hatsadi Tai*)

This group is different than that of others as it did not test the "measurement of hygiene behaviour" but looked at the present monitoring and evaluation system and practices of hygiene and sanitation in the given village.

The group visited the VDC office and interviewed the head of the village regarding the monitoring system and practices. They found out that there are total 175 hh in that village out of which 18 hh didn't have toilets in their home. Later, through the pilot project, toilets were built in those 18 houses for which the VDC granted loan for construction. One household was identified as pro-poor and hence they did not have to pay back the loan. 6 WatSan committees, each consisting of 14 people (4 women and 10 men) have been formed to observe and monitor the hygienic condition of the toilet in the village. Monitoring is basically done on the basis of problem reporting. Once the committee observes the toilet, the head of the committee reports the problem to the head of the village, who then analyses the problem and tries to fix it accordingly.

The group also interviewed a school-going child and found out that a school of 900 students has 5 toilets (3 for male and 2 for female) with a separate one for teachers. General monitoring of the school toilets are done by the teachers and a lady has been appointed to maintain the cleanliness of the toilet on a regular basis.

The VDC was responsible for overall monitoring of the toilets in the village, with the support of the WatSan committee and the village people. But monitoring was only done on physical aspect (construction and finance) and not on hygiene. The technical quality of the septic tanks and its filling up was also taken into consideration. However, monitoring was only limited to the pilot project and there were no records of monitoring beyond the project.

Looking at the present condition, it was concluded that it would be difficult to include hygiene behaviour monitoring into an existing monitoring system like this, as there are no incentives to do that and also the monitoring activities are confined to the project timeline.

2. Core aspects of performance monitoring of sanitation & hygiene

The second day of the workshop focused on the “performance monitoring” and hence the following sessions were conducted with the objective of highlighting the importance of hygiene monitoring in the sanitation and hygiene program.

- A. Presentation on the outcomes of the HH sanitation assessment in Laos**
- B. Presentation on Monitoring Hygiene: Lessons from Case Studies**
- C. Country presentation on current Government Monitoring System for Rural Sanitation and Hygiene**
- D. Introduction to Qualitative Information System (QIS)**
- E. Introduction to cost monitoring**

A. Presentation on the outcomes of the HH sanitation assessment in Laos

Mr. Erick Beatings, Sector Leader of SNV Laos made a presentation about the findings of the “Rapid Assessment of household Sanitation Services in Vientiane Capital” conducted by SNV Laos in collaboration with WSP and VUDA Laos (Vientiane Urban Development Association). The objective of this presentation was to give an overview of the rapid assessment recently conducted in Laos to assess the adequacy of existing domestic sanitation facilities in Vientiane, especially in middle- and low-income areas where investments in these facilities are likely to be modest. An overview of the presentation can be found in annex 3.

Plenary Discussion and Conclusion:

In regard to the monitoring of the septic tank, it is the responsibility of the VDC and the tank is usually emptied by the private sector. An official septic tank is 3 chambers and when it gets filled up too quickly, another one is built next to it. Most septic waste is dumped in the waste disposal site (in wet season). In the dry season, most of them try not to go to the waste disposal (sell or dump somewhere in the field). Though there are cases of high water table which could interfere in the construction of water table, not many efforts are put in this sector. More focus in being given in improving the drainage.

In regard to the reliability of the data collection, some modification and improvement is needed. Although there was daily supervision, some of the questions did not bring reliable information, especially the observation questions, for example “what is easy to clean”. Interpretation can be very difficult and hence can affect the reliability of observation. Likewise need to define durability.

Hence it was concluded that for the monitoring work, the capacity of the enumerator and the supervision plays a vital role. But these are not only the limiting factor and hence it should be complemented with good tools and indicators to match the objectives. Some examples of Indonesia and Bhutan could be considered where 4 different tests in Indonesia indicated that training and supervision was not sufficient and in Bhutan a list of definitions was developed and enumerators were trained on it. The duration and type of training should also vary according to the need. Not the same package could be applied in all countries.

B. Presentation on Monitoring Hygiene: Lessons from Case Studies

Mr. Peter Dawn, Head of International Programs of Water Aid Australia, gave a presentation on “Water Sanitation and Hygiene – Poor Cousins of MDGs” highlighting the relation of good sanitation and hygiene with good health among others with the F diagram. He also presented different case studies related to WASH and hygiene that had a focus on promoting hygiene and was quite successful in bringing behavior change among the targeted groups. An overview of his presentation can be found in annex 4.

C. Country presentation on current government monitoring system for rural sanitation and hygiene

Participants were divided into five country groups: Nepal, Bhutan, Vietnam, Cambodia and Laos, to describe the current monitoring system for sanitation and hygiene used by the government. A summary of the presentation of each country group is given below:

Bhutan	Nepal	Vietnam	Laos	Cambodia
Existing government monitoring systems that collect information about sanitation & hygiene in the country				
In Bhutan two monitoring systems are in place: 1. BHMIS (Basic Health Unit, and Monitoring Information System) and 2. RWSS (Rural Water Supply and Services)	In Nepal, three monitoring systems are in place: 1. Joint monitoring at district level, 2. Project/ Program monitoring at DDC/VDC level, and 3. Self monitoring at community level	In Vietnam, two official standard monitoring systems are in place. Indicators are fixed (for construction and use and maintenance) to monitor latrine and bathroom at household level	In Laos, different kinds of monitoring systems exist for different aspects such as: 1. Demographic, 2. Water and Sanitation, 3. Health, 4. Education and 5. Rural Development	In Cambodia, one national level monitoring system exists however with involvement of different agencies. But indicators are somewhat similar and do not vary much
Tools used for data collection on sanitation and hygiene in the countries:				
Questionnaire, observation and site visits are conducted for data collection	Observations and interviews with checklists, forms and format are being used for data collection Village mapping and pictorial are also used	Observations with checklists and forms and sampling done during field visits and trips Desk study from reports also carried out for data collection	Field visits are conducted and questionnaire and checklists are used for data collection	Field visits, interview and observations
Responsibility for field level data collection on sanitation and hygiene in the countries:				
Data are usually collected by the health assistants and health workers	Data are mainly collected by the WatSan/User committee; teachers, local clubs and political representatives; implementing agencies and health workers; and representative of district /regional WASH committee	Data are collected by the health workers at the village and commune level supervised by district and province level	Different authorities are involved in data collection - village and district leaders for demographic survey, DPI for Water and Sanitation, DoH for health, EDO for education and RDO for rural development	Data are collected by various implementing agencies adopting different methods
Timing and frequency of data collection in the countries				
Data are usually collected on an annual basis for sanitation, health and quarterly for water	At district level data is collected annually For project/ program data is	Data is collected monthly at the village and commune level and quarterly at the district and	Annually, especially in October every year	Usually done on an annual basis

supply Besides, a national health survey is done every 5 years	collected before during and after construction.	province level		
Use of the data after collection				
Data is mainly collected for progress reports, annual health bulletins and planning	Mainly for planning at DDC and VDC level and for ODF declaration	Mainly for the government planning and usage	Mainly for governments and programs	Mainly for government usage
Conclusion				
The monitoring system is quite reliable as an extensive household level survey is being conducted annually. The data collection process is also institutionalised. A limitation may be that data are mostly for upward use. There is opportunity for improvement by better informing the communities about the usage of data collected from them.	Monitoring is basically done within the project framework and toilet coverage is the main focus. There is a need to develop a common uniform method and criteria for monitoring across government departments and implementing agencies in order to be able to make better use of information.	There exists a very good structured and uniform monitoring and evaluation system. However the limitation is that the categories (4 types of toilet categorised starting with VIP and moving up) does not allow measurement of gradual progress as there is no system to monitor progress from temporary toilets or open defecation towards VIP toilets.	Several parallel monitoring systems co exist. The limitation is that some data are incomplete, some inaccessible and unreliable as there aren't many fixed indicators for toilet or latrine. A uniform monitoring system could be developed to overcome such problems.	Monitoring is basically done at the national level where multiple actors are involved in monitoring through different systems. The limitation is that sustainability of such system could be the major concern as issue of continuity of data management in changing systems/ decentralisation could come in light in future. Common indicators and methods for monitoring could be developed to avoid such problems.

Commonalities and overall conclusion of the country monitoring system:

- All countries have some kind of monitoring system, and in each country there are strong elements that other countries can learn from. In all countries, the current practice is predominantly a reporting system. The data collection is basically done for the reporting purpose towards higher levels. Though data is collected at the local level, it then goes up to higher level, and the use of data at local level is limited. Better use of data at local levels as well as national levels, could accelerate change locally.
- In almost all countries, multiple actors are involved in data collection and monitoring which makes it difficult to compare data and also indicates lack of uniformity in the monitoring system.
- Hygiene behaviour is not measured; major focus in monitoring is given on toilet coverage and technology.
- Though the tools for data collection are somewhat similar in all countries there is diversity in the frequency of data collection and the involvement of the concerned agencies.
- The quality of the data depends very much on the people responsible for the collection in the field. Usually these have several responsibilities in addition to data collection, and sometimes they have to collect similar data for different agencies/ministries with different formats. In several countries, these people are seriously overburdened. Often there is little incentive for these people to ensure quality data collection and capacity for quality control and check by the line agencies is of course limited. This is an area of concern.
- There is no or very little idea about the cost of monitoring in all countries.

D. Introduction to Qualitative Information System (QIS)

Ms. Christine Sijbesma, Sanitation Expert, IRC, gave a presentation on “Introduction to QIS – Quantification of Qualitative Information through Scale”. The idea behind this was to introduce the concept of QIS which focuses on measuring/monitoring the performance through scoring. An overview of the presentation can be found in annex 5.

E. Introduction to cost monitoring

Ms. Christine Sijbesma made a presentation on “Monitoring Costs” reflecting two issues:

1. The need to have more information about the cost of hygiene promotion (sanitation & hygiene programmes). This is important to be able to compare effectiveness of programmes and also to know what it will take to bring sanitation & hygiene programmes to scale. Currently, costs on sanitation & hygiene promotion are not always easy to determine. Often it is part of a larger RWSS programme and it is not clear what part of time and resources is dedicated to sanitation & hygiene promotion.
2. Another area of interest is the cost associated with performance monitoring as such. Ideally we would like to see performance monitoring to be sustained

over time, but for that we should have a better idea of the costs involved in data collection, analysis, storage and use. Again, these costs are not readily available.

An overview of the presentation can be found in annex 6.

Plenary Discussion:

In relation to the first point, monitoring the costs of sanitation & hygiene promotion, there was a discussion about:

- whether it is important or not to monitor those costs
- whether it will not be too expensive and divert time away from the actual implementation of sanitation & hygiene promotion programmes
- what would be the practical implications
- whether the time investment of communities in sanitation & hygiene promotion should also be considered part of the costs of the programmes

Below the main elements of the discussion are given from the perspective of each country group:

Arguments for	Arguments Perhaps
<p>Nepal: because we can verify how much is actually allocated to sanitation, as compared to what has been promised for sanitation and hygiene promotion in the National Sanitation Plan. Monitoring time of villagers will be good to keep us aware of their input (if too much they will not agree)</p> <p>BHUTAN: We should be clear on where we spend time and where we spend resources (also for other activities) But not be too ambitious.</p> <p>LAOS Monitoring system is already there in Laos within the government, but it is weak. It's possible to include costs.</p> <p>There is a hypothesis that sanitation & hygiene are under budgeted: people say that if money goes to WASH, 90% goes to water, 9% to sanitation and 1% to hygiene promotion. Having information on how much it costs could help benchmarking</p>	<p>VIETNAM We could do this in one province; we could also pull out a lot of information by classifying the costs. It may also be ambitious to list all the costs. The good thing is that we would be able to show to the government what is required for hardware & software.</p> <p>CAMBODIA It might be useful to know what hygiene promotion costs are involved, but considering current cash flows in provinces etc it might be too difficult or too costly.</p> <p>People may straight away conclude it's too costly and we cannot show the return on investment. We already have enough to do in monitoring.</p>
<p>Overall conclusion: After a long discussion, it was agreed that ideally the cost of hygiene promotion should also be included in sanitation & hygiene monitoring programs. But the challenge is how to do it in a cost effective way. It was also concluded that the monitoring of the cost of sanitation & hygiene promotion should first be calculated as a pilot exercise, which could provide a basis and example to the government to discuss how to do this within local government monitoring systems for sanitation and hygiene.</p>	

3. Learning from current BCC practices

This segment focused on sharing ideas, experiences and best practices from current BCC practices. Following sessions were conducted under this segment:

A. Motivators for hand washing with soap: Approach and lessons from Vietnam

B. Reflection of BCC materials by each country

A. Motivators for hand washing with soap: Approach and lessons from Vietnam

Nga Kim Nguyen, Coordinator of the Vietnam Handwashing Initiative for WSP made a presentation called “Developing an Evidence Based Hand washing with Soap Program”. The WSP handwashing campaign was initiated in 2006 with the objective of changing the hand washing behaviour of over 3 million poor women of age 15- 49 in Peru, Tanzania, Vietnam and Senegal. Nga’s presentation focused on the outcomes of Vietnam. She also introduced the idea of formative research and reflected its importance for effective design of BCC programs. An overview of the presentation can be found in annex 7.

Plenary Discussion:

Issue 1: Relevancy of HWWS in Vietnam

Prior to the baseline, there was no information on whether HWWS in Vietnam would be useful and important. But there were cases of flue and outbreaks of other diseases. Also diarrhea was affecting the minorities’ population and now WSP has also found out that other worm infestation and ARI is also related to HWWS. Moreover, Arcariasis is as high as 90% in Northern Vietnam, while is much lower in South. WHO is undertaking a worm disinfection program at different school level in Vietnam.

Issue 2: Cost of the hygiene promotion process

WSP will do a cost-effectiveness analysis but the case of Vietnam is different than other countries as there is already very detailed information on costs. Moreover, Nga believes that a large part of cost is related to development of methodology and that it could be done for smaller samples to reduce the cost.

Issue 3: Monitoring HWWS

There is no one sure way to measure handwashing behaviour. But monitoring requires trained persons for structured observation and data collection. Or else there are many ways in which it could go wrong. The only cost effective way is to spot handwashing facilities with soap and reporting it. For example there is a new study in Bangladesh looking at different handwashing proxy indicators:

- Spotting soap
- Handwashing knowledge
- Sensor equipped soap
- Structured observations
- Measuring bacteria on hands.

There are also examples from Cambodia where the community uses HWWS but the water quality is not good. Monitoring the demand and sale of soap in the community after the intervention could be another way of monitoring the progress.

Issue 4: Usefulness of formative research

Though many countries already have IEC materials, formative research is definitely useful but it should build on existing studies and this narrows the scope. Existing IEC materials can be used in different ways. Use should be reflected upon the basis on outcomes of formative research.

B. Reflection of BCC materials by each country

Members of each country presented and shared different kinds of communication materials being used at the country level for inspiration.



Laos



Cambodia



Vietnam



Laos



Bhutan

III. Conclusion

This segment consists of the **country reflection** and summary of **overall conclusion**.

A. Country Reflection

At the end of the workshop participants were divided into 5 country teams and given the three questions to present to the whole team (as given below). The major objective of this session was to get an idea which segment of the workshop was most useful to the participants and which required further inputs.

Q. What would you like to take home?

Q. What do you need to think more about?

Q. What would you leave behind?

TAKE HOME	NEED MORE THOUGHT	LEAVE BEHIND
Bhutan		
Make government investment in monitoring more visible	Indicators of monitoring costs	Sharing on village level monitoring form
Focused group discussions to fine tune BCC	Improved evidence based documentations	Confusion
Improve toilet (hygiene) categorisation data by using new insight on QIS	Opportunity for linking with other networks	Tiredness
New and old friends		
Nepal		
TAKE HOME	NEED MORE THOUGHT	LEAVE BEHIND
QIS	Common indicators (hygiene behaviour change and sanitation)	
Monitoring sanitation costs- allocation and expenditure	Monitoring investment and results	
BCC materials from other countries	Consensus on implementation and monitoring approach	
Principles of Water Aid Australia – not to claim the ownership of results	Balance between nice to know and must to know – to be careful during data collection	
Laos		
TAKE HOME	NEED MORE THOUGHT	LEAVE BEHIND
Concept of cost monitoring	Consensus on simple set of indicators	The idea of using 9 as non applicable because it is confusing
Concept of community input	Concrete monitoring system (sustainable)	
Keeping the sample location/size small	Who is going to collect data	
QIS with some modification		
Principles of water, sanitation and promotion hygiene		
Cambodia		
TAKE HOME	NEED MORE THOUGHT	LEAVE BEHIND
IEC Materials	Role of mass media for sanitation and hygiene	Latrine construction manual for hh
BCC steps and cycle development	Cost of monitoring – how detail	BCC materials
QIS	QIS	
Work on database of Hygiene promotion	Tools to measure the BCC	
Delegation of monitoring to sub national level		
Focus on children sanitation		
Vietnam		
TAKE HOME	NEED MORE THOUGHT	LEAVE BEHIND
Hand washing – proxy indicators and knowledge	QIS	Indicators/ checklist on toilet construction
Work on database of Hygiene promotion	Ideas for formative research for BCC	HH survey report
Delegation of monitoring to sub national level	Cost monitoring	
Focus on children sanitation	Tools to measure the BCC	
Cambodia's sharing on baseline for CLTS		

B. Summary of overall conclusions

As the main function of this workshop was to facilitate learning and strengthen capacities of the SNV advisors, local capacity builders and government and implementing partners on monitoring of hygiene behaviour in the sanitation and hygiene program, especially in the context of the existing monitoring systems led by the government, most of the sessions were geared towards reflecting the need and importance of performance monitoring in the sanitation and hygiene program and facilitating sharing of the best practices from the countries present in the workshop.

The workshop enabled to discuss the ongoing monitoring practices of each country and put forth current and potential issues related to hygiene monitoring in the given context. Inputs from the participants, especially the government partners provided a basis for better understanding of the current monitoring systems and possibility of integrating hygiene monitoring in the existing system. The outcome of this workshop was used to develop a specific performance monitoring framework for the sanitation and hygiene program being implemented in each country.

A brief synopsis of the major segment of the workshop and its conclusion is given below:

1. Practical issues of measuring hygiene behaviour

In order to get an idea of the practicalities of measuring hygiene behaviour, a short field visit to the surrounding area of Vientiane was organised on the first day of the workshop. Five issues: Excreta disposal- babies and young children; toilets and handwashing at public toilets; handwashing in households; toilet conditions and use in household; and monitoring practices were selected to measure hygiene behaviour, for which the participants came out with their observations, findings and conclusion. Some of the major conclusions were:

- Though child excreta disposal is important and should definitely be a part of hygiene promotion, it is yet not so clear on how to monitor the reliability as it is very difficult to measure it objectively.
- Though HWWS is an integral aspect of hygiene monitoring, knowledge of handwashing do not automatically translate it into practice. Therefore it is important to verify it through personal observations. Perhaps, HWWS could be best measured through proxy indicators.
- Since personal observation could vary from individual to individual in defining the toilet as hygienic or unhygienic, toilet use and hygiene could be best measured through criteria and common indicators.
- Some kind of incentives could definitely enhance monitoring of hygiene behaviour and QIS can also be very helpful because it visualises progress.

2. Country monitoring system and sustainable M&E

A session was held to discuss and present the ongoing monitoring practices of each country so that it could contribute to the development of monitoring of sanitation and hygiene in countries by learning from each other and discussing new ideas. It gave an opportunity to share the current monitoring practices and identify the limitations and loopholes which could be improved for more effective results. Each

country presented some strong element that the other countries could learn from. Some of the highlights were:

- Importance of the ownership of the monitoring program by local authorities
- Effectiveness of the monitoring program run by the local government
- Effectiveness of simple and cost effective program
- Need of getting back to the lower level i.e returning back the information to the communities
- Importance of being gender and poverty sensitive in the monitoring program and results
- Importance of quality control and proper training to the enumerators
- Importance of capturing qualitative information, but also being able to compare and quantify such information over a large area for which QIS could be used.

During the discussion we found that there were many commonalities in the ongoing monitoring system of each country. The common issues in all countries are given below:

- Lack of uniform and structured monitoring system
- Issue of diversity of actors and methods
- Issue of continuity of data management in changing system
- Lack of monitoring of hygiene behaviour
- Lack of incentives for quality enhancement and quality check and control
- No / little idea about costs of monitoring
- Most importantly these are predominantly reporting systems; data could be used better at local level for local learning and change.

Regarding the monitoring of the costs of sanitation & hygiene programmes there were discussions on issues of: the real need and importance of monitoring such costs; cost and time factor; practical implications; time investment of the communities etc and it was concluded that though it is essential , it is still not very straight forward on how to do it. This indicated that we should get much better idea on both monitoring of costs of hygiene promotion and the costs involved in maintaining a monitoring system.

3. Tool for a good BCC program:

The idea of formative research was introduced and the success stories of the BCC program conducted by WSP were shared with the participants. Based on their experience formative research was considered very useful and necessary for good BCC work. Importance of a formative research during the baseline survey was reflected but aligning to the present country context where we already have IEC materials, it was concluded that it could be built on the existing materials and studies. However a need of a more in depth understanding of the tools and approaches for a good BCC program was reflected.

Considering this, SNV and IRC will further take up the lessons learned in this workshop to develop their performance monitoring system and BCC strategies and formative research in other sessions in coming two days.

I. Annex:

Annex 1: List of participants

S.N	country	name	organisation	position	email
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Annex 2: Summary of D group discussion on performance monitoring

About two weeks ago we have concluded a three week email discussion around performance monitoring: monitoring progress towards ODF; how to define and measure toilet access, hygiene and use; and how to measure handwashing practices.

The results of the discussion have been used in the workshop on the same topics in Laos from 24 to 27 August 2010 and are also used to develop instruction sheets on performance monitoring and behavioural change communication.

For those who were not present at the workshop and also for those who would like to have the main elements of the discussion in one document, I have prepared a summary document with the introductions to the topic and the key issues discussed.

What did we discuss and who participated?

Through the D-group discussion we shared examples and developed ideas on *what* should be monitored for district sanitation planning (the key performance indicators), *how* (possible measuring methods and tools), *who* (possible departments, mass movements and/or, community organizations, and people that could be involved) and *when* (so as to meet both district and NGO programme requirements).

Participants of the D-group discussion were government partners (national, regional and district level), development partners (WaterAid, UNICEF, UNESCAP, GTZ, WSP?) and SNV advisors from Nepal, Bhutan, Laos, Cambodia and Vietnam, and some countries in Africa. The results of the discussion have been used in the workshop on the same topics in Laos from 24 to 27 August 2010 and are also used to develop instruction sheets on performance monitoring and behavioural change communication. We have discussed 3 consecutive topics, which are part of most S&H programmes, including the programmes SNV is involved in:

1. Monitoring progress towards ODF: what is it, what should be monitored, who monitors, and how? – See summary week 1, p.1
2. How to define and measure toilet access, hygiene and use? – See summary week 2, p. 3
3. How to measure handwashing practices? – See summary week 3, p. 5

Below you will find the introduction and summary of key issues discussed for each topic.

SUMMARY WEEK 1 (draft)

Discussion on “Monitoring progress towards ODF, sustainability & technical quality of toilets in households”

There were 4 questions:

1. What are the principles for monitoring of access to sanitation and hygiene at district level?
2. What should be monitored regarding sustained ODF and technical quality of toilets?
3. Who could monitor ODF, types of toilets and technical standards, including the gender aspects?
4. How could these aspects be monitored, including involvement of women and men, and the poor?

Q1: What are the principles for monitoring of access to sanitation and hygiene at district level?

The following could be principles for monitoring of access to sanitation and hygiene at district level:

- Ownership of the monitoring programme by the local authorities;
- Low cost and low effort for all (including rural households, and schools);
- Monitoring should be as less “extractive” as possible for local people;
- Information on performance should be returned to communities;
- Monitoring and the resulting data and analysis should be gender and poverty specific;
- Monitoring should have low sensitivity to distortions due to power relations in communities.

Participants discussion

Regarding the first question on principles, Raj from Bhutan and Suchana from Nepal pointed to the importance of community ownership of monitoring activities. Also, they requested for early institutionalisation, and ownership of local governments. In addition to that Henk from Nepal pointed out that there are always different perspectives regarding what is to be measured and to be achieved. This calls for the involvement of more different people.

Quynh from Vietnam made a pledge to keep monitoring simple and user friendly, and limited to the minimum key indicators. He explains that is it often too ambitious.

In summary, these are the principles mentioned:

1. Local communities should own the monitoring (together with others) and it should not cause overburdening or tensions. Participatory methods are preferred.
2. Local governments should own the monitoring, and we should seek alignment with national criteria. However, where national standards are too high and do not allow for progress monitoring, “more steps on the ladder” should be included.
3. Frequency: may be initially high and reduce gradually to core indicators;
4. Gender- and poor-specific results and analysed data need to get the support from the highest government officials (see below)

Q2: What to monitor regarding sustained ODF and technical quality of toilets?

There are two questions underlying this question:

1. Should districts only monitor outcomes or also progress towards and sustaining of ODF?
2. Which toilets do we consider sanitary^[1] and durable and how to count that, including ‘climbing the ladder’?

[1] For clarity’s sake, we have used the term *sanitary toilet* for toilets that meet minimal technical, environmental and health-related *construction* standards, and *hygienic toilets* for toilets that meet standards of hygienic operation and use. The first are discussed this week, the second in week 2.

Only monitor outcomes or also progress towards ODF?

In Kerala (India) and Indonesia, IRC supported programmes that monitor progress towards ODF. Promoters and/or village representatives keep lists of numbers of households (and out of them poor households), for the various stages of construction and ownership , for example:

Basic information	Total # and % of households in village <i>without</i> toilet or with <i>insanitary</i> toilet, incl. data for <i>poor households</i> ;
Demand raised	Total # and % of households without toilet and with insanitary toilet, , <i>who have entered their names on toilet construction lists</i> by (i) self or (ii) local mason, incl. for poor hhs;
Toilets constructed	Total # and % of households in village without toilet and with insanitary toilet, <i>who have started to build</i> their toilet, incl. data for <i>poor households</i> ;
Toilets completed	Total # and % of households in village without toilet and with insanitary toilet, <i>who have completed</i> their toilet, incl. data for <i>poor households</i> ;

Which toilets do we consider sanitary and durable and how to count that?

ODF status and/or toilet coverage obviously depends upon what you classify as a toilet. A starting point to define which types of toilets actually qualify as sanitary toilets is the definition below:

“hygienically separate human waste from human contact and the environment”.

Toilets that do *not* separate human waste from human contact or are open to water sources and/or flies would *not* be counted for coverage figures or ODF status under this definition.

There are two different ways to apply this in practice:

- Count only those toilets that comply with the official technology standards: Definitions of hygienic toilet technology standards in Nepal, Bhutan, Laos, Vietnam and Cambodia are still under development. It depends on the specific situation in the countries, and even within a country some technology types can be durable and environmentally adequate in one ecological zone and totally unmanageable in another.
- Count all toilets that comply with the agreed qualifying factors for a sanitary toilet: The SNV team in Bhutan has developed a toilet categorisation to address this issue. The reasoning is that technology may vary widely, as many toilets are built by households themselves.

In Bhutan simple pit latrines have long been considered acceptable standards, but this is now under revision. The Vietnamese government only considers double vault, pour flush and (semi-)septic tank toilets as hygienic. This is problematic as these technologies might be out of reach for most rural households, especially in more isolated areas. (The government is currently reviewing the standard). The Cambodian government considers five options: The Pour Flush Latrine (PFL), The Sealed Pit Latrine (SPL), The Ventilated Improve Pit Latrine (VIPL), The Dry Pit Latrine (DPL) and The Latrines for Disabled People (LDP). However, in practice preference is for PFL and the dry pit latrine has low acceptance with households due to its smell and the lack of ash. In the Indonesia programme, households sharing a sanitary toilet, e.g. 2 neighbouring and often related families which built and/or shared one toilet, became 'co-owners' and no longer counted as being without a sanitary toilet.

Participants discussion

Most of the discussion concentrated on this question. The consensus is that progress towards ODF should also be measured, in particular if government standards are high. However, there are many different views of what should be included as progress:

- Bimal from Nepal mentioned 4 stages:
 - i. ODF1: no. of observed public places and trails with OD;
 - ii. ODF2: no. of households with unsanitary toilets, also called OD in fixed places;
 - iii. ODF3: over 90% HHs access and use 'proper' and hygienic toilets, others construct or share;
 - iv. ODF4: situation 3 is sustained over time AND other positive features (such as HWWS);
- Quynh from Vietnam suggests considering all toilets that include "collection", "isolation from the environment" and "safe return to the environment of faeces".
- Sanna-Leena from Nepal, RVWRMP project, suggests including the reasons why people build or not build toilets as a way to measure in progress.
- Christine gave an example of lists at village level where not only people who had built a toilet, but also those that committed to building one were included.

Then on what do we actually want to achieve or what do we actually consider ODF, there were people like Tiwari from Kenya and Vanny from Cambodia that suggested following the JMP criteria. Others think JMP is not specific enough about the sanitary and hygiene aspects of toilets, and suggest using a list of criteria. Different assessment lists were presented. First of all, to avoid the confusion due to different terminology, let's agree on the following:

- Good toilets/ bad toilets is commonly used for construction quality (durability, strength) not for hygiene
- Sanitary/ unsanitary toilets refers to the toilet's environmental quality, i.e. excreta contained away from animals (e.g. rodents, flies), humans and water sources;
- Hygienic/ unhygienic toilets would be sanitary toilets that are also well used and maintained.

John, Kencho and Raj from Bhutan shared a list of 8 factors of what they consider a sanitary and hygienically used toilet. In Cambodia, as shared by Dr. Chea Samnang, there is an assessment check list to declare ODF. In Nepal, as mentioned by Bimal, there is a list of 12 criteria as used in Kalikot district (?), and Christine shared a latrine self-score list used at village level in Indonesia. Regarding what qualifies as a village and which area should be ODF to consider a community ODF, both John and Christine suggested to consider cat-san for fields, and focus on the inhabited areas. The definition of what are inhabited areas, if not defined by government, should be defined in consensus with the community Padam from Nepal pointed to the need to include institutions (schools!) and offices. A further suggestion was that when more households share a sanitary and hygienic toilet, either each household counts as served or the sharing households are a separate category; A challenge is what to do about OD in very small and scattered hamlets and individual or a few scattered homesteads. Here risks of infection thru OD are lower, although flies may still transmit faecal germs to other homesteads. The consensus seemed to be that we monitor in what local government classifies as hamlet or village, or rely on either the formal or community-drawn

boundaries, and disregard other very remote households in the ODF qualification (but not in the promotion activities of course).

Q3: Who could monitor ODF, types of toilets and technical standards, including the gender aspects?

Again there are two questions here:

1. Who should collect data?
2. Who should manage and analyse data?

One option for data collection is that specific village cadres, e.g. in Dept. of Health or Local Government, or leaders of local institutions such as women union, and headmasters, report the dates of agreed indicators to those responsible in their departments or union at district level. Reporting from village committees/schools to districts could even be by text message. Data management at district level would ideally be done by the district line agency or local authority. This agency would also share the data with other stakeholders (such as SNV) *and* feed back comparative summaries of the performance to the participating villages, so that they, too, can manage change at local level. The question here is what is sustainable in your country, considering constraints in time, resources and capacities that occur at district level?

Participants discussion

Who manages and uses the data. Most people who touched upon this point emphasised the importance that local community level organisations should be involved, as well as village level for example commune in Cambodia and VDC (village development committee) in Nepal. Sanna-Leena and Christine pointed out that it could be also a neighbourhood group (Ward), reporting to the VDC-wide institutions (such as VDC itself, or something like Health Post, main school, Water Resources Management Committee representing the whole VDC etc) In our working areas, there are many options, but no one-fit-for-all option.

At *district* level: 'local government' was mentioned by all. However we did not enter into the discussion whether this should be managed by line agencies (Health or Works or Rural Development) or by the local authorities, as this is very context specific. Raj emphasized that the discussion on institutional capacity and institutionalisation the data collection, management and analysis (the whole package) should start now. There are of course different monitoring efforts in the countries ongoing, so this is also context specific.

Q4: How could these aspects be monitored, including involvement of women and men, and the poor?

A complexity of social programmes, such as promoting and monitoring S&H is that the objectives include "community wide" achievement, and social inclusion. This implies that there is clarity about:

- a. Which households belong to the community?
- b. Which are the poorer, low-caste and female headed households respectively?

The proposal is to do this through social maps and wealth ranking exercises.

A complexity of large programmes is the need to aggregate qualitative data. The proposal is to do this through the use of scoring scales, which score different performance 'scenarios' with the help of scores from zero (the worst situation) via 25 (one step up), 50 (two steps up and the 'benchmark', or minimal standard aimed at) and 75 (the best but one scenario) and 100 (the ideal). IRC has several practical examples of these scales as used in Nepal (with NEWAH) and in Indonesia.

Participants discussion

Gender and poor-inclusive monitoring was mentioned, but there was little detail on how this should be done and this clearly needs further discussion. Segregated statistics on relative progress towards ODF and sanitary and hygienic toilets for the poor and female-headed households are of course the first step. The struggle here is how do we define the locally poor, and the female-headed households? Vanny from Cambodia pointed out that in Cambodia there are several categories of female-headed households (i) widows, (ii) divorcees, (iii) absence of a male spouse's contribution to household management, and (iv) absence of a male spouse due to migrant work, the latter may not always be easy to identify.

To identify poor households we may be having methods, but when we are working with a "subsidy free" concept what do we do with the people we categorize as "poor" any way? The proposal is to do

this through social maps and wealth ranking exercises. This is one difficult and debatable issue and this might differ in different cultural, social and economic situations. We could continue debate on this during week 2.

SUMMARY WEEK 2 (draft)

Discussion on "Monitoring sustained access to and hygiene of toilets and consistent use by all in households & schools"

There were 2 questions:

1. How to define and measure toilet hygiene?
2. How to define and measure toilet access and use?

Q1: Measuring toilet hygiene

Regarding the first question on measuring toilet hygiene Syvibola Oun finds it important to discuss the definition of toilet hygiene. Compared to Bhutan and Indonesia, Cambodia has no criteria she says and Vanny Suon confirms this.

The sub-questions triggered lots of discussion.

a. Do we combine technical quality and hygiene quality in one checklist?

All the contributors thought this was a good idea (Vanny Suon, Syvibola Oun, Phurpa Thinley and Gabrielle Halcrow. Although many mention that lack of human resources and finance may be a problem. Gabrielle also warns that "the amount of data collected can too quickly become overwhelming so keeping it simple, practical and feasible is best..."

Phurpa Thinley adds that "ideally, the person who will be using the data should be involved in collecting data or if not supervising the data collection process."

- b. Who does the scoring? Government staff from one Dept., e.g. health worker, sanitarian? Staff from several government agencies and movement, e.g. also women leaders, youth leaders, village heads? Volunteers e.g. wash committee members, school health club members, schoolchildren (for hygiene and arithmetic lessons)?**

John Collett emphasizes that whoever does the scoring, it is important to have dedicated people: there is a danger of the situation "Rubbish in, rubbish out"

Both Syvibola Oun, Vanny Suon and Gabrielle Halcrow stress the importance of properly trained facilitators. Phurpa Thinley writes that "it should initially be done jointly by program personnel and health staffs in the field. This is to build common understanding of scoring methods and approach. Also, ownership and accountability can slowly be handed over to government health staffs for sustenance of similar practices in other villages too." This aspect is also stressed by Gabrielle. It is important to add value to the existing health monitoring system at the provincial level rather than operating in parallel".

- c. Scope and frequency of scoring? All household toilets at regular intervals, or only the newly built toilets at three increasing intervals, assuming that after that the habits are formed (=the system in Kerala)?**

Syvibola Oun, Vanny Suon and Phurpa Thinley stress the importance of regular intervals for scoring, at least one time per year. Thinley would also like to see a mid-term scoring exercise to monitor change.

- d. Ease of data management? The more indicators, the more work for data entry and analysis. Do we want a minimum of hygiene (and technical) indicators? If yes, which are crucial?**

Syvibola Oun suggests a minimum of indicators

1. Are human faeces visible on the floor or slab of latrine?
2. Is there a handwashing place inside or just outside the latrine?
3. Is toilet structure good (wall, roof etc)

Christine Sijbesma stresses that **indicators need to be as objective as possible**. For the third criteria for example: “how do you observe “good”? What one observer says is good (enough), another may say that it is not good enough. Could we agree on which indicators can replace good.”

Phurpa Thinley mentions the following “must indicators”:

1. Faeces contained away from human/animal contact (e.g. flies, cockroaches and rodents)
2. No open faeces/ faecal smears visible on floor/walls
3. Anal cleansing materials used correctly and properly disposed (e.g. not in open basket)
4. Hand washing facility inside the toilet

Christine Sijbesma suggests to re-phrase the fourth, as in some cultures it is not done to have a handwashing facility inside the toilet “A special place to wash hands when coming from the toilet, with water and soap/soap substitute (e.g. ash, clean sand lunga) present”

She also adds a criterion on sustainability: 5) Is toilet durable (likely to survive the next monsoon)? (and if not, note if upgrade is planned?)

Q2: How to define and measure toilet access and use?

To ensure maximum use of toilet by all people, it should be constructed as nearer to the house, says Phurpa Thinley. Both Phurpa and Syvibola Oun say it is difficult to obtain true information from respondents. They mention observation rather than asking.

John Collett wonders if “health impacts are more likely to be seen if toilets are inside, attached to or conveniently close-by the home? On a practical note, it is probably not enough to simply look at the distance to the toilet – we also need to look at what the ‘journey’ to the toilet involves: 10 steps away may not sound very far but if it involves climbing up or down, negotiating slippery paths etc., who’s going to take the trouble – especially in the dark or in the rain?”

Antoinette Kome suggests to include user satisfaction as one of the ways to measure access. User satisfaction should be differentiated by gender and main age groups at least.

Principles

Finally there were some general statements about principles of monitoring. Antoinette stated that measurement should give meaningful information for improvement. In other words, in the discussion about “who should be involved to measure what”, I would also like to see the link to: who is going to use the information for what?

- a. One important use of the information can be to create incentives. For example the incentive for village heads to achieve/ be awarded ODF status, or for households to have their toilet ranked as a 3 star toilet (or pass minimal benchmark).
- b. Another important use of the information is to improve hygiene promotion programmes, for example by targeting at a specific group or addressing specific needs/ limitations for access.

John Collett also questions who is going to use the information and for what; “what can we do to help ensure the authenticity/ reliability/ veracity of data collected? And what can we do to help ensure that instead of simply extracting information from communities, the information (and the findings from its analysis) first and foremost serves the community?”

SUMMARY WEEK 3 (draft)

We have received eleven very good contributions to this last week’s discussion.

Discussion on “How to measure whether handwashing with soap is done by all household members at critical times?”

There were 4 questions:

1. Which are the critical times and how to define those in a local context?
2. Should handwashing be with soap?
3. How to measure if hands are washed with soap by all?
4. How to understand the factors that affect behaviour change regarding handwashing?

Q1: Which are the critical times and how to define those in a local context?

The USAID Hygiene Improvement Project considers the following five critical moments: 1) after defecation, 2) after cleaning a child, 3) before preparing food, 4) before feeding a child, and 5) before eating.

All the participants agree with these critical times and Kalawati mentions the first three as the minimum: after defecation, after washing baby's bottom and before eating.

Defining critical times in a local context was seen as important and could even be integrated in BCC activities. Gabrielle for example suggests that facilitating a group activity with the F Diagram to identify the transmission paths within a given community could be used for learning these critical times.

Syibola mentions the difference between rural and urban. She feels that in urban areas in Cambodia, handwashing with soap is not so much advocated as in rural areas. She wonders if faecal-oral diseases are more prevalent in rural areas than in urban areas.

Q2: Should handwashing be with soap?

There are still more questions than answers. Some wonder if ash is a good substitute at all times (Karma, Kalawati). John asks if we know which critical time is the most critical one: after toilet use or before eating. And he questions whether we are more likely to get sick from the uncleanness of our hands or from the unhygienic safety of the food and drink in front of us?

However, all participants stress the importance of handwashing with soap. "Now soap is taken as vaccine to prevent diarrhea and ARI", says Kalawati and she mentions that soap is mandatory in different field kits like home delivery kit of mid-wifery and point of use (PoU) in Nepal.

So, soap seems to be considered important, but what about the enabling factor: can people buy soap? A few comments were made on affordability and availability.

Affordability & availability - can people buy soap?

Syibola warns to be realistic. When people do not have enough money to have food three times a day, then we may need to focus on the first step: from not washing hands to washing hands on critical times. The next steps could then be to wash with ash and then with soap.

Kalawati says that if people are aware of the health benefits, they will be able to pay as they also invest in cigarettes and alcohol. John observes something similar from Bhutan: "A miniature bar of commercial body-soap in Bhutan costs about the same as five pieces of doma (which is habitually chewed by many men and women in Bhutan – 10 to 20 pieces or even more per day)." Kalawati adds that if there is demand, supply will increase, even in remotest areas. She also mentions public private partnership to make access of soap at subsidized rate and the need to encourage local supplier and cottage industries where are available.

Q3: How to measure if hands are washed with soap by all?

- One of the key lessons [3] from the Hygiene Learning Event by WaterAid Australia is that hygiene measurements should be participatory. There are two options:
 - Structured observation providing useful information on directly observed hand washing behaviours and the frequency of behaviours.
 - Self-reporting. However, research by Lisa Danquah [4] demonstrates that self report hand washing measures are subject to over reporting.

Other used methods are using so-called proxy indicators, such as:

- Whether people have knowledge about when to wash their hands. The limitation is that knowledge does not always result in behaviour.
- Whether there is a place for handwashing and soap is present. (Spot check methods of soap and hand washing locations) The limitation is that not all family members may be using it.
- Whether the handwashing place is at an accepted, convenient place for all family members/school children.

Participants feel there is a gap between knowing and doing. Karma for example writes: "Let's assume that the community or the participants know the importance of hand washing but do they practice it practically or just leave it in their brains [...]" Vanny mentions that "about 50% of respondents could

recall the hand washing advert produced by the BBC World Service Trust” but this awareness is rarely reflected in changed hygiene behavior because of common household constraints such as inadequate water supply near to the home; high cost of services and a lack of motivation or incentive for change.

Use of proxy indicators

All participants struggle with how to measure if people actually wash hands and the use of proxy indicators was discussed a lot. In Cambodia it was agreed to use proxy indicators such as know how to wash hand and a place for handwashing and soap is present (Syvibola).

Maybe the best practical proxy indicator we can take for hand-washing after use of the toilet is the presence inside the toilet, at the entrance, or somewhere along the path to the toilet of the means for hand-washing, says John.

He adds that regarding hand-washing before eating, the best practical proxy indicator may be the presence of a handwashing place near to where eating takes place of the means for hand-washing. If there is not a fixed hand-washing place, a presence of a water jug and bowl with soap (brought to the eating place) may be a common alternative.

However, John also gives the example of Bhutan: “In the Rural Sanitation & Hygiene Programme baseline survey in Bhutan we found that 91% of households had some type of soap available for hand-washing. However, only 30% of households had a hand-washing place near their toilet.”

Structured observation

What does this mean for the use of proxy indicators? Gabrielle mentions a study by Schmidt, Hirves and Curtis² called “Comparing the performance of indicators of hand-washing practices in rural Indian households” that concludes that hardly any proxy indicator provides an accurate guide to the actual practice or prevalence of hand-washing. Structured observation remains the best indicator of those tested.” There are however, some severe difficulties noted in the use structured observation by Nga (see box).

Using a combination of methods

Using a combination of methods appears to be the best option as participants know so far. “I’ve tended to rely on a combination of proxy indicators such as using an environmental check tool, hand washing demonstrations for mothers / school children and to engage communities using pocket chart voting similar to how they’re used in PHAST activities.” (Gabrielle).

And Nga writes: “[...] we have opted to use placement of soap near the latrine to be more practical proxy indicator of intention to HWWS. This can be easily combined with a household visit during field research or during monitoring of other water and sanitation programs and can also be combined with other methods such as self reported HWWS practices, etc.”

Q4: How to understand the factors that affect behaviour change regarding handwashing?

“Do we always wash our hands on the occasions we know it’s important to do so, or do we sometimes fail to do so? I guess most of us may have to admit that we are not very consistent – i.e. sometimes we do and sometimes we don’t.” says John, triggering the discussion.

Knowing why people act like they do is very important in order

Challenges of structured Observations – experience of Nga (adapted by Ingeborg)

1. During the SO, you must decide who is the "index person" that you will follow, e.g. the mother. During the course of the 5 hour SO, the mother would often leave the house in which case we had to decide to follow her or stay at the HH.
2. In larger compounds, it was often very difficult to choose a place to capture both HWWS before eating/preparing food and after using a latrine.
3. Field staff gathering the data must receive significant amount of training to be able to fill out the complex forms.
4. Validity of our data: the observed HWWS rates were higher than reported. (the research firm had changed their introduction and called it "study on sanitation", which likely sensitized the family to the need to increase their HWWS practices above what they normally would do.
5. Intrusive nature of SO: the family's habits maybe altered by the presence of an outsider.

² Birani, Schmidt, Juvekars, Hirves and Curtis (2008), “Comparing the performance of indicators of hand-washing practices in rural Indian households” in Tropical Medicine and International Health Journal, Volume 13 no 2 pp 278–285 february 2008 accessed online at <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.200702001.x/pdf>

to achieve behaviour change. This seems difficult to grasp and sometimes the discussion focuses on HOW (using a single message, using demonstrations or documentaries) instead of focusing on the WHY.

Regarding hand-washing after toileting, there are a number of factors to take into account according to John:

- First and foremost, the toileting place: Is there the means for hygienic hand-cleaning (soap and water) nearby, or have you brought your own means of hand-cleaning with you?
- Are people more conscientious about hand-washing after shitting compared to after urinating?
- Are females more conscientious than males or vice versa?
- Are washers more conscientious than wipers or vice versa?

Changing behaviour takes as long as it takes

Behavior change is a process -it seeks adequate time, patience to aware people since it must be realized individually and included in his/her daily life style, sincerely for own sake. (Kalawati)

Additional information shared during the D-group discussion

Handwashing tools

Example of hand washing demonstration activity

“Of every 3 school children asked, 2 are able to adequately demonstrate hand washing”

A scoring system is used which captures knowledge + availability of water and soap

Limitation: not validating if it actually happens (Gabrielle)

Voting for hand washing behaviour

WSUGs make sure that the people understand well before they start voting.

People can vote for each of these practices if they usually do it.

- Washing hand with soap before eating and after defecating
- Washing hand with soap before eating
- Washing hand with soap after defecation
- Washing hand with water only

Next, we will see did they change their behaviour from the above questions, and then we will see a significant change from the respondent. (Vanny)

How to make soap – two examples

Liquid soap John has sent a recipe for liquid soap (taken from SNV materials)

There's soap at home but not at school

A zero-cost solution from one school:

Liquid soap can be made from small scraps of bar soap. Grate the scraps into fine pieces and heat with the same weight of water. Be careful not to let the mixture boil. Stir the mixture as you heat it, and stop heating once all the soap has melted and the soap and water have formed a uniform liquid. This is your liquid soap! Experiment with the quantities of water used as this will vary slightly depending on the type of soap scraps you use. The liquid soap can be dispensed from a plastic container that can easily be secured in the hand washing area.

SNV

Connecting People's Capacities

Soap in a bag.



Christine has sent an example from WASH in Schools.


Teachers ask children to bring the final pieces of soap bars from home and knead it into a new ball. To prevent loss of soap, a bar can be put in a net and nailed next to the water vessel/basin.

Annex 3: Presentation of the HH sanitation assessment in Laos

Rapid Assessment of Household Sanitation Services in Vientiane Capital

23 August 2010

Introduction and Findings of HH Surveys




Rapid assessment of household sanitation services, Vientiane Capital

Outline of presentation

- Introduction to rapid assessment
- Findings of household surveys

Rapid assessment of household sanitation services, Vientiane Capital

Introduction to rapid assessment



Rapid assessment of household sanitation services, Vientiane Capital

Introduction to rapid assessment

Background

- ❑ Available information suggests that household sanitation is generally satisfactory in Vientiane:
 - Coverage of household toilets is said to be high in Vientiane:
 - Population and Housing Census (2005): 82.8% of population
 - UNICEF-WHO JMP (2008): 94% of urban population in Laos; 84% with improved facilities
 - Nam Saat (2009): 95.59% of population in Vientiane Capital
 - In Vientiane Capital households use predominantly onsite facilities:
 - pour-flush toilets connected to a septic tank or soak pit; and
 - Septic tank emptying services are widely available
- ❑ However, no substantive data is available to confirm this.
- ❑ Furthermore, the capital's rapid growth is raising questions as to the medium term viability of on-site sanitation.

Rapid assessment of household sanitation services, Vientiane Capital

Introduction to rapid assessment


- ❑ WSP and PTI agreed to commission a study to test some of the unsubstantiated assumptions and assertions.

Objective of rapid assessment

- ❑ To conduct a rapid assessment of the adequacy of existing domestic sanitation facilities in Vientiane, especially in middle- and low-income areas where investments in these facilities are likely to be modest.

Rapid assessment of household sanitation services, Vientiane Capital

Introduction to Rapid Assessment



Rapid assessment of household sanitation services, Vientiane Capital


Introduction to Rapid Assessment

Main activities

- ❑ Desk study of relevant laws, regulations, documents, etc. and interviews with main stakeholders, focusing on:
 - Legal and institutional framework
 - Local building regulations
 - Septic tank emptying services
- ❑ 500+ household surveys in 16 urban villages in 4 urban districts
- ❑ Survey of multiple occupancy accommodation focusing on dormitories
- ❑ Water quality testing to check for groundwater contamination

Rapid assessment of household sanitation services, Vientiane Capital

Findings of household survey



Rapid assessment of household sanitation services, Vientiane Capital Findings of HH survey

Findings of household surveys

Survey methodology

- ❑ 16 Urban villages were selected in consultation with VUDAA and District Public Work and Transport Office representatives in the four urban districts

Based on:

- ❑ Low and middle income areas
- ❑ Flood prone or high ground water levels
- ❑ Population density
- ❑ Rapid urbanisation

Rapid assessment of household sanitation services, Vientiane Capital Findings of HH survey

Findings of household surveys

Sampling procedures in selected villages

- ❑ Total survey sample of 525 HH including safety margin, divided proportionally over 16 villages
- ❑ Based on discussion with Village Authorities areas with relevant population and problems were identified:
 - Low and middle income houses/households based on occupation
 - Flood prone areas
 - Crowded and / or slum like areas
- ❑ Sampling intervals were calculated based on proportional sample size for the village and population of the target area
- ❑ Sampling was started randomly and next houses selected based on sampling interval

Rapid assessment of household sanitation services, Vientiane Capital Findings of HH survey

Findings of household survey

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

Household information

- 548 houses were surveyed
- 66% of the respondents were female
- Average age of respondents was 43 years
- 40% of respondents were the head of household
- 39% of respondents were spouse of the head of household
- On average 5.5 persons per house
 - minimum 1 person, maximum 25 persons
- 487 families were house owners (89%)
 - 4% tenants, 3% lodgers, 2% tied accommodation (2% missing data)

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

Water supply

- 91% had access to piped water
- 2.4% did not have access to water throughout the year

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

Of 548 houses surveyed

- 28 houses without sanitary facilities (5%)
 - 14 houses in Ban Nongdouangthong use a public toilet
 - 12 houses use their neighbours' toilet
 - 2 houses go "to the forest, or to the field"
- 520 houses with sanitary facilities (95%)
 - 594 seepage storages
 - 1 pit: 457 (88%); 2 pits: 54 (10%); 3 pits: 8 (1.5%); 5 pits: 1
 - 664 toilets
 - 1 toilet: 411 (79%), 2 toilets: 82 (16%), 3 toilets: 22 (4%), 4 toilets: 3 (0.6%), 5 toilets: 1 (0.2%), 6 toilets: 1 (0.2%)

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

The 664 toilets were used by

- 2851 HH members
 - In 51 houses one or two infants/small children were not yet using the toilet
- On average 4.3 persons per toilet
 - minimum 1 and maximum 20 persons using one toilet
- Or 2973 people, including neighbours and customers
- On average 4.5 persons per toilet
 - minimum 1 and maximum 22 persons using one toilet

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

Persons per toilet

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings of household survey

Design and functionality of 664 toilets

- 374 were inside the house (56%)
- 10 were part of the house but accessed from outside (2%)
- 280 were detached from the house (42%)
- All 635 toilets that were observed were flush toilets
 - 12% cistern flush; 88% pour flush
 - 78% had masonry walls, 15% walls of some type of sheeting, and 7% of other materials
 - 90% had roofs of various type of roofing sheets
- 67% of the toilets was observed to be durable

Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings for household surveys

Water for flushing

- All toilets have some form of water for flushing available

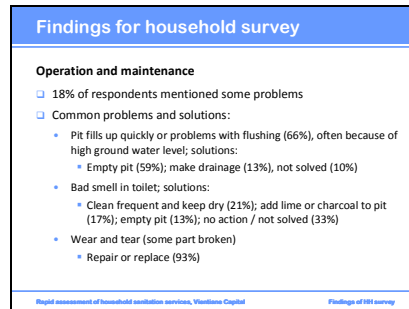
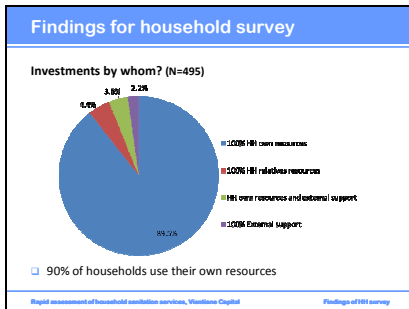
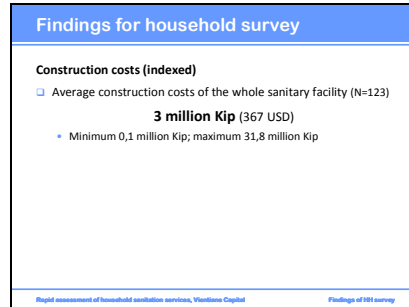
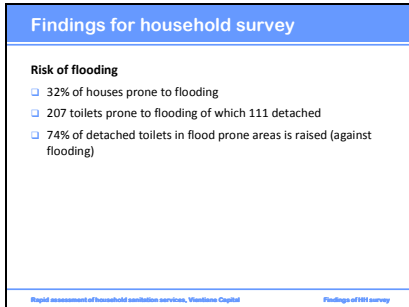
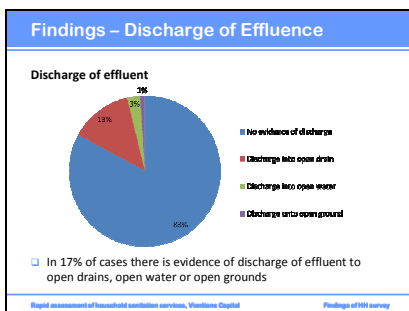
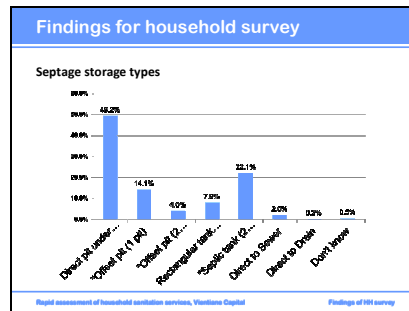
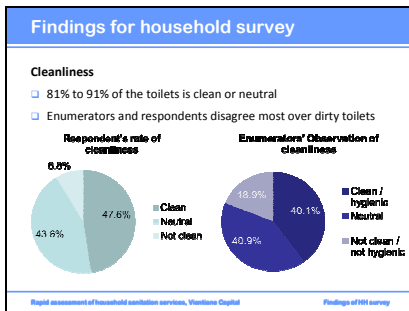
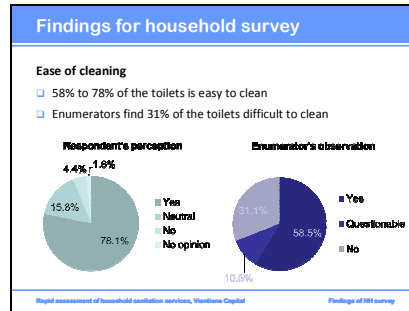
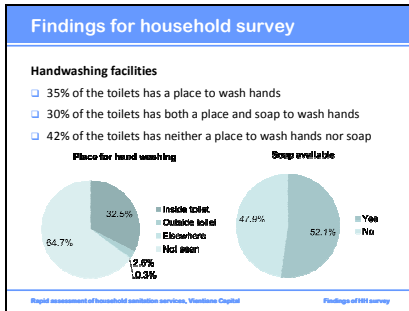
Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey

Findings – Water for anal cleaning

Water for anal cleaning

- 39% of toilets has tap inside the toilet for anal cleaning and for cleaning the toilet
- 4% of toilets do not use water for anal cleaning

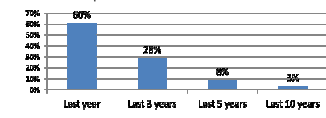
Rapid assessment of household sanitation services, Vietnam Capital Findings of HH survey



Findings of household survey

Emptying of septage storages

- 34% of septage storages build after 1990 had filled up
- 98% was emptied by vacuum tanker; 2% manually
- Last time emptied:



- Average costs for emptying: 200,000 Kip (25 USD) in last 5 years

Rapid assessment of household sanitation services, Vietnam Capital

Findings of HH survey



Rapid assessment of household sanitation services, Vietnam Capital

Findings of HH survey

SNV


Partnering for Impact

For




Annex 4: Presentation on Monitoring Hygiene: Lessons from Case Studies

Water, Sanitation & Hygiene





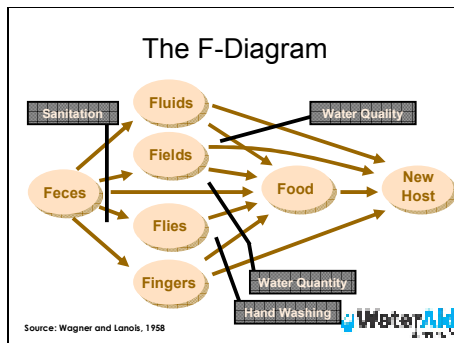
"Poor Cousins of MDGs"

Peter Dwan
Head of International Programs



WASH & Health

- links well known
- Faecal oral route

1981 - WaterAid UK


2003 - WaterAid Australia

Programs – Timor-Leste, PNG, Laos






2006 - WASH Reference Group

- 30 members -ANGOs, Universities
- Lobby for WASH - \$300million
- Community of Practice



Key WASH Problems:

- Sanitation
- Hygiene – esp HWWS
- Functionality of water systems

WASH Reference Group


- 2007- Sanitation booklet
- 2008 - SanWat Conference
- 2010 – Hygiene Workshops and booklet



Hygiene : 11 studies + overviews

The Case Studies

- School Focus:**
 - Children Without Worms, Cambodia
 - WASH 7, Fiji Red Cross Society, Fiji
- Community-based Approaches:**
 - WASH Action, urban slums Jakarta
 - Red Cross, Solomon Islands
 - Hygiene Improvement Project (USAID), East Africa
 - World Vision / WASH, Venezuela
 - University of Health, SOGRI Program, East Timor
 - WASH Projects, PNG
- Campaign Approach:**
 - Water and Sanitation Program (WSP), World Bank, Indonesia, Public-Private Partnerships
 - WSP World Bank, Vietnam, Mass Media
 - UNICEF HQ, Global Handwashing Day



FINDINGS:

1) Health is not only and primary motivator

Powerful others are the wish to:

- Avoid dirt
- Protect children
- Feel comfortable
- Be attractive

Health comes as a long-term effect.



2) Finding out about local drivers before designing an HP program is a wise investment.

3) Having fully-equipped places to wash hands with soap and manage drinking water facilitates both good practice and measuring behavior change



4) Programs have started to measure effects of HP (behavior change), but not yet cost of HP



BUT: Only 1 of 11 HP cases gave (some) cost data:

HP : training voluntary teachers, 26 classes with urban waste picker children 8-12,


Behavior Change: before & after measurement of children's hygiene knowledge and home practices showed average of 36% improvement

Resurvey after 3 months > drop of 11% due to lack of parents' support to children's practices, so now also parent's classes

Cost: Equipment US\$ 200, Materials US\$ 66/child/class
Training? Survey? Parent's class? Other?




Annex 5: Introduction to Qualitative Information System (QIS)



Introduction to QIS

Quantification of Qualitative Information through Scales


Christine Sijbesma



D-group on Performance Monitoring of S&H


We want PM to be:

- easy
- locally-owned
- measurable (observable, countable)
- not subjective (e.g. 'hygienic')
- participatory
- involve persons who also use the data
- allow for progress (steps on ladder)




Minimal Performance Monitoring

- Progress in access: with/no toilet, shared toilet, access for poor (3-4 scores);
- Toilet quality, technical + hygiene together Bhutan: 8 criteria, Nepal:12 (8-12 scores);
- Toilet use by sex and age (up to 8 scores);
- Handwashing (e.g. observable provisions - none, water, water & soap at 2 key locations) (2- 6 scores)



Plus include also institutions (schools, monasteries, etc.) say 6 scores/institution

TOTAL about 20-30 scores per household alone




How to get less data and make them comparable?

Solution Bhutan: rank households, villages, communes, VDCs, etc. by performance levels, (max. 3 points/criterion)

Level	Classification	Score
1	Basic and unhygienic	8-12
2	Moderate toilet	13-16
3	Good toilet	17-20
4	Hygienic toilet	21-24


EG: in District 1 on 1/8/10: Village 1: 50% - 40% - 8% - 2%
Village 2: 30% - 30% - 20% - 20% etc.

Measuring progress in time & comparing between places is simpler




Strengths, Weakness and Alternative

- Advantages: much less data, simple & objective scoring, comparing both between households, hamlets, villages, districts and over time (progress)
- Disadvantage: you cannot plan for improvements because you do not know for which factors the households, villages etc. do best or worst. No qualitative data, only numbers.
- How to link number with qualitative info? Link each score to a descriptive (qualitative) scale



The Bhutan criteria as scale


Level	Observation	Score
0	Toilet not in use as toilet	0
1	Toilet in use as toilet and feces contained away from people, animals and water sources (chart)	25
2	Toilet in use as toilet, feces contained and toilet free from any fecal smears in/on pan, floor,	50
3	Toilet in use as toilet, feces contained, toilet free from any fecal smears and privacy and close-by	75
4	Toilet in use as toilet, feces contained, toilet free from any fecal smears, with privacy and close-by, and handwashing provision with water and soap observed close-by	100



How will data base look like?

In hamlet/village X on 1/8/10:

#	HH ID	V.Poor 1=Y	Latrine?	Latrine Quality Score 9= not applicable	Latrine use score (Table to be made)
1	2770	1	0	9	
2	1457	2	1	75	
3	2398	2	1	50	
4	1987	1	1	50	
5	3044	2	0	9	
6	1768	2	1	25	



At commune level (3 hamlets) on 01/08/10

VIII.	# HHs	Poor	% Toilet	% Poor/ Toilet	Scores Toilet Quality					
					0	25	36	50	75	100
1	30	1/3	50%	1/4	7%	36%	13%	27%	7%	13%
2	24	1/6	83%	1/10	4%	25%	-	80%	5%	5%
3	16	1/16	26%	0	-	26%	-	26%	26%	26%

How to analyse:

Where in commune is performance in access to toilets better?

How does the share of the poor in total population compare with share of the poor in access to toilets?

How do hamlets in commune score on toilet construction quality and hygiene when you look at their distribution across the scales?

Where are the biggest gaps in scale levels?

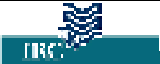
Annex 6: Introduction to cost monitoring



Workshop on Monitoring the Performance of Sustained Sanitation and Hygiene for All



MONITORING COSTS

Christine Sijbesma




Contents

1. Monitoring the effectiveness and the costs of the program
2. Monitoring the costs of the institutions
3. Monitoring the costs of the communities
4. The costs of the monitoring itself:
 - a. for the institutions
 - b. for the community

Monitoring costs: Which costs? Whose costs?




- We monitor HP/BCC activities and outputs, but how effective is the program? → Evidence-based HP/BCC, performance monitoring
- Governments, donors want to know: "Effective at what costs?"
 - We monitor the costs of the activities, but:
 - Which costs in which institutions? Costs of HP/BCC time-inputs of local functionaries? (They may not promote full-time...) Which functionaries? (More may be involved...) Which other BCC costs? (Studies, materials development and production, allowances, transport.....did I forget any other?
- And are there also HP/BCC costs in the community and/or households?



BCC Costs of communities/households


- Costs of community time inputs? (e.g. for attending HP meetings, for BCC work by village committees and voluntary workers)
- Household investment costs for hygiene? E.g. handwashing stations
- Household recurrent costs for hygiene? E.g. soap

Example BCC program in Burkina Faso:
 HH costs: \$ 7.3 /year (mostly soap)
 Est. savings \$ 4.6- 30/hh/yr (in case child dies) (Borghi et al, 2002)

How much does the monitoring itself cost?


- How much does the monitoring itself cost? → Data collection? Entry? Aggregation? Analysis? , Reporting up? Reporting down?
- To what use? Use of data for program management? Information and documentation?
- Costs to Community?



Cost of monitoring by community & gender: case from Kerala

Example Kerala (S. India)

- 1 ward = 500 hhs
- At start 30% had toilet (150 hhs)
- 1 Watsan Ctee had min. 3 women
- Toilet monitoring: quality, O&M knowledge, hygiene: 3 visits, at construction, after 1 month and after 3 month.
- One batch could be 25 toilets, so each of 3 ctee member spends 3 x 8 hours to monitor > gender issues of double burden women and complaints from family



Annex 7: Motivators for hand washing with soap: Approach and lessons from Vietnam

Developing an Evidence Based Handwashing with Soap Program

Picture

The process

- Step 1:** Who do we want to communicate to?
 • Method: Audience Research
- Step 2:** How do we organize research findings?
 • Method: Use a behavior change model
- Step 3:** What do we want to say?
 • Develop Key Communications Messages
- Step 4:** How do we convey our messages most effectively?
 • Campaign positioning and execution
- Step 5:** How to we monitor changes because of our program?
- Step 6:** Revisions to improve the program for phase II

Step I: Audience Research

- "I only need to HWWWS if my hands are dirty or smelly"
- "I simply forget to HWWWS when I'm in a hurry"
- "Soap is too expensive to be used for HW"
- "HWWWS is simply not important"
- "Weather and/or uncooked food cause diarrhea"
- Water and soap are available in most households near the kitchen area, less so near latrines
- Ms. Thuy enjoys watching TV every night and does not listen to the radio or have time to read the newspaper
- Health Workers & Women's Union members are her most trusted source for information

Mrs. Thuy

What Mrs. Thuy values

- Having a child = huge involvement of mothers
- The family is the corner stone of Vietnamese society
- It is well entrenched in the society that dedicating oneself to your children and hence the future is of great importance

RESEARCH FINDING

- "Handwashing is not linked to diarrhea"
- "Rinsing hands with water is enough to clean my hands"
- "Changes in the weather cause diarrhea – there's nothing I can do about it"
- "I simply forget to wash my hands with soap"

DETERMINANT



Step III: What we want to say

After the campaign, the target audience will:

- KNOW that even clean-looking and clean-smelling hands can have germs (**knowledge**)
- BELIEVE that HW with water alone is not enough - soap is needed (**belief**)
- BELIEVE that HWWWS is time well spent (**belief**)
- BE REMINDED to HWWWS at critical junctures (**cues to action**)
- FEEL empowered that HWWWS is something **they can do** to ensure the well-being of their children (**locus of control**)

Step IV: How do we convey our messages most effectively?

Multiple rounds of creative materials to convey Good Motherhood

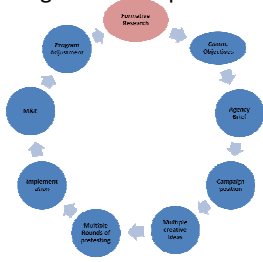
Results of Pretesting Round I

In A Mother's Hands

- Very emotional, very appealing, that is US.....
 - But in a Mother's Hands is more than HW, it's about the future of our children and our role as a mom
 - It makes us feel as if we are not doing enough – guilt!
 - The hands on the posters are interesting but not related to HWWWS
 - No direct connection between campaign and HWWWS message. 😞
- #### 5 Fingers Clean –
- Appealing, but more importantly reminds us to HWWWS!
 - "Everyone knows the song and my grandkids would sign the song to remind me"
 - It reminds us that water is not enough. 😊

Tagline "Health," "development" were most closely associated with mother's concerns for children under five. "happiness", "future" were not associated with such young children

Program Development Process



Why invest in formative research?

- Formative research is the basis for program interventions, communication objectives, campaign messages, monitoring and evaluation.
- Audiences insight tell you:
 - If there is actual or latent demand for products and services
 - Appropriate pricing for products and services
 - What would motivate them to adopt a new behavior or invest in a latrine
 - Confirm or challenge your assumptions about the appropriate intervention
- Program interventions designed without audience research is like building a house without a foundation
- Don't assume you know "their world" – especially children

Thank you

For more information, contact

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