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A STUDY TO FIELD EXPERIENCES IN HYGIENE EDUCATION

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A STUDY TO FIELD EXPERIENCES IN HYGIENE EDUCATION

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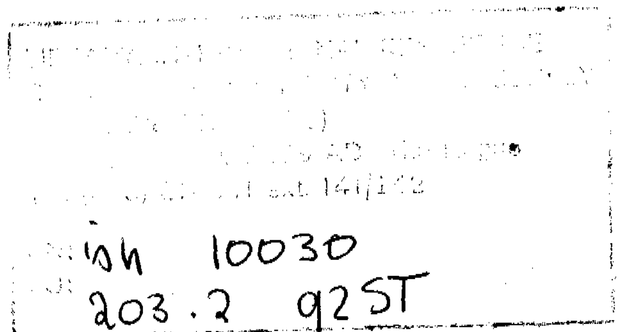

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PREFACE

This thesis has been written as the final element of the scientific research period of my study in Health Sciences. Being engaged into the main subject of this study, Health Education, I often wondered how the quality of health education programmes could be upgraded. Because I am also interested in issues related to developing countries, I wanted to combine both of these interests during the research period of my study. For these reasons, I decided to fulfil my apprenticeship at the IRC International Water and Sanitation Centre in The Hague.
During my apprenticeship I have investigated the field experiences of hygiene educators in water and sanitation projects. The findings of this investigation are embodied in this report. The intended primary users are those responsible for the development and implementation of hygiene education in water and sanitation projects. In addition to this report the results of my study will also be published as an "Occasional Paper" of the IRC International Water and Sanitation Centre.

I am thankful for the valuable support and advices Marieke Boot gave to me. I learned a lot while working with her. My special thanks go to all the respondents. They spent a lot of time and effort filling in the questionnaire or being interviewed. I also want to say "Thank you for your aid and advices" to Martien van Dongen and Neeltje Mosterd. I am also thankful to Carmen Sloot for carefully editing this report. Last but not least I wish to thank Roel van der Zwaan for his support whenever it was necessary.

Wilma van Driel
Maastricht, August 1992

1 INTRODUCTION

Water is necessary to survive. In many countries of the world an insufficient amount of water is available. When the quantity of water happens to be adequate, the quality may be bad. Many people suffer from diseases caused by an insufficient quantity and quality of water. For example, it is estimated that annually more than 875 million cases of diarrhoea and 4.6 million deaths in Africa, Asia and Latin America can be ascribed to bad water quantity and quality (Esrey et al., 1990: 9). Especially young children are the victims of diarrhoeal diseases.

One of the objectives of most water and sanitation projects is to increase the health of the target group. Until now, a lot of water and sanitation projects have been developed and implemented. However in many of these projects the incidence of water and sanitation related diseases did not decrease. Sometimes even the contrary is true. For example, in water resource development projects (dams, fisheries etc.) the spread of Schistosomiasis has increased because of the extension of snail habitats (Listori, 1990: 58). Thus the mere provision of improved water supplies and sanitation facilities is not a guarantee for decisive improvements in health of the target group. This is one of the major lessons of the International Drinking Water and Sanitation Decade (1981-1990).

The incidence of water and sanitation related diseases may also be influenced by hygiene behaviour. This behaviour helps to prevent water and sanitation related diseases. Examples of hygiene behaviour are: washing of hands, bathing, cleaning latrines. To promote these behaviours, hygiene education should be provided. Hygiene education can be defined as all activities aimed at encouraging behaviour and conditions which help to prevent water and sanitation related diseases (Boot, 1991: 4). If water and sanitation projects aimed to improve the health of the target group, hygiene education should be an integrated part of them. Hygiene education gradually became a common component of water and sanitation projects during the second half of the Drinking Water and Sanitation Decade.

Hygiene education is a specific form of the wider concept of health education. Whereas hygiene education is confined to water and sanitation-related health problems, health education concerns the activities that promote health in general and reduce all kind of health risks (Boot, 1991: 20).
Health education can be defined as: "any combination of learning experiences designed to facilitate voluntary adoptions of behaviour conductive to health" (Green et al., 1991: 17).
A lot of how to implement, develop and evaluate health education programmes is already known and described in literature. Until this moment, it is not so well investigated how hygiene education is actually done in practice. To obtain information on this subject, field experiences of many hygiene educators were investigated. One way to find out the working experiences of these educators is by asking them what they see as factors that contribute to the success of the hygiene education programme in which they are working. To be clear, the aim of this study was not to investigate whether a hygiene education programme is successful or not. Comparative studies on the impact of various approaches to hygiene education can hardly be found. It is therefore difficult to give an indication whether a certain approach is more successful than another. However, experienced hygiene educators can very well indicate what factors they feel as contributive to the success of their work.

When these factors are clear it can be helpful for other hygiene educators to take them into account in order to develop more successful hygiene education programmes.
Some kind of theoretical background information can also be useful.

The main question of this study was formulated as follows:

Which factors contribute to the success of hygiene education programmes, according to practical experienced hygiene educators ?

This is one of the first attempts to collect information from many experienced hygiene educators in one study. Therefore, qualitative research methods were used in this study. The experiences of hygiene educators were collected through questionnaires, interviews and case-studies.

The questionnaires were sent all over the world to people who have been involved in hygiene education in water and sanitation projects.
The interviewees were persons who had recently been working as hygiene educators in water and sanitation projects. During the interviews, the interviewees were staying in the Netherlands.
In this study, case-studies are descriptions of hygiene education programmes in water and sanitation projects. These descriptions were traced in reports and scientific periodicals.

This report is structured as follows:
In ***chapter 2*** three approaches to health education are described. These approaches are related to planning, participation and communication.
Chapter 3 gives information on the methodological aspects of this study.
In ***chapter 4*** an analysis of the data collected through the questionnaires, interviews and case-studies is given.
In ***chapter 5*** the findings of the study are discussed in relation to the main question.
Finally, in ***chapter 6***, the main conclusions and recommendations are presented.

In annex I, a specimen of the questionnaire and the accompanying letter can be found. A summary of the data collected through the questionnaires, interviews and case-studies is given in annex II. These summaries are presented by means of tables. A complete overview of the data, tallied per information source, is given in annex III.

2 THREE APPROACHES TO HYGIENE EDUCATION

In this chapter three approaches to hygiene education are described. These approaches are focused on health education. As hygiene education is part of a wider concept of health education, these approaches can also be applied to hygiene education. In scientific literature about health education the topics planning, participation and communication have been described very often. These topics seem to be of extreme importance in the field of health education. Therefore, the three approaches to health education that will be described here are:

* Planning;
* Participation;
* Communication.

Of each approach the main theoretical background information is given. The description of these insights are illustrated with examples from practical situations in health and hygiene education programmes. These examples are written in italics. Although these approaches are described separately, they have also some kind of overlap. For example, on the one hand elements of participation and communication should be planned in hygiene education programmes planned. On the other hand participative programmes and communication methods can not be implemented without an adequate planning strategy. But each approach has its own specific focus.

2.1 PLANNING

Planning can be defined as: "The process of establishing priorities, diagnosing causes of problems and allocating resources to achieve objectives" (Green et al., 1980: XV). Although many definitions of planning exist, they all have in common that planning is necessary to achieve a certain goal. As hygiene education aims to encourage people's behaviour and improve conditions which help to prevent water and sanitation related diseases, an adequate planning strategy should be part of each hygiene education programme.

One of the existing theories on planning is the PRECEDE-PROCEED framework of Green et al. (1991). This model is especially designed for planning health education programmes. According to Green et al. (1991: 17) health education can be defined as "any combination of learning experiences designed to facilitate voluntary adaption of behaviour conductive to health". The PRECEDE-PROCEED framework consists of eight phases (figure 1).

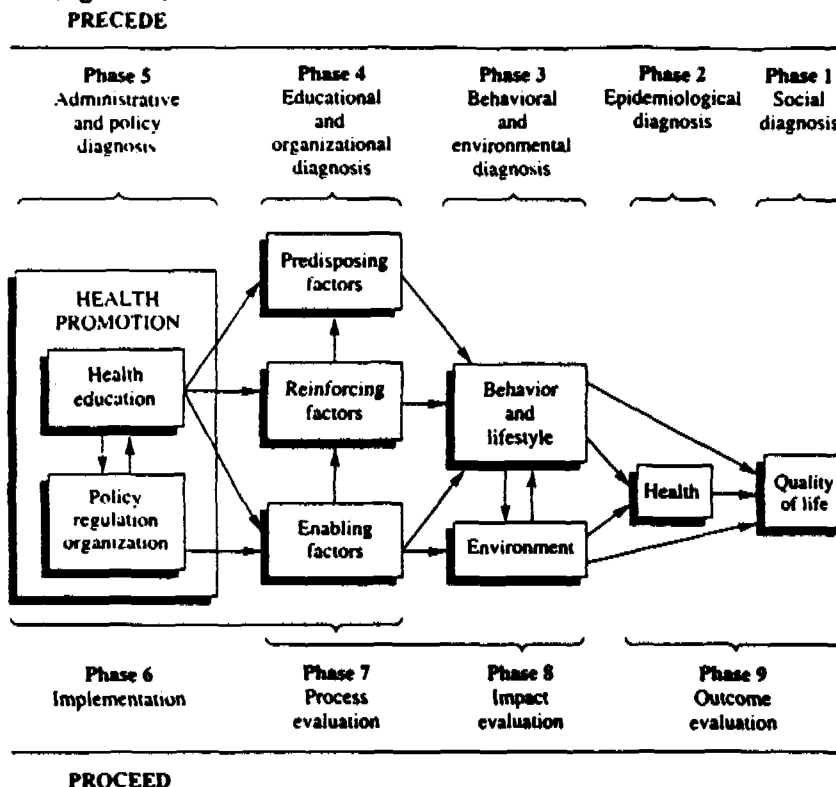

Figure 1. The PRECEDE-PROCEED model for health promotion, planning and evaluation (Green et al., 1991: 24).

PRECEDE is an acronym for predisposing, reinforcing and enabling constructs in educational/environmental diagnosis and evaluation. The PRECEDE part of the framework takes into account the multiple factors that shape health status. Going through the PRECEDE part of the framework, helps the planner to set highly focused goals for intervention.

PROCEED is an acronym of policy, regulatory and organizational constructs in educational and environmental development. This part of the framework provides additional steps for developing policy and initiating the implementation and evaluation process.

The PRECEDE framework directs initial attention to outcomes rather than to inputs. The planner starts the planning of the health education programme with the desired final outcome and determines what must precede that outcome.
The framework consists of six basic phases. Evaluation of programme impact and outcomes can extend it to seven or eight phases, which depends on the evaluation requirements. The eight phases are described below.

Phase 1

The PRECEDE-PROCEED framework starts with the outcome end. In the framework the final goal at the outcome end is to upgrade the quality of life of the target group. Conducting a social diagnosis can be helpful to determine the quality of life in this group. The social diagnosis can be defined as: "The process of determining people's perceptions of their own needs or quality of life, and their aspirations for the common good, through broad participation and the application of multiple information-gathering activities designed to expand understanding of the community" (Green et al., 1991: 45).

The term quality of life is difficult to define and even more difficult to measure. Nevertheless, many approaches are available for assessing the quality of life in communities, both objectively and subjectively. Objective measures include social indicators such as unemployment rates, living conditions, crime rates. Subjective assessments of the quality of life can be obtained through talking with and listening to the people in the target group and asking what they see as the most serious problems and needs in their lives. As Green et al. (1991: 45) stated: "Nothing assures the success of a programme more than to engage the people of a community in assessing their perceived problems, needs and aspirations and their shared priorities for dealing with them. If you cannot find a way to link the health mission to the social goals and concerns of a target population you have little hope that the services you could offer that community will be valued or used".

Because participation of the target group is a very important factor to achieve success in health education programmes, the participative approaches get more attention in paragraph 2.2.

As soon as it is obvious what the problems and needs are, an overall goal can be defined. An example of the overall goal can be:

To reduce the mortality rate of children under five years of age.

Phase 2

In phase 2 the specific health problems that may contribute to the problems and needs found in phase 1 will be identified. The classic indicators of health problems are mortality, morbidity and disability. To determine the relative importance of health problems, one makes comparisons. Such comparisons allow identification of health problems that are more serious in this community than in other places or are most important within the community or specific group in that community. After comparisons of the data it could be found that, for example:

In village x the incidence of diarrhoea in children under five years of age appears to be higher than in village y. In village y, women are used to wash their hands more often than in village x.

These findings can provide a basis for further investigation of the health problem. When the health problem has been specifically defined and the risk factors have been identified, the next step is to develop the programme objectives. While formulating an objective the following questions should be taken into account:

Who will receive the programme ?
What health benefit should they receive ?
How much of that benefit should be achieved ?
When should it be achieved ?

Now the programme objective can be formulated more specifically as follows:

To achieve a 60% reduction of the incidence of diarrhoea in children under five years of age in village x within three years of time.

Phase 3

Phase 3 consists of identifying the specific health-related behavioural and environmental factors that can be linked to the health problems chosen in phase 2. As hygiene education is focused on behaviour a distinction has to be made between behavioural and environmental causes of the health problem.

Behavioural factors:
* *Personal hygiene*
* *Latrine usage*
* *Eating habits*

Environmental factors:
* *Air pollution*
* *Heavy rainfalls each year*
* *Infectious agents*

Before defining the ultimate hygiene education objective a choice has to be made which behavioural factors are relevant for the hygiene education programme. To come to the relevant behaviours, they have to be ranked according to importance and changeability.
The importance of a specific behaviour is indicated if data are available showing that the behaviour 1) occurs frequently and 2) is strongly linked to the health problem.

Ranking behaviours in terms of changeability is not easy, therefore a few rules of thumb may be helpful. High changeability is probable when behaviours are still in a developmental stage or have only recently been established. Most resistant to change are those behaviours that have an addictive component, those with deep-seated compulsive elements and those deeply rooted in cultural patterns or lifestyles or routines. Changeability depends largely on the communication methods that are used in the health education programme. More information on this aspect of health education is provided in paragraph 2.3.

These two characteristics, importance and changeability, can be put in a matrix (figure 2) to facilitate the choice for an appropriate hygiene education objective.

	More important	Less important
More changeable	High priority for program focus (quadrant 1)	Low priority except to demonstration change for political purposes (quadrant 3)
Less changeable	Priority for innovative program; evaluation crucial (quadrant 2)	No program (quadrant 4)

Figure 2. Matrix of health behaviours (Green et al., 1991: 140).

The behaviours allocated in quadrant one are both important and relative easily to influence. Therefore, behaviour in this quadrant has a high priority as a target for hygiene education. Once the behaviour(s) that are relatively important and easily to change have been identified, the immediate behavioural objectives can be formulated. These objectives should be stated as precisely as possible in order to prevent that educational efforts are scattered rather than focused. An example of a behavioural objective is given below:

Within three years of time 80% of mothers of children under five years of age should wash their hands and the hands of their children after visiting the latrine.

Handwashing after latrine use is both an important behaviour to prevent diarrhoeal diseases in children and a behaviour which may be relative easily to perform.

Phase 4

The fourth phase consists of sorting out and categorizing the factors that seem to have direct impact on the target behaviour. Three categories can be distinguished: predisposing factors, reinforcing factors and enabling factors. The classification of these three factors makes it possible to group the specific features of the situation according to the types of intervention available in health education.

Predisposing factors

Predisposing factors, which include knowledge, attitudes, beliefs, values and perceptions, provide the rationale for a certain behaviour. It is important to take into account the predisposing factors of the target group. The hygiene educator often looks at behaviour from his point of view and places too much emphasis on health and medical factors as cues for action. The target group may consider other values as equally or even more important, such as economic survival, status and prestige (Hubley, 1988a: 4). An example of conflicting beliefs between the hygiene educator and the villagers is given below:

An attempt to convince Peruvian villagers to boil their water achieved only limited success. Because, according to their belief, water boiled one day and not used becomes dangerously "cold" the other day. The water has to be reboiled in the morning - an expensive and time-consuming proposition (Favin et al., 1986: 42).

Enabling factors

Enabling factors, often conditions in the environment, facilitate the performance of a behaviour. Included are the availability, accessibility and affordability of health care and community resources. Such community resources are, among others, water supply and sanitation facilities, money, school-buildings. Enabling factors also include new skills to perform a certain behaviour, for example, the skill of how to prepare a good Oral Rehydration Solution. The following example illustrates that the provision of an "enabling factor" is not a guarantee that it is used properly:

In a programme in a very poor area in India, latrines were built of bricks. The latrines had locks on their doors. However, the houses did not have locks on their doors, so people used the latrines, not for sanitary purposes, but to store their valuables, such as bicycles and chickens. As far as the people were concerned the latrines were a great success - for storing valuables (Feuerstein, 1986: 6).

Reinforcing factors

Reinforcing factors are related to the feedback the person receives from others. This feedback may be either to encourage or to discourage changes in behaviour. Social benefits (such as recognition), physical benefits (such as convenience, comfort, relief of discomfort), tangible rewards (such as economic benefits), and vicarious rewards (such as improved appearance, self-respect) all reinforce behaviour. Whether the reinforcement is positive or negative depends on the attitude and behaviour of the people who are important to that person. It is unreasonable to expect a person, no matter how convinced, to go against the wishes of those around them in the community (Hubley, 1988a: 9). The next example illustrates the importance of reinforcing factors:

In an urban community many women suffered from schistosomiasis. The behaviour identified as the main cause for their health problem was that they were used to washing clothes while standing in schistosomiasis infected water. One of the factors contributing to this behaviour was a long and generally accepted habit of washing clothes in this way (Boot, 1991: 25).

At this point in the planning process, a decision has to be made which of the identified predisposing, enabling or reinforcing factors will be the major focus of the hygiene education programme. As in phase 3 the decision can be based on the importance and the changeability of these three factors.

In some cases enabling factors will come first, e.g. a latrine must be available before latrine use can be promoted.
In other cases the hygiene education must be focused on predisposing factors, e.g. when latrines are available, the target group must know how to use the latrines hygienically.

Phase 5

Once the specific factors for intervention have been selected, the health education strategy can be developed. A health education strategy is a plan of action which includes a combination of educational methods and materials that may be used to affect the predisposing, enabling and reinforcing factors.

Green et al. (1980: 113-114) give some rules of thumb for selecting educational strategies:

1 select a minimum of three educational strategies for any health education programme. People learn in different ways. And using a variety of teaching strategies increases their interest. Make sure that all factors - predisposing and enabling and reinforcing factors - receive attention.
2 In most health education programmes, audiovisual aids or other media techniques should be one of the three strategies used. They are effective in reinforcing and strengthening other educational strategies.
3 The longer the health education programme lasts, the greater are the number of educational strategies.
4 A programme is best begun with the simpler, cheaper educational methods that influence the predisposing factors. If these strategies are unsuccessful, more sophisticated and expensive strategies can be applied.
5 The more complex the causes of the behavioural problem, the greater the range of strategies that will be required.
6 Programmes that are designed to influence predisposing, reinforcing as well as enabling factors will have the greatest payoffs in long-term behavioural changes.

In this phase an assessment should be made of the resources required by the proposed educational methods and strategies. Resources are, for example, time, personnel, skills and money. The first and most critical resource is time. Time can not be recovered once it is expended, it is inflexible in its supply and it affects the availability and cost of all other resources. The time required has been estimated with the formulation of realistic objectives. Staffing requirements take precedence over other budgetary considerations in the resource analysis because the personnel category generally constitutes the largest and most restricted item in most budgets. Budgetary requirements include personnel benefits for salaried workers, materials or supplies, printing, postage, travelling, overhead costs etc.

Prior to the implementation of the health education programme, it should be examined of it's fit with existing policy, regulation and organization. Often some kind of negotiation and persuasion is necessary for proper implementation of the programme. Special attention should be paid to working relations within the health education programme, between the programme and the water supply and sanitation project and between the project and other organizations involved in water, sanitation and health.

Before the hygiene education programme is implemented on a large scale, it must be pre-tested. Pre-testing means field testing of the education programme before it is implemented on a large scale. This can be done by interviewing members of the intended target group to find out whether they easily comprehend the intended message and whether they like and understand the materials. In testing the materials and methods it is also prudent to test the ease and attractiveness of their use for hygiene educators. Pre-testing the programme will save costs and time of implementing an inappropriate programme. An example of how an apparent clear picture can be easily misunderstood:

In Nepal, rural people without formal education were questioned about different types of drawings. A picture of a house produced vastly different responses. While 91% in the Eastern Region and 78% in the Central Region recognized it as a building, only 26% in the Far West Region gave this response. The reason for this variation may well be that houses in several parts of the Far West of Nepal have flat roofs and not sloping roofs as in the drawing (Burgers et al., 1988: 74).

Phase 6

In phase 6 the actual implementation of the health education programme takes place. Phase 6 is the first phase of the PROCEED part of the framework. This part of the PRECEDE-PROCEED framework provides additional steps for developing policy and initiating the implementation and evaluation process.

Phase 7 and Phase 8

Evaluation is an integral and continuous part of the whole planning and implementation process, so this phase is not mentioned separately in figure 1. Although the evaluation component is part of the PROCEED framework, the criteria for evaluation fall naturally from the objectives defined in the corresponding steps in the PRECEDE framework. Green et al. (1991: 217) defined evaluation as: "The comparison of an object of interest against a standard of acceptability". Three levels of evaluation can be distinguished.

The first level is process evaluation. In process evaluation the potential objects of interest include all programme inputs, implementation activities and stakeholder reactions. The second level, impact evaluation, implies assessing the immediate effects of the programme on the target behaviour and its predisposing, enabling and reinforcing antecedents. During conducting outcome evaluation, the third level, the objects of interest are health status and quality-of-life indicators that were identified in the earliest stages of the planning process.

Depending on the evaluation requirements of the health education programme, it can be planned in the seven or/and eight phase.

Evaluation is necessary for several reasons (Boot, 1991: 132):

* Timely action in case of any problem can be taken;
* Planning, implementation and sustainability can be improved;
* Supervision and training of manpower can be improved;
* Organization and management can be improved;
* Effectiveness and efficiency can be increased;
* New or adapted objectives can be set;
* More about hygiene education requirements can be learned.

After conducting the evaluation some adaptions can be made. An example of this is described below:

In Guatemala the content of the audio cassettes and the hours of operation were adapted to coincide with times of visits of women to the community laundry place, where the cassettes were played in public. The health information programme had to be oral to allow women to continue to work while listening to the messages (Burgers et al., 1988: 71).

2.2 PARTICIPATION

In the previous paragraph, it was described that adequate planning is important to reach the goals of hygiene education programmes. Planning is useful to make hygiene education a structured activity instead of a set of haphazardly taken actions. But, how well planned a hygiene education programme may be, when the target group does not feel involved in the programme all the effort is worthless. Only a few years ago, participation of the target group was not an essential part of water and sanitation projects. At this moment, in nearly all objectives of water supply and sanitation projects the word "participation" can be found. In many projects this means merely a change of words instead of a change in the approach. In some water supply and sanitation projects, the community is considered to have participated when it provides free, unskilled labour for construction and donates raw materials in "the spirit of self-help" (Srinivasan, 1990: 16). In this kind of projects the decisions are made by the staff or the local leaders.

The participatory approach in hygiene education programmes should start with the question "How do I help people to achieve what they want to achieve ?" The main characteristic of this approach is joint problem analysis and problem solving (Burgers et al., 1988: 39). Werner and Bower (1982: 26-12) see the participatory approach as "to start with looking at ways of helping groups of people become more aware of the social factors that affect their well-being and discover their own ability to change and improve their situation". This participatory approach is rather learner than teacher-centered (Srinivasan, 1990: 26). The education sessions have no predetermined goal, because the target group itself determines the contents of the programme. Therefore, a real participative approach is impossible in e.g. water and sanitation projects. Often, these projects have predetermined goals like "constructing 300 handpumps in four years of time". Even when this kind of goals are not defined, it is still a water and sanitation project. The project has to deal with, at least, water and sanitation. Only an approximation of the participation approach can be obtained. Srinivasan (paragraph 2.2.2) shows how these approximation can be realized.

The starting point of the participatory approach should be the day-to-day concerns of the people involved. More or less the same can be found in the first phase of the PRECEDE-PROCEED framework according to Green et al. (1991: 45).
For better understanding of the target group it can be valuable to know how people see the world around them. Paolo Freire describes how to find this out. He classifies the perception of the world of the target group in three stages of awareness. When it is clear which stage the target group has reached a more appropriate participative programme can be developed. Werner and Bower (1982) and Srinivasan (1990) describe how participatory education methods can be developed.

2.2.1 Freire's stages of conscientizacao

Many hygiene educators ask themselves "Why is it that so many people "just don't seem to care" about changing or improving their situation ?" and "What can I do to help people awaken to their own possibilities ?"

To get an answer to these questions it may be useful to discuss the following "stages of awareness". These stages are based on the ideas of Paulo Freire. Freire's methods for development of "critical awareness" became widely used in Brazil as a part of literacy programmes (Smith and Alschuler, 1976: 1). One of the important points in the stages of conscientizacao (the Portuguese word of awareness) is to provoke recognition of the world, not as a "given" world, but as a world dynamically "in the making" (Freire, 1985: 35). Freire has described three stages of awareness (Werner and Bower, 1982: 26-12):

A. Magic awareness;
B. Naive awareness;
C. Critical awareness.

A. Magic awareness

At this stage people explain the events and forces that shape their lives in terms of myths, magic or powers beyond their understanding and control. They tend to be fatalistic, passively accepting whatever happens to them as fate or "God's will". Usually no one has been blamed for the suffered hardships and abuses. People endure these as facts of life about which they cannot (and should not) do anything. Although the problems are great- poor health, poverty, lack of work etc.- they commonly deny them. People are being exploited, but at the same time they are dependent upon those with authority and power, whom they fear and try to please. They conform themselves to the image given to them by those on top (authorities, big landholders, religious leaders etc.). They consider themselves inferior, unable to master the skills and ideas of persons they believe are "better" than themselves. The following example illustrates magic awareness:

Talking with campesinos in Ecuador about their lives and work on the hacienda. They said: "If the hacienda owner is bad, the oppressed must conform to his will and wait for him to become good. What can be done ? ..... Nothing. What should be done ? ..... Wait. What have you done ? ..... Wait. What will you do ? ..... Wait some more (Smith and Alschuler, 1976: 22).

B. Naive awareness

Persons at the naive stage of awareness no longer passively accept the hardships of being "on the bottom". Rather an adaption has been made in order to make the best of the situation. However, they continue to accept the values, rules and social order defined by the leaders. In fact, they try to imitate these leaders as much as possible. For example, the clothing, hair styles, and language of outsiders have been adopted. At the same time, they tend to reject or look down upon their own people's customs and beliefs. They blame the hardships of the poor on their ignorance and lack of ambition. No attempt has been made to critically examine or change the social order. An example of naive awareness is described below:

In many parts of the world, little children are more and more bottle fed. In spite of the fact that the old tradition of breast feeding is safer, better and cheaper. The popularity of bottle feeding is partly due to promotion of international companies. The women change to bottle feeding practices because the western babies in the advertisements looked more healthy and fatter than their own children (Werner and Bower, 1982: 1-11).

C. Critical awareness

When persons begin to develop critical awareness, they look more carefully at the causes of poverty and other human problems. Things are explained more through observation and reason than through myth or magic. These people start to question values, rules, and expectations passed down by those in control. They discover that not individuals, but the social system itself, is responsible for the inequality, the injustice and the suffering. These persons discover that the system is set up for the benefit of a minority group, to favour the few at the expense of many others. Yet they see that those in power are in some ways also weak and are also dehumanized by the system. Critically aware persons come to realize that only by changing the norms and procedures of organized society the most serious ills of both the rich and the poor can be corrected. As their awareness deepens, these persons also begin to feel better about themselves. They take new pride in their origins and traditions. Yet they are also self-critical and flexible. Neither the old nor the new standards have been rejected. As soon as their self-confidence grows, they begin to work with others to change what is unacceptable in the social system. Their observations and critical reasoning lead to positive action (figure 3).

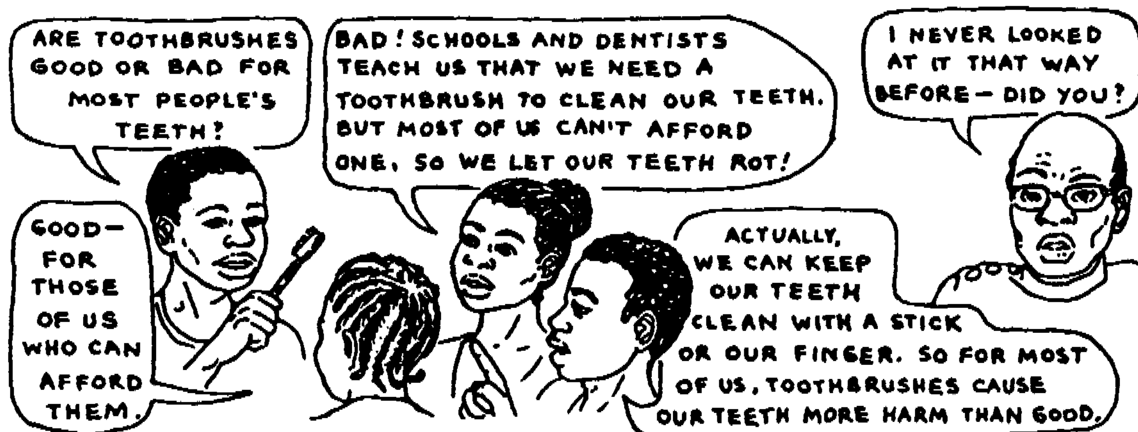

Figure 3. An example of critical awareness (Werner and Bower, 1982: 20-27).

In reality, of course, nobody is at only one stage of awareness. Many people are fatalistic of some things, naive of other issues and at the same time critically aware of another point. Still to reflect one of these stages can be useful when working with the community. To enhance the self-confidence of the target group it is important to start with a subject of which the people are already critically aware of. When people are critically aware of a topic they are more likely to take actions to improve their situation. To determine to which stage of awareness the target group belongs, three types of questions can be asked. These three types of questions are related to: naming, reflecting and acting. Examples of the accompanying questions of each type are described below (Smith and Alschuler, 1976: 17, 18, 21):

a. ***Naming***: What are the most dehumanizing problems of your life ? Should things be as they are ? How should they be ?

b. ***Reflecting***: Why are things this way ? Who or what is to blame ? What is your role in the situation ?

c. ***Acting***: What can be done to solve those problems ? What should be done ? What have you done or what will you do ?

The answers to these questions can give an indication to which stage the people belong. Starting with these questions provides basic information about the community and their considerations.

2.2.2 What are participatory methods ?

The participatory approaches are different from most educational situations, because the questions that are raised during the group dialogues have no predetermined answers. There is no expert who has the answers ready and whose job it is to pass his knowledge on to others. Everyone can learn from each other. The distinction between "teacher" and "student" fades away. In the training field of today the most widely used training approach is what is known as didactic teaching. The traditional didactic style is a content-focused approach in which information is largely passed into one direction from the outside expert to the learner. The participatory style is a learner-centered approach in which the focus is on the learner's developing abilities and skills to diagnose and solve his own problems (Srinivasan, 1990: 24).

The trainer's role is mainly one of asking questions. These questions should help the group members see the world around them as a situation that challenges them to change it, not as something unchangeable and beyond their control (Werner and Bower, 1982: 26-16). Unlike traditional teaching methods which have emphasized the transfer of knowledge, messages or contents pre-selected by outside specialists, participative training methods focus more on the development of human capacities to assess, choose, plan, create, organize and take initiatives. These aims are synthesized in the following five characteristics of the so-called SARAR approach (Srinivasan, 1990: 22):

- *S*elf-esteem of groups and individuals is acknowledged and enhanced by recognizing that they have the creative and analytic capacity to identify and solve their own problems.
- *A*ssociative strengths: the methodology recognizes that when people form groups, they become stronger and develop the capacity to act together.
- *R*esourcefulness: each individual is a potential resource to the community. The method seeks to develop the resourcefulness and creativity of groups and individuals in seeking solutions to their problems.
- *A*ction planning: to solve problems is central to the method. Change can be achieved only if groups plan and carry out appropriate actions.
- *R*esponsibility: the following-through is taken over by the group. Actions that are planned must be carried out. Only through such responsible participation do results become meaningful.

Participative training methods foster a process of human development, but they do not take place in a vacuum. They are supported by a number of practical experimental activities which engage learners in creative problem solving and provide opportunities for new forms of self-expression.

Figure 4 shows a picture that can be used as a tool to come to a new form of self-expression of the target group:

One of the pictures used in a Guatemalan workshop was the picture of a parrot (figure 4). At the first glance the picture does not seem very interesting - hardly a discussion starter for helping develop greater critical awareness, but it proved to be a good introduction to a discussion. The leader starts with questions like:
What do we see in this picture ? What are these birds doing and where are they ? From the discussion about the birds the members of the group begin to reflect on their own lives and experiences. They asked themselves: In what ways are we free ? How could we become more free or live more according to our human nature ? What stops us ? (Werner and Bower, 1982: 26-26).

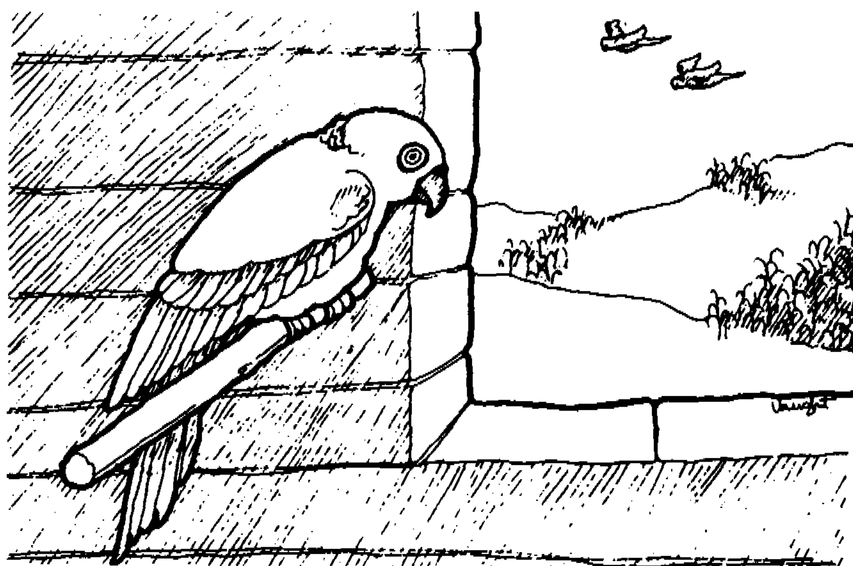

Figure 4. Picture that can be used in participative education programmes (Werner and Bower, 1982: 26-26).

Helping people to realize that they themselves have the capacity to understand and change their situation is not easy. This is especially true for persons who have learned to silently endure their misfortunes and who see themselves as persons who are powerless, ignorant and hopeless. But these are the persons for whom a more critical understanding of their situation can be the bridge toward a healthier life (Werner and Bower, 1982: 26-16).

2.3 COMMUNICATION

Until now information was given about planning a hygiene education programme and on the participatory approach of hygiene education. Hygiene education works through communication. Communication is sharing verbal and nonverbal information (including ideas, emotions, knowledge and skills) among two or more persons. Communication involves at least two persons. One person is telling or showing something to the other, who reacts by telling or showing something to the first. In technical terms, the first person is the source who is sending the message to the receiver, the second person. When the aim of communication is to influence knowledge, attitudes and behaviour conductive to health, it is the quality of the communication which comes into focus. Communication helps to equip people with facts, ideas and attitudes they need to make informed decisions about their health.

The communication process can be summarized in one sentence (McGuire, 1985: 258):

Who says ***what***, via what ***medium***, to ***whom*** directed at what kind of ***target***.

These five variables (who, what, medium, whom, and target) can be manipulated by the designer of the hygiene education programme. Below a brief description of these variables is given.

1. ***Who*** (source) refers to the characteristics of the person(s) or organizations from which the communication messages comes from, e.g. the health worker, national radio station. People are exposed to communication messages from many different sources. They are more likely to believe a message from a person or organization they trust. Source credibility is an important determinant of effective communication methods.
   Another important characteristic of the source is the extent to which he has the same age, culture, educational level, experiences as the receiver. A person with a similar background as the community-members is more likely to share the language, ideas, motivations.

The following example shows the importance of source similarity:

Mrs Tome is an experienced midwife. She tells the women in the village not to eat eggs when they are pregnant. If they eat eggs they would give birth to unhealthy children. The women follow her advice and they do not eat eggs. Even if the western doctor gives them a different advice. The village women respect the midwife and follow her recommendations. They may not want to listen to a young doctor who, in addition, may come from a different country (WHO, 1988: 11).

2. ***What*** refers to the message characteristics. Examples of these characteristics are: what is stated in or omitted from the message; how the message contents are organized; quantitative aspects such as length and repetition. The message must entertain and attract the attention of the community. It must be built on ideas, concepts and practices that people already possess. Many religious and supernatural beliefs are concerned with water quality, sanitation and proper hygiene practices. These beliefs can be used as means of communicating the message, for example, ritual washing (Education for health, 1988: 8). The message should be formulated using simple language with local expressions and should emphasize short term benefits of action (Hubley, 1987: 4). Loevinsohn (1990: 791) has found that health education can be successful in improving health if the number of messages is limited and if they are repeated frequently.

3. ***Medium*** or channel through which the message is transmitted. There are two main groups of methods: a) interpersonal and b) mass-media. Interpersonal or "person-to-person" methods involve face to face interaction between the "who" and the receiver. The strength of interpersonal communication is the opportunity for giving feedback, asking questions, clarification of the messages, exchange of feelings and ideas etc. Interpersonal communication can be a strong tool in influencing knowledge, attitudes and practices for health improvement. However, when interpersonal communication is used in a one-way teaching method, with the hygiene educator telling the target group what to do, it will rarely be effective. Interpersonal communication should be used as much as possible for participatory communication methods.

For example, dialogue, group discussions, sharing of experiences and joint problem-solving (Hubley, 1988b: 12). Changes in behaviour and adoptions of practices are more likely the result of interpersonal methods than of the use of mass-media.

Mass-media include the broadcast media like radio and television as well as the printed media like newspapers, books, leaflets and wall posters. The main characteristic they share is that they do not involve face-to-face interaction between source and receiver. Mass-media can be used for spreading simple information to a community and for awareness raising purposes. Mass-media are rarely influential enough to bring about changes in behaviour.

Traditional channels of communication such as songs, drama and story-telling can be used in hygiene education. When methods and media are "home made" they have the advantage of being tailor made to the target community (Hubley, 1988b: 36). An example of locally designed educational material is given in figure 5. This picture was designed in Thailand. The message of this picture can be formulated as follows: "always wash your hands before preparing food, giving food to your child and after latrine use". With respect to channel factors, as many as possible different methods must be used to convey the messages (Hubley, 1987: 4; Liedekerken et al., 1990: 55; Loevinsohn, 1990: 791).

Figure 5. An example of locally designed educational material (Sent by a respondent from Thailand).

4. ***Whom.*** Another class of variables in any communication situation refers to the personal characteristics of the receiver or audience. Some of the main characteristics of the audience that need to be taken into account are: age, educational level, beliefs and interests, readiness to change, patterns of communication and personal features such as gender and ethnicity. Some of these characteristics will depend on the personal background, other are part of the cultural heritage of a community.
   The following example illustrates the importance of taking into account the characteristics of the target group:

   In Yemen, a nurse was trying to convince a mother to breast-feed her children. The nurse explained that breast-feeding was easy, cheap and best for infants. These arguments appeared to getting nowhere. Another nurse who happened to overhear the conversation pointed out to the women that breast-feeding helped men have closer bonds with their mothers. This interjection, more in consonance with the women's values, seemed to have great effect (Favin et al., 1986: 42).

5. ***Target.*** These factors refer to the specific target at which the communication message is aimed. For example, an immediate or long-term change, a change on a specific issue or across a whole ideological system. The promoted actions must be realistic and feasible within the constraints faced by the community (Hubley, 1987: 4). The objective of a communication message has a number of distinct components. It should specify ***What*** change should take place; ***how much*** of that change should take place; ***who*** should change and which ***channel*** or ***method*** should be used. An example of such an objective can be formulated as follows:

   Three weeks after the nurses had visited the mothers, 80% of the mothers with children younger than five years should wash their hands after changing nappies of their child, in village x.

Communication can be defined as the exchange of information. In most cases the aim is not only to exchange information but also to promote an improvement in health through behaviour change. In order to achieve these objectives the communication process must pass through a number of stages (Hubley, 1988b: 23-39).

Stage one: ***Getting attention.***

No matter how good a communication method is, it will not be effective unless it is seen or heard by the intended audience. It is essential to carry out research on the target group to find out where they go, what their listening and reading habits are etc. The messages should be directed at places where the people are going to see or hear them. A common cause of failure of programmes is "preaching to the converted". For example, a poster is placed in the health centre so it is only seen by mothers who have already brought their child to this centre.

Stage two: ***Holding attention.***

It is not enough merely reaching the audience. Any communication method should attract a person's attention so that she/he will read or listen to it and understand the message. If a communication method fails to gain the target group's attention it will not be effective. Examples of such failure are: a poster lacks striking features or it does not stand out compared with attractive commercial advertisements. Careful thought about the design of a poster, colour, size, lettering and use of pictures can increase its likelihood of gaining people's attention. Also the communication method which attracts attention deals with subjects the target group wants to know something about, i.e. fit in with their felt needs and interests. People like to be entertained. The communication can be made attractive by using a variety of methods.

Stage three: ***Understanding the message.***

Once a person pays attention to a message, she/he tries to understand it. A person's interpretation of the message depends on many things. Misunderstanding can easily take place, for example: when the message contains a complex language and unfamiliar technical words, unfamiliar subjects, too much information in the radio programme, poster or leaflet. Special attention should be paid to, so called, visual illiteracy. When people are not so much exposed to pictures they can easily misinterpret it. To overcome this kind of problems the educational materials should be locally designed and carefully pre-tested before use.

Stage four: ***Promoting change.***

A communication message should not only be received and understood, but should also result in changes in behaviour. The different variables discussed earlier (Who, what, medium, whom and target) are all relevant to achieve changes in behaviour. For example, if the source has a low credibility according to the community, it is unlikely that the message has any impact.

Stage five: ***Changing behaviour.***

In this stage the factors which are mentioned in phase four of the framework of Green et al. (1991) must be taken into account (predisposing, reinforcing and enabling factors). A communication method may result in a change in beliefs and attitudes but may still not influence behaviour. For example, a woman who is not allowed to use family planning methods by her husband (reinforcing factor). Part of this stage is also learning skills to perform the advocated behaviour.

Stage six: ***Improving health.***

Improvements in health will only take place if the behaviours are selected carefully so that they really do influence health. This depends largely on successful application of epidemiology to the understanding of the causes of ill health (Hubley, 1988b: 38). An important issue is that the new behaviour must be maintained in order to achieve also long-term benefits.

The six stages and the five variables mentioned above can be put into a matrix (table 1). This matrix can be used for developing the actual hygiene education message. Not all the thirty cells may be filled in easily. In practical situations, the matrix can be useful as a kind of checklist. To use the matrix in this way, each cell can be considered as a question.

For example, which source gets most attention (cell 1); which message is best understood (cell 9).

Table 1. Matrix for developing a hygiene education message (Adapted from Hubley 1986: 25 and McGuire, 1981: 45).

	WHO	WHAT	MEDIUM	WHOM	TARGET
GETS ATTENTION	cell 1				
GAINS ATTENTION					
IS UNDERSTOOD		cell 9			
IS ACCEPTED					
CHANGES BEHAVIOUR					
CHANGES HEALTH					

Failures in the communication process can take place at each of the six stages described above. It is important to try out the methods and materials first with a sample of the intended audience before it will be used in the whole community. This process of trying out the communication is called pre-testing (see also paragraph 2.1, phase 6).

In this chapter theoretical background information has been given on how to plan the hygiene education, what a participation approach is and what needs to be taken into account when choosing the right communication method. In the next chapter the survey design will be described.

3 STUDY DESIGN

This chapter deals with the study design of the investigation. In this study it was investigated what hygiene educators see as factors that contribute to the success of the programme in which they have been working. This was one of the first attempts to collect the same information from many experienced hygiene educators in one study. If relatively little is known about a certain subject, qualitative methods can be used to get a deeper insight in that particular area (Swanborn and Rademaker, 1982: 50). Therefore, in this study qualitative methods were used. The results of this study can be used as a basis for further investigations. Qualitative measures tend to produce data in the language of the subjects. To collect qualitative data open-ended questions and semi-structured interviews are commonly used (Green and Lewis, 1986: 151). More specifically, this study can be seen as a kind of illuminative evaluation. An illuminative evaluation is used for innovating or developing programmes. Because of the relatively short history of developing and implementing hygiene education programmes they have not been investigated and evaluated so well. Therefore these programmes remain still in a developing stage. One of the questions that can be asked within the context of illuminative evaluation is: "What does programme personnel consider to be the programme's strengths and weaknesses" (Green and Lewis, 1986: 162). Answering this kind of question can help to obtain a thorough understanding of the hygiene education programme. The obtained information can also be useful in developing more successful hygiene education programmes in the future. The main question of this investigation is:

Which factors contribute to the success of hygiene education programmes, according to practical experienced hygiene educators ?

Factors that contribute to the success will not be defined here. Each respondent had to cite factors which, in their opinion, contribute to the success of the hygiene education programme in which they are working.

Success can be defined at three levels in the programme. The first level is related to the educational outreach, for example, the number of posters distributed. The second level of success is dealing with changes in knowledge, behaviour and so on. The third level of success can only be measured after a long time because it deals with changes in the quality of live (Favin et al., 1986: 36).

Hygiene education is defined as all activities aimed at encouraging behaviour and conditions which help to prevent water and sanitation related diseases (Boot, 1991: 4). Often hygiene education is related to water and sanitation projects.

Practical experienced hygiene educators are persons who are practising hygiene education themselves or are strongly involved in hygiene education programmes.

To obtain an answer to the main question, three data collecting methods were used. These methods are: questionnaires, interviews and case-studies. Four items of the questionnaire were particularly important. These four questions were presented to all the respondents in order to collect more or less the same information from them. Answers to these four items can be helpful to provide a thorough understanding of the hygiene education programme in which the respondents were engaged. The main four questions were stated as follows (the numbers in brackets refer to the corresponding numbers of the questions in the questionnaire (see annex I)):

- What do you consider to be the strong points of the hygiene education programme ? (10)
- What problems and bottlenecks do you face in the hygiene education programme ? (11)
- How would you like to improve or change the hygiene education programme ? (12)
- What advice do you have for your colleagues on how to make a hygiene education programme successful ? (13)

3.1 CHARACTERISTICS AND SAMPLING METHODS OF THE RESPONDENTS

The respondents in this study were field experienced hygiene educators. These hygiene educators have been working in hygiene education programmes all over the world. Each respondent related the answers to the hygiene education programme in which she/he has been working. The hygiene educators were selected through a nonprobability sampling method. This method may be applied if not all the sampling units are known or identifiable. In this study not all the persons who are involved in hygiene education could be identified, so this kind of sampling method may be justified. More specifically, the used sampling method was the strategic informant sampling method. Strategic informant samples consist of persons in key positions or roles who are assumed to be exceptionally knowledgeable about the phenomena under study (Green and Lewis, 1986: 234). As the experienced hygiene educators are specialists in issues related to hygiene education programmes this kind of sampling method was applicable. More information on methods of data collection is given below.

3.2 METHODS OF DATA COLLECTION

To collect the information from the selected hygiene educators three methods were used:

- Questionnaires;
- Interviews;
- Case-studies.

These three data collecting methods were chosen to contact as many hygiene educators as possible. All the hygiene educators were presented the same questions. These questions can be found in annex I. Specific information on the questionnaires, interviews and case-studies is described in separate paragraphs.

3.2.1 Questionnaires

The questionnaire was sent to persons who are appointed as hygiene educators or who are strongly involved in hygiene education programmes. Often these persons have been working in developing countries. The addresses of the hygiene educators were obtained from the professional staff of the IRC. They were asked if they knew people who were involved in hygiene education programmes. Other appropriate addresses were found in CAS (Computer Address System) of the IRC. Some questionnaires were sent to persons who had published relevant articles in scientific periodicals. All the hygiene educators who appeared to be qualified, according to my supervisor at the IRC and myself, received the questionnaire. Most hygiene educators were stationed abroad. But some of them were staying in the Netherlands. Only if they were not eligible for an interview, they received the questionnaire.

In total 91 questionnaires were sent to places all over the world. Each of the selected persons received a questionnaire, an accompanying letter, a return envelop and the promise that, if they would return the questionnaire, they would receive an abstract of this study. Some staff members of the IRC also enclosed a personal letter with the questionnaire because the addressees were personal friends of them. This might be an extra incentive to return the filled in questionnaire. The persons approached had approximately six weeks' time to return the filled in questionnaire. It required a lot of time to send the questionnaire to very distant countries and remote areas. In advance it was decided not to send a reminder to persons who had not succeeded to return the questionnaire in time.

Before the questionnaire was sent, the contents were checked by four experts of the IRC. One of them completed the questionnaire to pre-test it. Because this completed questionnaire contained a lot of information, it was also analyzed together with the received questionnaires of the actual investigation. The final version of the questionnaire and the accompanying letter can be found in annex I.

3.2.2 Interviews

The interviewees were persons who:

- were staying in the Netherlands at the moment of the interview;
- had been involved in hygiene education activities in water and sanitation projects until recently.

In total twelve persons were interviewed. Seven addresses of the interviewees were obtained from the professional staff of the IRC. These persons were not very difficult to contact because personal references could be made. However, some more interviews were planned and other appropriate persons had to be found. The "list of addresses" of the Dutch Ministry of Foreign Affairs was used to locate (Dutch) organizations that are dealing with water and sanitation projects. After a lot of phone calls and letters to explain the purpose of the interview, 5 other persons agreed to be interviewed.

In order to collect the qualitative data, semi-structured interviews were used. In semi-structured interviews, the questions are determined beforehand. In this study the 18 items of the questionnaire (see annex I) were used. The answers remained open-ended. The interviewee could give the information she or he would like to give, but at least the pre-determined questions had to be answered. The advantage of this way of interviewing was that more or less the same information could be collected during all the interviews. This facilitated the analyzing and comparison afterwards. As the answers were open-ended, indepth information and understanding were also gained.

Before the actual interviews started a "pre-test" interview was taken. The information of this interview was very useful so this was also analyzed. During the interviews some adaptations to the style of interviewing were made to improve the quality of the obtained information. For example, the answer to the question "What bottlenecks did you face in the hygiene education programme ?" was always: "there were no bottlenecks". After stating the question as follows "Afterwards, what would you have changed in the hygiene education programme ?", a more informative answer was given. Every interview took one to two hours. Nearly all the persons were interviewed at their places. The interviews were tape recorded. Only one interviewee raised objections against tape recording the interview. Afterwards the entire interview was typed out and analyzed.

3.2.3 Case-studies

It was very difficult to find appropriate case-studies, i.e. well described cases of hygiene education programmes in water and sanitation projects. The key-words which were used to detect the case-studies in the several libraries were: hygiene education, water and sanitation, health education, communication and participation. In addition to this, volumes of relevant scientific periodicals were investigated in order to find appropriate case-studies. These periodicals were Hygie, Education for Health, Dialogue on Diarrhoea, Health for the Millions, Waterlines, Bulletin of WHO, Health Education Quarterly and so on. Although a lot of case-studies related to hygiene education were found, only a few were well described. The criterion to include or exclude a certain case-study was: all the questions of the questionnaire (see annex I) could be answered. Unfortunately it was not possible to find descriptions of case-studies which met this criterion. Therefore, it was not applied that strictly. The ultimate criterion was that at least the four main questions (10, 11, 12, 13) should be answered. A short description of the hygiene education programme should also be part of the case-study. The first case-studies were found in the library of the IRC. In this library a huge amount of information, studies, articles and books. about water and sanitation can be found. However, in this library only four studies met the criteria. The libraries of the Royal Tropical Institute in Amsterdam, the RIVM in Bilthoven, the University of Maastricht and the library of the "Gezondheidsraad" in The Hague were also visited. These visits resulted in the detection of two other appropriate case-studies.
It was planned to analyze 10 to 15 case-studies but due to difficulties in finding appropriate studies only six were actually analyzed.

3.3 METHODS OF DATA PROCESSING

The data obtained from the three data collecting methods - questionnaires, interviews and case-studies - were analyzed in the same way. After the questionnaires were returned, the interviews were taken and the case-studies were studied, a summary of the obtained information was made. From each information source the answers to the first 13 questions of the questionnaire were summarized and put into tables. These tables can be found in annex II. After that the answers to the main questions (10, 11, 12, 13) were tallied per information source.

For example, to question 10 (What do you consider to be the strong points of the hygiene education programme ?) four interviewees answered: "There was a good cooperation between the social and technical section of the project". If the answers were related to the same issues they were grouped together. The detailed analysis of the answers to the four questions can be found in annex III.

The five most frequently mentioned answers per question are described in the next chapter. Each answer mentioned was equally taken into account. That is to say, while counting the answers it did not matter whether the answer was obtained from a questionnaire, an interview or a case-study. This could be done because from each respondent more or less the same information was obtained. In total 31 questionnaires, 11 interviews and 6 case-studies (48 information sources) were analyzed.

4 RESULTS OF THE INVESTIGATION

In this chapter the results of the investigation are described. The emphasis in this investigation was on four items in the questionnaire.
First, general information of the respondents, the water and sanitation projects and hygiene education programmes is given. This information was obtained from the first 9 and the last 3 questions of the questionnaire. After that the five most frequently mentioned answers to the main questions are described. Illustrative examples obtained from the questionnaires, interviews and case-studies are also given.

4.1 CHARACTERISTICS OF THE RESPONDENTS

Questionnaires

In this part of the paragraph the respondents are the persons who returned the questionnaires.
Only eight respondents are graduated health educators. Seventeen respondents have a social professional background but they are not graduated health educators. They received, for example, education in anthropology, community development and social sciences. Six respondents had studied technical sciences. Sixteen respondents had received additional training in hygiene education. Only one of the six persons with a technical background received any specific training in hygiene education. Because it was not the major focus of this study it is difficult to say something about differences in approaches to hygiene education in relation to the professional background of the hygiene educators. It seems that hygiene educators with a technical background used more often top down approaches to education. In general, it may be said that differences in given answers can not be related to differences in educational backgrounds of the respondents.

In total 91 questionnaires were sent to places all over the world. Finally 35 persons (38.5%) returned the questionnaire. For this kind of mail survey this percentage is quite high. In table 2 an overview is given to which region the questionnaires were sent and where from they were returned.

Table 2. Overview to which region the questionnaires were sent and from which they were returned.

	Number of questionnaires sent	**Number of questionnaires received**
Middle East	4	5 (125%)
Asia	27	11 (41%)
Africa	37	12 (32%)
South America	9	3 (33%)
Europe/USA	13	4 (31%)

Four respondents (from Europe and the USA) sent a letter to mention that they could not fill in the questionnaire because of lack of experience in hygiene education programmes. Therefore, not 35 questionnaires but 31 (34.4%) questionnaires were analyzed. Four questionnaires were sent to the Middle East and five persons returned the filled in questionnaire. The reason for this was that one respondent in the Middle East had asked her colleague to fill in the questionnaire also. The relatively high response from Asia may be ascribed to personal contacts of the staff of the IRC in that area.

Interviews

In total twelve persons were interviewed. One of the twelve interviews was not useful for this study because the interviewee was not really involved in hygiene education in developing countries. The majority of the interviewees had received some kind of social education. One of the interviewees had studied health education and one had studied French. Nearly all of them had been working one to three years in the project they referred to during the interview. Three of the interviewees had worked in Asia and eight of them in Africa. The twelfth interviewee did not work in a developing country.

Case-studies

Due to difficulties in finding adequate case-studies, only six were analyzed. The professional background of the persons working in the described programmes was not always clear. Three of them received training in health education and communication. It was not known what the professional background was of the other persons. It was also not known how long they had been working in the programmes described in the case-studies. One case-study was related to a project in the Middle East, one to a project in Asia, three to projects in Africa and one to a project in South America.

4.2 CHARACTERISTICS OF THE HYGIENE EDUCATION PROGRAMMES

The hygiene education programmes in which the respondents were working, were nearly all part of water supply and sanitation projects. Only one of these education programmes had no direct relation with the provision of water and sanitation facilities.

Improvement of the quality of life was the main objective in 26 of the water and sanitation projects. Other project objectives were, for example, provision of sustainable water and sanitation and to decrease the workload of women.

The modal class of the total intended coverage of the project was 10.000-50.000 people. The range of the coverage went from 600 people to over 22 million people. Sometimes the project area covered only one or two villages, for example, in Senegal. And sometimes the project covered the whole country for instance in Guinea-Bisseau.

The type of water and sanitation improvements in the projects were mainly concerned with the provision of water and sanitation facilities, for example, the provision of latrines, handpumps, solid waste collection and disposal facilities.

The general structure of the organization and implementation of the hygiene education activities can be described as follows. Often the head of the project was an expatriate supervisor. She/he supervised relatively high educated local and/or expatriate staff. This staff should go to the villages to train the educators at village level. The local educators were presumed to provide the hygiene education to the community.

In the example below, a description of such a hygiene education programme in Yemen is given:

"A team of 4 Yemeni women under supervision of a Dutch expert is going about 8 times on successive weeks in the afternoon to a village where the water supply project is under construction. That afternoon two health education sessions for women were planned, in two different houses. There is a programme for the different subjects and the women have been thoroughly trained in implementing the programme. Sometimes a village walk is done to see of some if the visible advices are followed up. Sometimes some lessons are given at the school. Sometimes the Dutch expert is having some sessions with the men. If the village has health services, a male and/or female supervisor of the provincial Health Office is going with the team and the primary health care workers are integrated in the programme. The introduction to this programme is given to the men by the project staff" (Q-1).

In general, the hygiene education programme objectives were not so well described. Examples of bad described objectives are: "effective behaviour change" (Q-25) or "to contribute towards eradication of guinea worm" (Q-21). An example of a more specified objective is: "dish washing immediately after eating" (Q-8). The best described hygiene education objective was stated as follows: "75% of the children younger than four years of age should have been correctly rehydrated" (C-6). Even though in this objective it was not clear when this percentage had to be achieved.

4.3 THE RESULTS RELATED TO THE FOUR MAIN QUESTIONS

In this paragraph answers to the four focus questions are reported. These questions are (The number in brackets refers to the number of that item in the questionnaire):

* What do you consider to be the strong points of the hygiene education programme ? (10)
* What problems and bottlenecks do you face in the hygiene education programme ? (11)
* How would you like to improve or change the hygiene education programme ? (12)
* What advice do you have for your colleagues on how to make a hygiene education programme successful ? (13)

In the tables 3, 4, 5 and 6 the results of the separate analyses of the questionnaires, interviews and case-studies are combined. The five most frequently mentioned answers were put into these four tables. The figures refer to how many times that answer was given in the questionnaires (Q), interviews (I) and case-studies (C). Each table is related to one of the four questions. A detailed analysis of the answers to the focus questions can be found in annex III.

Table 3. Five most important issues related to the strong points of the hygiene education programme (hyed).

	Q (n=31)	I (n=11)	C (n=6)	total (n=48)
Well chosen education methods	16	11	3	30
Hyed was based on a community diagnosis	13	2	2	17
Already existing personnel and organizations were used	8	2	3	13
Local people were educators and staff members	10	1	0	11
Women were involved in the hyed	6	1	3	10

Most of the respondents saw as a strong point in their hygiene education programme that well chosen education methods were used. According to these respondents, well chosen education methods were adapted to the target group. These methods had to be attractive and understandable. It was also necessary that people should be interested and motivated to go to the hygiene education meeting. Different methods were used to make the hygiene education meeting more pleasant to attend. In Zambia a theatre-group started the education programme with singing well-known local songs. The villagers became curious of what was going on. They came closer to the theatre-group and started to listen and dance. After song singing, the theatre group performed a play about, for example, a woman who did not use the special bucket to get water from the well. After the play the villagers could discuss this topic. In India the women were offered tea and biscuits during the hygiene education meeting to make it more attractive for them to attend.

Another strong point of the hygiene education programme was that it was based on a community diagnosis. Although the respondents mentioned the same concept, they interpreted it different. Some of them defined a community diagnosis as a KAP-study (Knowledge, Attitudes and Practices study). Other respondents referred to a community diagnosis as follows: "Let the community diagnose their felt needs and plan with them how to solve the existing problems. Themes and topics can be selected to help to educate the community" (I-2).

The use of already existing personnel and organizations was seen as a strong point because the hygiene education could be integrated in the daily life of the community. No new personnel had to be contracted and paid. The organizations could also be useful to gain an entry into the community.

It was also seen as a strong point to contract local staff. In the Philippines the hygiene educators were a local midwife and a local dietician. They provided the hygiene education. These women spoke the local language and were familiar with the habits and customs in that community.

Many respondents emphasized the importance of involving women in hygiene education programmes. There were several reasons for this. One of the reasons was that in some areas women have the major responsibility for water, sanitation and family health. They also have to take care of the children. Another reason for involving women in the programme was related to awareness raising of the position of women in that community. Some respondents mentioned the following measures to enhance the position of women: "This approach was developed with the conviction that women could not voice their needs because of lack of self-consciousness and self-esteem and excessive respect for men. Hence the key concept in this approach is awareness building about the women's capabilities" (Q-11) or "Women meet educated women in the meetings. This has a significant impact on them. They see that women can be educated and they become more interested in education" (Q-10).

Table 4. Five most important issues related to the bottlenecks of the hygiene education programme.

	Q (n=31)	I (n=11)	C (n=6)	total (n=48)
Lack of well trained and motivated staff	16	8	3	27
Problems with adequate planning	18	3	5	26
Lack of cooperation between field and organizational level	10	9	2	21
Community does not feel involved in the hyed	15	1	0	16
Lack of cooperation between social and technical section	7	7	1	15

The most frequently mentioned bottleneck was lack of well trained and motivated staff. It was sometimes very difficult to find well educated personnel, this was especially the case with women. A respondent clearly illustrated this point: "In Yemen, it is very difficult to get women who are well trained and allowed to work in the project. Even when they are hired they can be removed suddenly because their father, husband or brother will not accept rumours that are spread in town" (Q-5). One of the reasons why local staff was not so motivated was that they did not achieve any kind of incentives. Sometimes the local educators were paid but the wages were very low. In general, the educators who were working in the field earned even less. In Guinea-Bisseau the maintenance engineer of the handpump received a bicycle as an incentive. Unfortunately, he had not enough money to repair the bicycle when it broke down.

Related to adequate planning strategies of hygiene education programmes, the most important problem was lack of time. A respondent from Egypt stated it as follows: "Usually projects are limited in time and finance, not taking into consideration that human behaviour change is a long process" (Q-2). Another issue related to proper timing of the hygiene education was: "The programme was timed during the farming period and market days. This resulted in poor response by the people" (Q-26). These examples illustrate that time phasing of the hygiene education programme have to be done very carefully.

The third bottleneck was lack of good cooperation between field levels of the project and governmental levels. Governmental levels range from village level to higher decision levels. An extreme example of lack of cooperation was derived from the Philippines. The project was threatened sometimes because the government had labelled the NGO as a dangerous communist organization. More often bad cooperation was mentioned in relation to slow decision making or delayed release of budget by governmental organizations.

The fourth bottleneck was that the community did not feel involved in the hygiene education programme, because it had other interests and priorities. Especially in poor areas income generating activities were more important to the target group than attending a hygiene education session. Sometimes it was very difficult to reach the poorest people.

Also big problems regarding the cooperation and integration of the social section and the technical section of the project were mentioned. One interviewee experienced a lot of problems related to working relationships with the technical staff. She started working in the villages to prepare the community for the installation of water and sanitation facilities. This preparation phase took well over a year. Sometimes, already after a few months the technical section started with drilling wells. Other times the technical section did not even come to the village and the prepared community did not receive the facilities at all.

Table 5. Five most important issues related to the recommended improvements in the hygiene education programme.

	Q (n=31)	I (n=11)	C (n=6)	total (n=48)
Work closely with the target group	8	3	0	11
Better cooperation between social and technical section	8	0	1	9
Hyed based on a community diagnosis	8	0	1	9
Conduct a monitoring and evaluation methods	7	0	1	8
Better cooperation between field and organizational level	6	1	0	7

The most frequently mentioned improvement was: work more closely with the target group. For example, in Lesotho the pitso (general public meeting) could be used in the initial stages of the programme in order to involve the entire community in the hygiene education activities. These public meetings should be followed by group-discussions, home visits etc.

Special emphasis was put on an improvement of the relationship between technical staff and social staff. It was seen as an important factor that in order to achieve any success the social and technical sections must cooperate and integrate well.

The hygiene education programmes should be based on a community diagnosis according to nine respondents. Related to this issue, the respondents mentioned that they would have set goals in cooperation with the target group. The programme should be more adapted to the needs and wishes of the people.

The fourth recommended improvement was related to monitoring and evaluation activities. More attention should be paid to what is really done in the community, how it is done and what is the result of that particular activity. From Bolivia the following illustration was derived: "Realistic evaluation criteria should be agreed upon at the outset by all parties to the project, including the communities" (C-6).

Not only on field level better cooperation and integration was needed. But also related to higher decision levels this was seen as an important issue. Without support of governmental levels it was very difficult to implement the hygiene education programme properly. Especially in relation to continuation of the programme this was an important factor. A respondent from India stated this point as follows: "The hygiene education programme should be planned and organized in such a way that the government department is able to take over and not only continue work in the project areas, but also be able to replicate the strategy in other villages" (Q-15).

Table 6. Five most important issues related to the given advices to the hygiene educators.

	Q (n=31)	I (n=11)	C (n=6)	total (n=48)
Base the hyed on a community diagnosis	19	3	4	26
Work closely with the target group	11	7	0	18
Plan/develop carefully the hyed programme	8	5	2	15
Obtain good cooperation between the social and technical section	5	0	5	10
Choose carefully the education methods	0	4	4	8

Nearly all the five mentioned advices have something to do with involving the target group in all phases of the hygiene education programme.

Related to the community diagnosis the following advice stemmed from Ethiopia: "Let the community diagnose their felt needs and plan with them how to solve the existing problems. The educational methods can be selected accordingly" (Q-20). A respondent from Kenya advised: "Listen to the community even when they seem ignorant. Often they have a reason for every act or behaviour" (Q-28).

"Work closely with the target group" was the next important advice. One interviewee said: "Let the people do it all themselves, your role is on the background. Only when necessary discuss a certain approach" (I-3). The staff must consist of local people because they know the situation, the habits, the taboos and they speak the same language.

Advices related to planning that were received are: "Changes in behaviour in the majority of the target group can not be expected until health education has been carried out for a long time. Therefore ample time for the implementation of the programme should be secured" (C-1) and "For the purpose of evaluation conduct a baseline study and set clear and measurable objectives" (C-2). The recommended time to obtain changes according to the respondents, ranged from six months to more than seven years.

Mainly in the interviews it was mentioned that one has to start with *listening* and talking to the target group. Look around in the village and become familiar with the existing organizations and circumstances. Their advice was not to start immediately with planning and implementing the hygiene education programme.

The importance of good cooperation between the social and technical section was already emphasized before. In Zambia a better understanding of social and technical section was achieved through organizing a training course for both sections. After this training course they were more able to cooperate with each other.

The fifth advice was concerning well chosen education methods. From Peru came the following advice: "Choose the education method in consultation with the target group and respect their advices and comments. Link the hygiene education message to something that makes the lives of the target group more convenient" (Q-30). Other advices are: Use local methods and materials; make the education session pleasant to attend; pre-test the hygiene education programme to find out if it is understood and popular with the target group.

In the next chapter the results of this study will be discussed.

5 DISCUSSION

This study was done in order to determine what practical experienced hygiene educators saw as factors that contribute to the success of the hygiene education programme in which they have been working. Information from field experienced hygiene educators may contribute to the development of more successful hygiene education programmes in the future. The main question in this study was formulated as follows:

Which factors contribute to the success of hygiene education programmes, according to practical experienced hygiene educators ?

To collect information on this subject three methods were used. These methods were: questionnaires, interviews and case-studies.

The questions in the questionnaire were stated rather open-ended. It was surprising that all the respondents interpreted the items in the same way. In contrary to what might be expected, differences in the professional background of the respondents did not result in differences in answers. Persons who had studied technical sciences tend to use a bit more top down approaches than the social scientists. A probable explanation for the lack of differences in answers is that hygiene education has a short history. Therefore it is difficult to determine why a certain educator has better results than another. The results may be due to the differences in educational background of the hygiene educators. Perhaps other factors as enthusiasm and motivation are of more importance. The main focus of this study was not to investigate relations between the performance of the hygiene educators and their educational background. Therefore no firm conclusions can be drawn about this topic.

A lot of respondents mentioned that the hygiene education should be based on a community diagnosis. The target group should be involved in all phases of planning and implementing hygiene education programmes. But in many programmes neither a community diagnosis was conducted nor did some kind of involvement of the target group take place. Fortunately, the respondents mentioned it as a bottleneck or as recommended improvement. They also gave the advice to involve the target group in all phases of the hygiene education programme. Thus, although the community was not involved in all hygiene education programmes this was seen as an important factor to achieve success in hygiene education programmes.
Special emphasis was put on the role of women in the programme. Not only men but also women should be involved in all phases of the hygiene education programme.

The bottleneck that was mentioned most frequently was lack of well trained and motivated personnel. This was not surprising, because local staff was mostly always underpaid and received hardly any reward for its work. The local staff lacked materialistic support as well as emotional support. To get more motivated personnel, staff should receive fair wages for its work. Local staff should also be trained, supported and supervised regularly. The availability of well trained and motivated personnel is an essential factor in order to achieve any success. Well trained local staff might also be important to maintain the programme.

Related to planning many issues can be discussed. One of the most striking issues was that hardly any project stated well defined and measurable goals. It would be very difficult to measure any success when it is not clear what kind of goal has to be achieved. Therefore, each programme should start with an adequate planning strategy. This strategy should be done in close cooperation with (representatives of) all persons that were involved in the hygiene education programme. Cooperation and discussions with all the persons involved may also result in better understanding and working relationships. This means not only good cooperation and communication between staff and target group but also within the staff and between staff and higher decision levels. If the community should be involved in all phases of the hygiene education programme the education methods may be more adapted to the target group. The target group can decide which methods seem to be appropriate in their community and develop and implement it according to their wishes and needs.

Unfortunately no other studies of this kind were found so comparison of the data is not possible. In literature a lot is known about how to conduct successful hygiene education programmes. It was remarkable that almost no respondent referred to a certain theory or approach on which the hygiene education programme was based. Almost all mentioned issues can be found in literature about health education. A selection of three approaches to health education can be found in chapter 2. These descriptions of approaches can be useful for the hygiene educators. Especially if they want to know how to cope with certain problems in the hygiene education programmes or if they do not have enough knowledge about a certain issue. For example, it was frequently mentioned that the hygiene education should be based on a community diagnosis. Sometimes the hygiene educators do not know how to conduct a community diagnosis. Green et al. (1991) provide this kind of information in the PRECEDE-PROCEED framework. More or less the same can be said about how to choose the right communication methods. In paragraph 2.3 information about communication methods is given.

One of the issues that has not been described so well in literature about health education is related to better cooperation between field level of the project and higher decision levels. This factor was very often mentioned by the respondents. Maybe this information can be provided by experts in this particular area.

To come to the most frequently mentioned answers, each answer was of the same importance. This does not implicate that the five most frequently mentioned answers are of the same importance according to the different information sources. For example: thirteen respondents saw as a strong point in their hygiene programme that it was based on a community diagnosis. Only two interviewees mentioned that issue. Nearly all the interviewees saw as a bottleneck lack of cooperation between the social and technical section. Only seven answers related to this issue were described in the questionnaire. More examples of this kind can be found in the tables 3, 4, 5 and 6. The different frequencies between the information sources may be due to the differences in data collecting methods. Each method has its own specific advantages and weaknesses. Therefore the answers obtained from each data collecting method show little differences in issues that were mentioned.

Some potential sources of bias are described below. Most addresses of respondents were obtained from the professional staff of the IRC. Although the IRC is an independent organization with a lot of contacts all over the world this can be a source of selection bias. However, some addresses of respondents were not obtained from the IRC. These respondents did not mention different issues in comparison with the answers of the respondents known by the IRC.

Another source of bias could be related to the analysis of the results. Because this is a qualitative study it is very difficult to analyze the results objectively. First the information was summarized. Everyone summarized the information according to her/his own insights. After that, the issues were tallied. The issues had to be grouped together because it was not practical to count all the issues separately. Sometimes it was difficult to make a choice to which group of answers an issue belonged, therefore it could also be a source of bias.

But although this kind of biases could be possibly made, it is very likely that the most important factors were described in the results.

6 CONCLUSIONS AND RECOMMENDATIONS

In this chapter the main conclusions are described. At the end of the chapter some suggestions for further investigation are made.

The following question was the main question of this investigation:

Which factors contribute to the success of hygiene education programmes, according to practical experienced hygiene educators ?

The main focus in this investigation was on the items 10, 11, 12 and 13 of the questionnaire (see annex I). The first two questions are related to what the hygiene educators saw as strong points and bottlenecks in the hygiene education programme they have been working in. The third question dealt with the recommended improvements in the hygiene education programme. The last question was what kind of advice the hygiene educators would like to give to their colleagues.

From each of the four questions the five most frequently mentioned issues are described below. The numbers in brackets refer to how often that issue was mentioned by the respondents (n=48).

What do you consider to be the strong points of the hygiene education programme ?

* Well chosen education methods were used. (30)
* The hygiene education programme was based on a community diagnosis. (17)
* Already existing personnel and organizations were used. (13)
* Local people were educators and staff members. (11)
* Women were involved in the hygiene education programme. (10)

What problems and bottlenecks do you face in the hygiene education programme ?

* Lack of well trained and motivated staff. (27)
* Problems with an adequate planning. (26)
* Lack of cooperation between field and organizational level. (21)
* The target community does not feel involved in the hygiene education programme. (16)
* Lack of cooperation between the social and technical section. (15)

How would you like to improve or change the hygiene education programme ?

* Should have worked more closely with the target group. (11)
* There should be a better cooperation with the social and technical section of the project. (9)
* The hygiene education should be based on a community diagnosis. (9)
* Monitoring and evaluation should be conducted. (8)
* There should be a better cooperation between field and organizational level. (7)

What advice do you have for your colleagues on how to make a hygiene education programme successful ?

* Base the hygiene education programme on a community diagnosis. (26)
* Work closely with the target group. (18)
* Develop and plan carefully the hygiene education programme. (15)
* Obtain a good cooperation between the social and technical section of the project. (10)
* Choose carefully the hygiene education methods. (8)

It can be concluded that the next four factors are mentioned most frequently by the respondents in order to achieve successful hygiene education programmes.

Especially the involvement of the target group in all phases of the hygiene education programme was mentioned very often. The respondents also emphasized the involvement of women in the programme. The importance of involving the community in the education programme is also underlined by Green et al. (1991), Srinivasan (1990) and Werner and Bower (1982). They all emphasize that the education programme must be based on the needs and wishes of the target group. In the PRECEDE-PROCEED framework of Green et al. (1991) the first phase deals with the community diagnosis. In this phase it is described what should be taken into account if one wants to conduct a community diagnosis. Srinivasan (1990) and Werner and Bower (1982) describe how to realize involvement of the community in the programme. Involvement of the target group can be reached by using participatory education methods. Particularly Srinivasan (1990) emphasizes the importance of involving women in all phases of the programme.

The next important factor, mentioned by the respondents, was that the hygiene education methods should be well chosen. The respondents meant by well chosen methods: use of local methods and materials; the education session should be pleasant to attend; pre-test the hygiene education programme to find out if it is understood and liked by the target group etc. To obtain any success in the hygiene education programme it is very important that appropriate education methods are chosen and used. Hubley (1986, 1987, 1988a and 1988b) and McGuire (1981 and 1985) provide background information on how to choose the best education methods.

The third important issue is: obtain a good cooperation with all the persons and organizations which are involved in the project. Not only a good cooperation with persons and organizations at field level appeared to be important, but also of importance is to obtain good cooperation with higher decision levels (project and governmental). In the area of health education this particular subject is not so well described. Only Green et al. (1991) provide little information about cooperation and integration of project personnel. Since this is an important issue according to the hygiene educators, more research has to be done in this area.

Last but not least, issues related to an adequate planning strategy were also mentioned quite often by the respondents. Particularly timing, monitoring and evaluation appeared to be important. Green et al. (1991) provide a framework that was especially developed for planning purposes in health education programmes. Timing, monitoring and evaluation are well described topics in this framework.

In this study a lot of factors that contribute to the success of a hygiene education programme were mentioned by the respondents. These issues and, if necessary, theoretical background information can provide relevant knowledge to develop and implement more successful hygiene education programmes in the future.

But this study is not enough, a lot of additional research has to be done. The results of this study can be a basis for further research. The next step is to investigate all the important factors more thoroughly.

Suggestions for further investigation are:

- Are hygiene programmes, based on a community diagnosis, really more successful than when they are not based on this concept ?
- Are participatory methods attainable in water and sanitation projects or does it take too much time and does it cost too much money ?
- Which hygiene eduction methods are precisely used in practice ? What are the experiences of the hygiene educators with the different methods ? Which of these methods actually achieve changes in behaviour ?

In the future one of the first efforts should be on stating measurable goals and objectives. When these are defined the whole programme must be regularly monitored and evaluated. After that it may be possible to say something about the effectiveness of a certain approach or programme. This also means that all phases of the programme should be documented very well. Only after carefully planning the hygiene education programmes, more specific information about how to achieve success in these programmes will become available.

SUMMARY

Hygiene education gradually became a common component of water and sanitation projects during the second half of the Drinking Water and Sanitation Decade (1981-1990). To improve the quality of hygiene education programmes it may be useful to learn from experiences in this field. The aim of this study was to determine what practical experienced hygiene educators see as factors that contribute to the success of hygiene education programmes. In this study qualitative data collecting methods were used. To obtain the information from these hygiene educators, 91 questionnaires were sent to addresses all over the world, 12 persons were interviewed and 6 case-studies were analysed. All the respondents were asked about their experiences in the hygiene education programme in which they are working. The main focus was on questions related to what the hygiene educators see as the strong points and bottlenecks in the hygiene programme, what kind of improvements they want to make in the programme and which advices they have for colleague hygiene educators.
After analysis of the data, it became clear that the next four success-factors were mentioned most often by the respondents. First, the members of the target group should be involved in all phases of the hygiene education programme. The second factor is the use of well chosen education methods. The third important factor is related to obtain a good cooperation with all the persons and organizations which are involved in the hygiene education programme. Hygiene education should be properly planned, was mentioned as the fourth important factor.
In this report not only practical experiences are described but also some theoretical background information has been given.

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ANNEX I

I R C

International Water and Sanitation Centre

Centre international de l'eau et l'assainissement

Telephone :

General

31 - (0)70 - 33 141 33

Direct

31 - (0)70 - 33 141 .

ref / ref
48.674/WvD/lw

your ref / votre ref

date
3 February 1992

Subj.: Hygiene Education Questionnaire

Dear Sir/Madam,

This letter is an invitation to fill in the enclosed questionnaire. The questionnaire is part of a study to determine which factors contribute to the success of the hygiene education programmes in a water and sanitation project. This study is part of my apprenticeship at the IRC International Water and Sanitation Centre and of my thesis for health sciences from the University of Maastricht, The Netherlands.

The IRC International Water and Sanitation Centre is an independent non-profit organization. It is supported by and linked with the Netherlands Government, UNDP, UNICEF, the World Bank and WHO. IRC provides information and documentation services, training, and research and development support to water supply and sanitation projects and programmes in developing countries. For several years, hygiene education in water and sanitation programmes has been one of the major areas of work for IRC.

The aim of this study is to achieve a deeper understanding of how we can make hygiene education programmes more successful. The study will be based on a literature review and key-informant interviews in addition to this mail questionnaire. The results of the study will be presented in a paper for project, government and NGO staff involved in the planning and implementation of water, sanitation, and hygiene education projects. It is hoped that by sharing experiences on this important subject, future hygiene education programmes will benefit.

Your contribution to this study would be highly appreciated as your knowledge and practical experience can contribute to developing more successful hygiene education programmes. If you feel it would be more appropriate that someone else involved in hygiene education fill in this questionnaire, kindly pass it on.

Please return the completed questionnaire before March 15, 1992. You can return the questionnaire in the pre-addressed envelope provided, or fax it to + 31-70 - 38 140 34.

If you have any materials and reports that you feel would be useful for this study, I would be very pleased to receive these from you. They can be sent to me at the address below.

Thank you for taking the time to fill in this questionnaire. When the study is finished (around July 1992) I will report back to you with the results.

Yours sincerely,

Wilma van Driel

MAIL / COURRIER : P.O. box 93190, 2509 AD The Hague, The Netherlands ADDRESS : Prinses Margrietplantsoen 20, The Hague, The Netherlands

TELEFAX : (0)70 - 38 140 34 TELEX : 33296 irc nl TELEGRAMME: Worldwater The Hague BANK : ABN bank The Hague 51.42.18.428, Postbank 4218421

QUESTIONNAIRE

Please relate the questions in this questionnaire to the hygiene education programme in which you are presently involved. If you are not presently involved in a hygiene education programme, please relate the questions to the most recent hygiene education programme in which you were active.

OVERALL PROJECT DATA

1. Name of the project:

2. Project area:

3. Overall project objectives:

4. Total intended population coverage of the project:

5. Starting date/year of the project: - 19

6. Final date/year of the project: - 19

7. Type of water and sanitation improvements:

HYGIENE EDUCATION PROGRAMME DATA

8. What are the specific objectives of the hygiene education programme:

9. Can you briefly describe how the hygiene education programme is a) organized and b) implemented:

10. What do you consider to be the strong points of the hygiene education programme (for example with respect to human resources; organization; approaches and methods; timing and phasing; financial resources, etc.):

11. What problems and bottlenecks do you face in the hygiene education programme (for example with respect to human resources; organization; approaches and methods; timing and phasing; financial resources, etc.):

12. How would you like to improve or change the hygiene education programme:

13. What advice do you have for your colleagues on how to make a hygiene education programme successful:

PERSONAL DATA

14. Name:

15. Position in the project:

16. Professional background:
    - O Technical
    - O Social
    - O Other:

17. Did you receive any specific training in hygiene education. If the answer is yes, please specify.

18. How long have you been working/ did you work in this project:

ANNEX II

INFORMATION SOURCE	Q-1	Q-2
NAME OF THE PROJECT	Support Rural Water Supply Department (SRWSD)	Women, Water and Sanitation
PROJECT AREA	Dhamar area, Republic of Yemen	Two villages in Lower Egypt
PROJECT OBJECTIVES	* Provision of sustainable ws + s * Participation of women * Cooperation and participation of the Local Council and the villages * Promoting of the SRWSD approach	* Initiating water and sanitation education programme * Mobilizing community workers and villagers in improving the village sanitary conditions
COVERAGE	29.000 people	± 600 women and ± 400 school children
STARTING DATE FINAL DATE	1983 1994	1986 1991
TYPE OF WS IMPROVEMENTS	* With participation building from borehole up to the distributionline * Advice for maintenance + operation * Handing over responsibilities to the beneficiaries after finishing * What to do with waste water * Building pour-flush toilets	* Garbage collection system * Feasibility study of the ground water table * Fixing public stand pipes
HYED OBJECTIVES	* Knowledge of the causes of diarrhoea worms and the danger of human stools * Stimulation of hygiene behaviour * Prevent waste water * Stimulation of proper toilet use * Stimulation of handwashing * Garbage control * Importance of the role of women	* To demonstrate and evaluate the effectiveness of and hyed programme stressing: environmental, home and personal hygiene in order to lower disease transmission in relation to water
DESCRIPTION OF THE HYED PROGRAMME	A team of 4 thoroughly trained yemen women under supervision of a Dutch expert was going ± 8 successive weeks in the afternoon to a village where the water supply project was under construction. 2 health education sessions were held with women in 2 different houses. There was a programme for different subjects. Sometimes a village walk was done for evaluation purposes. Sometimes lessons were given at schools and the Dutch is having some sessions with men	Various approaches utilized by different groups of HE recruited locally. The selected approach depended on the need of the villagers. The message based on the results of intensive observations prior to implementation. Nurses of the health unit give HE on weekly basis to mothers who brought children to the clinic. It took a form of a dialogue between the women and the nurses. Primary school teachers gave HE during each day of the summer club. One hour was spend on a particular health issue.
STRONG POINTS OF THE HYED PROGRAMME	* A well trained team of Yemen ladies * The women section is well integrated * Same schedule of the hyed and ws + s * The project is supporting the HE * Overtime of the women is compensated * Women themselves conclude how to prevent illnesses, this is both entertaining and effective * After 3 months a monitoring-visit is made to reinforce the HE * Availability of a good budget * Women are seen as very important	* Use of local administrators and train them to carry on the job * Training was an ongoing process, not only as a part of the project * Teachers and nurses, if trained monitored and evaluated can resume the whole of effective hygiene educators
BOTTLENECKS OF THE HYED PROGRAMME	* Not easy for women to work * The villages are very remote * No follow up session for the women	* Limited time and finances, not taking into consideration that behaviour change is a long process and affected by environmental constrains
RECOMMENDED IMPROVEMENTS	* More regular lessons at the school, with the teachers and the men * Cooperation with the Health Office more systematically	* Hyed should meet local needs * Hyed should be based on indepth community study
ADVICE FOR COLLEAGUES	* Train the HE thoroughly * Play roleplays with the H educators * Keep the atmosphere in the training pleasant and have jokes at hand * Exaggerate bad behaviour in role plays, they don't feel offended * Keep bad things general and praise individuals * Work in line with your project	* Work with local leaders and villagers * Do not impose any ideas * Project members must be of the same culture
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-3	Q-4
NAME OF THE PROJECT	Rada Integral Rural Development Project	Rada Integral Rural Development Project
PROJECT AREA	Al Bayda Province, Republic of Yemen	Al Bayda Province Republic of Yemen
PROJECT OBJECTIVES	* Increase agricultural productivity of farmers. * Improve the health/nutrition standards of the rural families * Improve the mobility services	* Increase agricultural productivity and incomes of farmers * Improve the health/nutrition standards of the rural families * Improve the mobility services
COVERAGE	Al Bayda Province: 380.000 people	Al Bayda Province: 380.000
STARTING DATE FINAL DATE	1977 1992	1977 1992
TYPE OF WS IMPROVEMENTS	* Water supply: survey, design and construction of village water supply through local contractors * Sanitation: Hyed and sanitation extension. Implementation activities and supporting activities	* Type of ws improvements: survey, design and construction of village water supply schemes * Implementation activities * Hyed and sanitation extension * Supporting activities
HYED OBJECTIVES	* Water from the improved or new water supply systems will be used at household level in a healthy way * Domestic garbage will not cause a health or environmental problem * The same for domestic waste water * Human waste will be safely disposed	* Water from the improved or new water supply systems will be used at household level in a healthy way * Domestic garbage will not cause a health or environmental problem * The same for domestic waste water * Human waste will be safely disposed
DESCRIPTION OF THE HYED PROGRAMME	The HE programme consists of a hygiene and a nutrition part. It is supportive to the technical parts of the projects. The team consists of 1 expatriate female HE advisor, 1 specialized extension agent and 3 village extension agents. After training the VEA gives the message to the women, do homevisits and demonstrations. They are supervised by the SEA. Hyed of a male extensionist in cooperation with a Yemeni construction supervisor for men. The emphasis on garbage collection and disposal	The HE programme consists of a hygiene and a nutrition part. It is supportive to the technical parts of the projects. The team consists of 1 expatriate female HE advisor, 1 specialized extension agent and 3 village extension agents. After training the VEA gives the message to the women, do homevisits and demonstrations. They are supervised by the SEA. Hyed of a male extensionist in cooperation with a Yemeni construction supervisor for men. The emphasis was on garbage collection and disposal
STRONG POINTS OF THE HYED PROGRAMME	* Financial resources are abundant * VEA have impact on local Hygiene practices * Hyed developed after careful research on daily practices * It is understood by illiterate women * SEA developed interviewing skills * The engineering section recognized the importance of women	* Local staff is involved in hyed, in cooperation with expatriate staff * Local staff received on the job training * Health workers of the mother and child clinic are involved in hyed * HE is coupled with the implementation of ws + s facilities * Assistance on request-> motivated * Financial resources are enough
BOTTLENECKS OF THE HYED PROGRAMME	* Lack of staff * HE and the technical section are not developed in cooperation and are not integrated * Difficulties due to the role of women	* Lack of well trained local staff to carry out the hyed after withdrawal of the extern advisors * It is difficult to reach the poorest communities, because 30% village contribution to costs is required
RECOMMENDED IMPROVEMENTS	* Full integration of the educational and the technical section * Availability of higher qualified staff for the hyed programme	* More and better qualified local staff should be available, based especially in villages where facilities for hygiene improvement were implemented
ADVICE FOR COLLEAGUES	* Plan joint activities of hyed and ws+s * Take care of enough staff members * Develop the hyed carefully, using all the information available * Get some technical knowledge * Collect information on the use of extension materials * Choose the hyed approach carefully	* Have a good knowledge of the local language * Know the real needs of the community * Have a clear idea about the hygiene as well as social problems in the area * Limit hyed to what is exactly needed * Limit hyed to the knowledge and experience of the local educator * Do not interfere in subjects beyond hyed (tribal or family problems)
ADDITIONAL INFORMATION	VEA: Village Extension	Agent

INFORMATION SOURCE	Q-5	Q-6
NAME OF THE PROJECT	Rada Water Supply and Sanitation Project	Community Water Supply and Sanitation Programme
PROJECT AREA	Rada Urban Area, Republic of Yemen	Nepal, coverli hill and mountains
PROJECT OBJECTIVES	Permanently improvement of the health situation in Rada. By establishing a number of public services.	* To improve the health of the rural population by provision of clean water * To decrease the workload of women
COVERAGE	50.000 to 75.000 people (100%)	
STARTING DATE FINAL DATE	april 1988 december 1994	1975 still going on
TYPE OF WS IMPROVEMENTS	* Water supply * Waste water disposal * Solid waste collection and disposal * Rainwater drainage	* Gravity water supply systems * Pit latrine construction * School latrines * Hygiene education
HYED OBJECTIVES	* To inform and gain cooperation of the Rada population during the introduction, implementation and proper use of the improved ws + s * To provide HE about these sectors * Train/organize training for staff and project related organizations	* To reinforce the impact of ws through changed hygiene behaviour * To motivate people to build sanitation facilities * To promote ORS
DESCRIPTION OF THE HYED PROGRAMME	The hyed is executed by the extension and training section. The section is responsible for environmental HE, communication with the population and training of staff in all the components of the project. The information to the people is given in meetings with the population, intermediate organizations and sub target groups like children, women, head of the mosque etc. The target groups are informed through discussion meetings, educational meetings, etc. Special media is developed like leaflets, posters and educational films.	Hyed activities (>1986) based on a baseline survey. Training of female representatives of tapstand users. Both in villages with a tapstand and a tap stand being build at that moment. Training was in hyed and preventive maintenance of tapstand. Under guidance of staff they were supposed to organize monthly tapstand meetings on various topics. Hyed staff also supported technical staff in villages where the pilot activities were not taking place and gave inputs in the training for technicians.
STRONG POINTS OF THE HYED PROGRAMME	* Men and women work together * Responsibility and enthusiasm of the people working at the section * Training for men as well as women * In country or in region training -> arabic speaking * Financial resources are enough	* Variety of methodologies * Hyed slowly become an issue on national level * Raises enthusiasm of technical staff * Opportunities for better contacts with village women * On-the-job training of staff
BOTTLENECKS OF THE HYED PROGRAMME	* Difficult to get well trained staff * Difficult to get women who are allowed to work * Training of the women outside the project is difficult to get approval * Special efforts are requested to explain the technical delay and keep the communication going with the population * Cooperation with the other sections is sometimes difficult.	* Difficult communication between the field workers and decision makers * Slow release of budget * Low educational level of field staff * National level very output oriented * Little support from regional/national level * Difficult to reach the prime target group, the poorest people * Too little integration with the technical component * No real monitory system is set up.
RECOMMENDED IMPROVEMENTS	* More practical messages in the hyed * Communication and extension activities should be developed more closely together with the technical section (and vice versa) * More qualified and trained staff should become available	* Find some procedure to set goals in consultation with the target group * Improve cooperation/ integration with technical component of the programme * Better working conditions for field staff * Get more support from regional level * Set up a good monitoring system
ADVICE FOR COLLEAGUES	* Conduct a baseline survey * Base the hyed on this survey * Train the local staff	* Establish cooperation with all staff * Try to enter villages as a team * Carry out a good baseline study * Keep staff motivated -> good working conditions, additional training etc. * Set goals with the target group
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-7	Q-8
NAME OF THE PROJECT	Social Welfare Programme of the State Owned Plantations in Sri Lanka	Hygiene promotion and evaluation for the prevention of diarrhoeal diseases
PROJECT AREA	250 Tea and Rubber Plantations	Northern Thailand
PROJECT OBJECTIVES	* To increase the quality of life of the plantation workers	* To develop methods and materials for communication strategy * To develop simple behaviour indicators * Evaluation of communication strategy in terms of messages received and behaviour changed
COVERAGE	± 185.000	20.000 people
STARTING DATE FINAL DATE	january 1986 june 1992	august 1990 july 1992
TYPE OF WS IMPROVEMENTS	* Construction of pipe borne water supply; 1 standpipe for 5 families * Construction of latrines; 1 per fam.	* Handwashing * Dishwashing
HYED OBJECTIVES	It may be strange but true that such activities are not implemented as part of the ws + s programme	* Promoting handwashing before cooking; before eating or feeding a baby; after latrine use or cleaning baby's bottom * Dish washing immediately after eating
DESCRIPTION OF THE HYED PROGRAMME	However there is a health education programme, dealing with maternal and child care, family planning, control of diarrhoeal diseases etc. Which is implemented through plantation health staff and volunteers. As such the target group is able to gain some knowledge in order to develop attitudes and practices.	It is a research project so the organization has been directed specifically for the purpose of testing different methods for developing communication strategies and evaluating this strategy with a controlled study design. Implementation has been done by workers hired by the project and trained specifically for the project aims. These workers have to work with appropriate institutions on village, district and provincial level.
STRONG POINTS OF THE HYED PROGRAMME	* Implemented in consultation/ association with the HE bureau which is a national body * Same policies and priorities as the bureau * Trainers are identified and trained * They train the volunteers * The volunteers are trained to be able to identify primary health problems in their plantations and to take the necessary action in consultation with the trainers when needed	* Project has his own staff which makes the organization much easier * Participation has been encouraged * Social marketing approach has been used, better then traditional methods * Behaviour trials and in-depth interviews of specific groups worked out for rapid assessment * Time and phasing have been planned to suit project evaluation * The project has donated a plastic container to facilitate handwashing * Teachers and VHW's are involved
BOTTLENECKS OF THE HYED PROGRAMME	* Lack of qualified/ experienced HE * Lack of training facilities * Lack of training materials * Difficulties in coordination * Difficulties in monitoring * Difficulties in evaluation	* Failing to stimulate participation * The practices are not of high importance to the target group. * Just one communication strategy * Motivation is difficult to achieve * Lot of time in testing and developing several methods + materials
RECOMMENDED IMPROVEMENTS	* Appoint regional health educators * Establish the importance of the subject on the plantation management * Recognize volunteer experience for future employment in welfare work * Strengthen the volunteers programme and tie it up with the construction programme	* We have been able to develop and improve the programme throughout the study due to the nature of the project; we also want to evaluate the most effective of the different methods employed
ADVICE FOR COLLEAGUES	* Involvement of the target group * Identify problems from their point of view so they will accept the messages * Recognize cultural practices early * Go through the opinion leaders or matured people. * Use existing organizations, rather than creating new ones	* Pre-test all the materials * Try out 2 different communication strategies on small scale * Be realistic about goals * Find ways to monitor the programme simple and effectively * Make behaviour change possible * Without an effective evaluation the programme is a waste of time and money
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-9	Q-10
NAME OF THE PROJECT	Pilot Project of Punchiwilaththawa	Quetta Sewerage and Sanitation Project
PROJECT AREA	A village in the north of Colombo, Sri Lanka	City center of Quetta and 6 peripheral areas with illegal settlements
PROJECT OBJECTIVES	Increasing the health in the community through improved wells, sanitation (toilets) and health education	To improve cleanliness in the compounds
COVERAGE	250 households, ± 2000 people	14.000 families
STARTING DATE FINAL DATE	1984 1986	1987 1994/1995
TYPE OF WS IMPROVEMENTS	* 4 new deep open wells * 2 wells rehabilitated * 60 basic toilets	* In city center, sewerage will replace bucket systems and septic tanks and * In peripheral areas by pour flush latrines
HYED OBJECTIVES	To train health volunteers from the community in basic health and sanitation needs and be in charge of these in the village, to make use of wells and toilets provided for the community in the most hygienic way in an attempt to eradicate w+s related diseases.	The families will adopt proper hygiene habits = those habits which are directly related to sanitation (how to flush latrines, how to keep them clean, handwashing etc.)
DESCRIPTION OF THE HYED PROGRAMME	Based on a baseline survey it was decided that diseases were related to lack of proper ws+s. The HE programme started even before the wells and toilets were completed. The community selected 25 young women who received an intensive training by HE at the hospital. The volunteers were given 10 houses each to look after and train the mothers and children to do hygiene practices. Refresher courses were given to the volunteers. Nutrition was brought in at a later stage as children and mothers were malnourished. After this aspect a nutrition center was set up.	In each community a local office is set up. Staff of that reference center consists of a manager, a female social organizer who is responsible for hyed, civil technologist. Also 4 illiterate people from the community who are working as promoters and hyed. The staff of the center belong to the same ethnicity as the area they work in. After the latrine was build, the promoter conduct three visits per household. They tell the women how to use and maintain their latrines. During the second visit the message was repeated and during the final visit the women had to tell how they use and maintain the latrine
STRONG POINTS OF THE HYED PROGRAMME	* Selection of the young women because they know the families * The girls were free and keen on getting into doing something * The community wishes came first * There was an organized group through which decisions could be made * Finance was never a problem * It was phased for two years so responsibilities could be handed over	* Local women were first trained and than give training to other women * Meetings for hyed are organized. It is a good chance for women to meet other women * Women meet an educated woman in the meetings this has a significant impact on them. They see that women can be educated and they become more interested in education.
BOTTLENECKS OF THE HYED PROGRAMME	* Some of the volunteers found jobs and left the village, they had to be replaced * The organized group wanted the latrines for themselves and their friends	* In this Islamitic area it is sometimes difficult to find women who are allowed to work * Women who give other women hyed are illiterate themselves -> keep messages simple and not too many * Government people and engineers do not see hyed as an important subject
RECOMMENDED IMPROVEMENTS	* We should have get the consensus of the community about their needs * We could have visited other projects	* Obtain more information on women's ideas on hygiene, existing stories and songs on hygiene. Prepare hyed with the use of adapted traditional songs
ADVICE FOR COLLEAGUES	* Practical testing of the theory at schools is best * Be aware of taboos, cultural norms and traditional beliefs. Tailor programmes taking these into account Especially when water, children and human waste are involved	* Keep messages very simple * Involve women intensively in the programme * Make it attractive to attend the meetings by offering tea and biscuits * Take time for the women
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-11	Q-12
NAME OF THE PROJECT	Hygiene and Sanitation Education in Schools	Sanitation and women's involvement in drinking water supply
PROJECT AREA	Selected urban and rural areas, India	Nepal, Ilam district
PROJECT OBJECTIVES	* To review the sanitary and hygienic conditions * To review the present knowledge of the women, teachers and pupils in sanitation and hygiene related problems	* To improve the health of the rural population through sanitation and health education to women * To improve the quality and sustainability of the gravity flow water supply system
COVERAGE	20 selected schools of the rural and urban population ± 100.000 people	per year about 1000
STARTING DATE FINAL DATE	november 1991 march 1992	1989 still going on
TYPE OF WS IMPROVEMENTS	/	* Better maintained drinking water syst. * 50%-60% of the households use well constructed sanitary latrines * A monitoring checklist is developed to monitor changes in hygiene behaviour.
HYED OBJECTIVES	To bring a social and cultural change in the individual hygiene habits	see the project objectives
DESCRIPTION OF THE HYED PROGRAMME	Collecting data and diagnosing the hygiene conditions through interviews and observations. Opinion of the individual and the key-personnel and involve for effective participation. Educational campaigns for adopting usage of latrines, soakage pits, drainage etc. Convincing and adoption of the above. Research. Evaluation.	On district level and sanitation team, 1 sanitation coordinator, 1 sanitation supervisor and 4 nepali sanitation women A 10 day training is given in the village by a pair of trained sanitation women to representative women from each tapstand, sanitation volunteers. Teaching methods contain drama's, role play etc. The aim is that the Nepali government will take over the teams.
STRONG POINTS OF THE HYED PROGRAMME	* Intersectoral approaches * Responsive community * Teachers coming from the places where hyed is conducted * Demonstrations for adoption * Participatory approach * Peoples effort and voluntary contributions for self-reliance	* To train representative women from each tapstand to educate a larger body of women, so that the hygiene behaviour is sustained and improved * The key concept of this approach is awareness building about one's own capacities * A lot of teaching methods
BOTTLENECKS OF THE HYED PROGRAMME	* Cooperation * Non involvement of the people and their concerns in the project * Timing of the people, schools and community * Financial assistance funds for construction of hygienic latrines, handpumps, wells for protected water supply, drainage system, etc. * Educating the educators for social change	* Objectives, targets and organizational set up are haphazard an ad hoc basis * The structure of the programme is very top down and single input oriented * The supportive structure does not support enough to encourage * programme development * area and population coverage to be increased
RECOMMENDED IMPROVEMENTS	* Holistic approach is the problem * Focus on target groups * Training and improving knowledge of the target group * Undertake studies and recommend for action oriented programmes * Change in the education programme to bring an adaption of individually good hygiene practices	* Objectives, targets and organizational set up should be clear * National sanitation policy should form the basis of the programme * Different ways of implementing the programme * Definitely not top-down as only input * Integrate sanitation in SNV's own managed integrated programmes.
ADVICE FOR COLLEAGUES	* Involve community participation * Influence the leading * Organize and mobilize the community * Provide knowledge and change attitude of the individual * Conduct small studies to change the socio-cultural behaviour * Mobilize and utilize mass media * Demonstration of successful projects for adaption.	* Our monitoring method and teaching methods are worth sharing * Never implement the hyed as a single input in a top down structure * Feasibility study beforehand are necessary to measure the extent of receptivity among the target group * Additional integrated programmes might be necessary to raise the receptivity * Use an intensive approach
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-13	Q-14
NAME OF THE PROJECT	Health Awareness Project, Santalpur Regional Water Supply Scheme, India	Indo-Dutch Environmental and Sanitary Engineering Project (Ganga action plan)
PROJECT AREA	3 admin blocks of Banaskantha District	Mirzapur, India
PROJECT OBJECTIVES	Improving the health status of community through various types of non-formal education and awareness generation on health related areas	* Reduction and prevention of pollution of the river Ganga * To improve the environmental and living conditions of the target group
COVERAGE	97 villages	122 Lakhs
STARTING DATE FINAL DATE	january 1991 december 1993	1987 december 1993
TYPE OF WS IMPROVEMENTS	* To make people understand their existing practices regarding handling of water, personal hygiene, household hygiene and environmental sanitation * Need to improve their hygiene habits * Try to bring changes through education	* Under crash programme handpumps were installed by U.P. State. * Piped ws, augmentation of ws and rehabilitation of ws * Provision of individual pour flush latrines and public complexes * Provision of sewerage systems under which a massive programme of rehabilitation of road side drains is taken up
HYED OBJECTIVES	Create awareness through essentially training among community related to: * Hygiene (personal, household etc) * Management of drinking water * Handling of drinking water * Practices in treatment of illness that may/may not be related to work	* Training in operation and maintenance of facilities and education of public health and environmental hygiene * Training to highlight user participation as well as developing positive community attitudes towards safe drinking w+s
DESCRIPTION OF THE HYED PROGRAMME	HE is the major component of Integrated Child Development Scheme. The field level worker (AWW) of this scheme is responsible of imparting HE at village level. On salary day, each month, a training session was given to the AWW. They were trained on several subjects related to hyed. They were also trained in doing hyed sessions. An evaluation was planned.	Three day training of community volunteers and handpump caretakers for launching the hyed. The CV's and HCT's are selected from the target areas. Different techniques are applied: mass media, at convenient times for women village meetings, films and slides, question hour sessions etc.
STRONG POINTS OF THE HYED PROGRAMME	* Because of high rates of illiteracy, women are eager to learn something * Building up the confidence and self-esteem and giving them social recognition through meetings in their own villages * Forwarding their names to the Water board as Pani Panchayat members * Excellent working relationship between the government and the NGO	* The techniques of dissemination * Community change agents who are commun representatives prove to be the best disseminators of the programme * Approaches and methods are proving to be effective at community level because of the use of dialect * Timing and phasing prove to be effective since the goal is to reach out to maximum recipients
BOTTLENECKS OF THE HYED PROGRAMME	* NGO is unable to adhere to request of the community because they could only be solved by the government or donor agency * Women's first desire is to know how much money they can make out of the training * Lot of energy goes in making the target group aware of the importance of education * Constant motivation has to be provided to keep the programme going	* Not all approaches and strategies could be used for all target groups. -> alterations on a scale which require time as well as resources * The rescheduling has to be done in terms of the need of the area, requirement of the area and the activity which needs more concentration in any particular area * Components of the programme time-phasing has to be done depending on the receptive capacity of the people
RECOMMENDED IMPROVEMENTS	* Start health activities along with watersupply. Don't do the hyed afterwards because people find it very difficult to see its use	* By developing the module on the most recent approach to hyed. * Within the similar target group reorientation of the approach is required to have the desired impact
ADVICE FOR COLLEAGUES	* Start other, result oriented activities e.g. income generation after health education have made a headway. Because the most pressing issue in this area is income	* Constantly be receptive to acceptability of an approach of the community * Constantly incorporate changes as well as ideas according to the target group * Try to listen instead of to speak
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-15	Q-16
NAME OF THE PROJECT	Rural Water Supply and Sanitation, Andhra Pradesh	DANIDA Drinking water and Sanitation Projects
PROJECT AREA	Districts: Prakasham, Guntur, Nalgonda Krishna, Kurnool, Medak, Mahabubnagar	India, Kerala state, Kannur Kozhikode and Malappuram Districts
PROJECT OBJECTIVES	To support the Government of Andrha Pradesh in providing drinking water to identified problem villages, within the overall framework target and strategies of the WSS decade	Provision of potable water to 90% of the population within 250 m walking distance in the selected area. Improvement of health through improved ws+s which is affordable and acceptable
COVERAGE	486 villages, 15 lakhs	600.000
STARTING DATE FINAL DATE	AP I 1979 AP II 1987 Ap I 1989 AP II 1993	march 1987 july 1994
TYPE OF WS IMPROVEMENTS	* Source of ws: surface water * Piped ws scheme - individual schemes and comprehensive ws schemes * Household latrines and environmental sanitation (soakage pits,drains etc)	* Piped ws mostly supplemented with hand-pump where needed * Encouraging domestic connections * Introduction of low cost, locally constructed latrines
HYED OBJECTIVES	To support the Government in the effective and efficient supply, use, management and maintenance of the PWS schemes, and thus contribute towards the improved health and life standard of the people, through complementary activities like hyed and partici- pation, sanitation, income generation	* Identification of the intervention areas for change in behaviour patterns, which are conducive to healthy living and practices, all of which should lead to reduction in disease occurrence and improve life standards
DESCRIPTION OF THE HYED PROGRAMME	Voluntary agencies (volags) organize women's groups, youth groups and finally form Village Action Committees to take care of the ws+s facilities. Hyed classes are organized for the women, youth and children in schools and then shramdhans are organized to a follow up to these classes	*Identification* of the hygiene related problems. From all these info a plan of action is formulated according to the needs and priorities and our programmes. The agencies who will be responsible for each of the procedures are identified and assigned these. Regular meetings are held to review the progress of work.
STRONG POINTS OF THE HYED PROGRAMME	* Around water the whole community can be organized * A powerful elite lend their cooperation in organizing hyed * Establish the volags in the project areas for other programmes * Financial resources for hyed are more than adequate	* Pooling of human and financial resources for a common aim * The burden of health is shared by all organizations and agencies also the community * The approach is to convince the community to be self sufficient for their own needs
BOTTLENECKS OF THE HYED PROGRAMME	* The community was not involved in the planning and implementation * The community did not feel that the facilities belong to them -> no responsibility for it * The idea of hyed has not been institutionalized * The volags become go-betweens the people and department * No adequate incentives were given * The volags are identified late in the project. They become sales representatives	* The areas of operation are at times very remote and it is extremely difficult to organize and conduct programmes here * It is difficult to get sufficient interest because of their own various preoccupations and priorities * An overburdened staff involved with other priority programmes have lessened initiative or motivation to be involved in this programme * The government goes more for short term populism programmes
RECOMMENDED IMPROVEMENTS	* A proper strategy must be developed to understand the role of hyed * Hyed is a process and it requires time and tools to measure impact * Hyed must be taken over by the government and must be duplicated * Hyed must be institutionalized	* We would like to focus on programmes for women and children. Material is lacking and is difficult to develop * Need for follow-ups and regular visits * Each session should address a specific topic/message. * A number of classes spread over time
ADVICE FOR COLLEAGUES	* All collaborating agencies should be aware of the overall objectives * Constant reviews with all agencies * Government must have interest hyed * Volags must get some incentives * Integration of the technical and hyed component	* Involve the beneficiaries and local bodies to the maximum possible * Get them to take on the responsibility of the community's health * The aim should be primarily focussed on their being *self sufficient*, and less dependant on outside agencies
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-17	Q-18
NAME OF THE PROJECT	SIDA Water and Sanitation, Health and Hygiene Education Masholnaland project	Adansi West Water and Sanitation Health Team
PROJECT AREA	Mashonaland East Province, Zimbabwe	Adansi West District, Ghana
PROJECT OBJECTIVES	To improve the living condition in the communal lands and resettlement areas through the provision of protected watersupplies, improved sanitation facilities and health education for better hygiene practices	* To promote understanding of the beneficial effects of safe water and clean environment on one's life * To educate the community in proper use and maintenance of ws+s facilities * To ensure a sense of responsibilities
COVERAGE	121.6229	± 126 village in the district
STARTING DATE FINAL DATE	01-07-1990 30-06-1993	second half of 1992 still going on
TYPE OF WS IMPROVEMENTS	* Watersupply: 1600 wells and springs * 9500 Household Blair Latrines * 90 Multicompartment School Latrines * 90 School washing-tanks	* Rehabilitation of waterboreholes * Development of handdug wells and Henderson Boxes * Development of Sanitation Facilities
HYED OBJECTIVES	* Motivation of groups with no sanit. to build and use Blair Latrines * Motivation to upgrade the ws and prevent contamination of drinking water at the source and in the house * Ensure that latrines and water sources are maintained hygienically * Encouragement of hygiene practices * Personal and environmental hygiene	* Promotion of good hygiene and encouraging the construction and use of safe pit latrines * Obtain understanding of water related diseases * Set up a local w + s committee * Identify individuals responsible for maintenance of facility and tariff collection
DESCRIPTION OF THE HYED PROGRAMME	The project educator undertakes detailed planning and training required to mount an intensive HE and hyed programme by training environmental health technicians and VCW's so that they become promoters of health and hygiene. Training in participatory techniques in identifying and proposing solutions to their health problems and producing HE materials to support the ws+s project	The education team will train the village level committees to carry out HE and to encourage construction and maintenance of w+s facilities. Education of the community about the importance of clean water and good hygiene. A village level committees is set up. They are responsible for the maintenance activities. Carry out evaluation activities and assess the impact of the programme on the health of the community
STRONG POINTS OF THE HYED PROGRAMME	* By fully involving all the health and medical cadres in health and hygiene educating the community * Involving the entire population during all phases of the programme * Involving women in construction act. * Apply the bio-psychological approach and to encourage use of participatory methodologies * To start when the population is motivated and mobilized and there is an impeding w+s health crisis * In the end they finance their own programmes for sustainability	* The team will work on grass-root level * The villagers will maintain and develop their own w+s facilities * HE is a primary focus of the team * The team will work independent of any other government organization * The team has had a lot of publicity and thus a lot of support from village leaders
BOTTLENECKS OF THE HYED PROGRAMME	* The hw does not use the learned teaching methods * The target population have other priorities than the hw * Methods are sometimes not well understood by the hw or community * Financial resources depends too much on donor funds	* Hardly no personnel with skills and knowledge * All the personal have to go through extensive training -> high costs * It is difficult to find a funding organization for projects of this size * Because of the size of the health team villages have to wait for the hyed
RECOMMENDED IMPROVEMENTS	* By using understood and acceptable health education approaches, methods and materials and to use multi-media	* The project will not start until funding is available. Because of lack of human resources->no local follow up
ADVICE FOR COLLEAGUES	* To first carry out an KAP study of the community before embarking on any health education programme * To know the target population well in terms of beliefs, cultural background etc and factors related to resistance to change	* The health team operates as a NGO independent from government organization -> no conflicting objectives. The team controls its own resources and is not responsible to an other organization, so it is more likely to succeed
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-19	Q-20
NAME OF THE PROJECT	Facts for Life health Education Initiative	Integrated Holistic Approach Urban Development Project
PROJECT AREA	20 regions in Tanzania mainland	Kebele 30, 42, 43; Ethiopia
PROJECT OBJECTIVES	The overall goal of the project is to make sure that communities are capable of assessing, analyzing and taking action on common disease factors affecting their well-being	* To break the poverty chain * To implement PHC activities * To create social awareness and human development * To give HE about the related problems * To improve environmental and personal sanitation
COVERAGE	22,533,158	40.000 people
STARTING DATE FINAL DATE	1990 ± 2000	june 1989 1995
TYPE OF WS IMPROVEMENTS	* Boiling water before drinking * Using protected well water * Importance of rainwater harvesting * Proper storage of drinking water * Prevent pollution of all sources * Use of VIP latrines * Burning and burying solid wastes	* 3 public fountains + 2 showers * Maintaining the existing watertaps * Suction track which gives services to suck 22 pitlatrines /week * 1 dry waste bins for 2 families * 4 skips are lifted once a week * Monthly cleaning campaign by the comm.
HYED OBJECTIVES	* To draw out points in favour of inter-sectoral coordination in HE * Identify roles of various sectors and institutions * List HE methodologies used in educating the community * List (dis)advantages of de-centralization of HE activities	* HE with special reference to the cycle of environmental sanitation malnutrition and infectious diseases * To break the vicious cycle of malnutrition and infection * To improve personal and environmental hygiene * To achieve a better quality of life
DESCRIPTION OF THE HYED PROGRAMME	Identification of the disease factors for training purposes. Intersectoral coordinating committee. This committee developed the plan of action. The plan consists of training of trainers at several levels, communication and information, mass media and other activities. Because of an intersectoral approach there are many ways to achieve the goals	30 Extension Education workers who are adequately trained, train the community. These workers are selected from the target area. Nurses and CHW teach also the community. Implementation during community meetings, before services are distributed. Education was done by homevisits, discussion and role plays. Any material that was available was used to do HE.
STRONG POINTS OF THE HYED PROGRAMME	* Use of Village Development committees, involvement of people on grass root level * Evaluation is planned * Some of the financial support of the Tanzania Government and a great support from UNICEF	* Campaign cleaning by the community -> they did it themselves * Distribution of waste collection bins -> increased community participation * Communal pit latrines->sharing=caring * Showers and clean water fountains are provided to practice the HE * Organization of neighborhood groups
BOTTLENECKS OF THE HYED PROGRAMME	* Human resources/ training team at ware level are small * Intersectoral approach can be good but it is difficult to get things go * Approach and methods in the training are weak, no pretesting was done * Not enough time was planned for training the Village Trainers Team * At village level the allowance given to the trainers was too small. Too much money came from UNICEF -> sustainability and maintenance	* The change of living conditions in state of poverty is the biggest battle to overcome * >75% of the family head are females * Ignorance is aggravated when the poverty state is worst -> the teaching methods are not applicated as expected * The episodes of diarrhoeal diseases again is closely attached to poverty and malnutrition
RECOMMENDED IMPROVEMENTS	* Improvement is possible if more resources are invested at grass-root level	* To make HE to be practiced by the community integration approach is vital to break the chain of malnutrition and poverty
ADVICE FOR COLLEAGUES	* Start the implementation at a stage which is not very far away from the beneficiaries e.g. district level	* Let the community diagnose their needs,plan with them how to solve them * The physical and social development must come to be applicable * HE as well as facilities must be provided
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-21	Q-22
NAME OF THE PROJECT	Village Water Reservoirs Archdiocese of Tamale	Maintenance project rural water provision
PROJECT AREA	Northern Region Ghana	Guinea Bissau
PROJECT OBJECTIVES	Provision of drinking water of a reasonable quality to villages that do not have water within a reasonable distance in the dry season	* To set up a decentralized maintenance and control structure of the water provision
COVERAGE	± 6000 persons per year	The entire population of Guinea Bissau
STARTING DATE FINAL DATE	1988 earliest 1994, probably longer	1987 1993
TYPE OF WS IMPROVEMENTS	* Drinking water reservoirs for villages where there is no ground-water and insufficient rainfall to harvest. The reservoirs are fenced to keep out people and animals * Small water-reservoir for cattle	* To set up a maintenance and control structure of the pumps
HYED OBJECTIVES	* To contribute towards eradication of guinea worm * To promote behaviour change to improve the quality of drinking water * HE that is consistent with MOH for PHC and to work with its agents to obtain maintenance + sustainability	* To prevent contamination of ground water in the neighborhood of the pump by cleaning the surrounding of the pump
DESCRIPTION OF THE HYED PROGRAMME	First a base line survey was done. Participation in the HE. HE is aimed to eradicate guinea worm. VMT get a training on hyed to keep well facilities clean and other hygiene related issues. A training is held every year in the dry season. The VMT's were trained in teaching and learning methods. After dam construction there is a two-year follow up phase.	In every village with a new water supply a eduction programme was given by 3 HE teams. During this session a local maintenance engineer and a water committee was chosen. These persons were responsible for proper use and maintenance of the water source. They also could give some hyed. After the project was finished the committee and the village were responsible for it.
STRONG POINTS OF THE HYED PROGRAMME	* Linked with the provision of a facility that the villagers seriously want * The timing of the hyed is good above * Education methods seem appropriate in that people appear to enjoy the sessions * Issue related, e.g. filtering of water	* The message is not too complicated and easy to practice * Every village have its own maintenance committee, they have also hygiene tasks
BOTTLENECKS OF THE HYED PROGRAMME	* Not always are VHW's available to be involved in the maintenance committee * High rates of illiteracy * Problems with building appropriate latrines * Limited interest of the people in hyed related issues	* The programme is too large scaled, so the villages didn't get not enough attention to obtain behaviour change * Top down teaching methods and only a few participative methods * Hyed after the construction of the water taps instead of in advance * Hyed is no priority * Hyed is part of the Ministry of natural sources-> no priority for them
RECOMMENDED IMPROVEMENTS	* By narrowing down the scope of the hyed * Hold a workshop about how to deal with free range defecating, when there is no good latrine available * Half way solutions are always better than no solutions	* To start with the hyed before the pumps are installed * Try to involve the ministry of health and education * To base the education on the felt needs and problems of the villagers
ADVICE FOR COLLEAGUES	* Link hyed with the improvement of facilities * Behaviour change will be very slow * Use participatory methods but don't expect that when people talk enthusiastically about hygiene that this will reflect in changes	* Hyed programmes have to be longer lasting and on a small scale basis * Base the hyed on the felt needs and problems of the target group * A contact person per villages and intensively support this person
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-23	Q-24
NAME OF THE PROJECT	Rural Sanitation Projects	Centros Experimentais da Educacao e Formacao C.E.E.F.
PROJECT AREA	Berea, Leribe, Mokhotlong, Buthe-Buthe Qacha's Nek, Quthing, Mohale's Hoek, Maseni districts/ Lesotho	Three areas, North, 1 school/ 7 classes; South, 4 schools/ 4 classes and Uno (island), 6 schools/ 16 classes
PROJECT OBJECTIVES	Reduction of diseases related to poor sanitation throughout the country	* Educating teachers * Integrated programmes * Lessons will be given in Creole
COVERAGE	All 10 districts of Lesotho	see project area
STARTING DATE FINAL DATE	1983 1995	1985 1993 maybe longer
TYPE OF WS IMPROVEMENTS	* Use of VIP latrines * Health education on personal and household hygiene	* Cleaning up the classrooms * In the future latrine building and proper use of the latrines * Hyed is already part of the lessons
HYED OBJECTIVES	* By 1999, 90% of the rural households have hygienic sanitation facilities * Each member of these households should practice acceptable standards of personal and domestic hygiene	* Education about parasites and (related) illnesses/ first degree * Hyed about water use and cleaning the surrounding of the well * HE about food/ second degree * HE about diseases, traditional and western medicine and the prevalence of diseases/ third degree
DESCRIPTION OF THE HYED PROGRAMME	The hyed in the villages is carried out by health assistants with support of VHW's. HA's are primarily responsible for ensuring the maintenance of environmental and personal hygiene. Hyed is implemented in the following forms: Pitso (general public meeting), group discussions, home visits, participatory sessions and drama	Part of the lessons
STRONG POINTS OF THE HYED PROGRAMME	* The operational staff have been trained in various teaching methods * People seem to like these participatory methods and feel that the programme is theirs * Health assistants stay in the communities and know the right timing of the hyed	* It does not cost anything/ very much * It belongs to the lessons * It is adapted to young children who are an example for the next generation
BOTTLENECKS OF THE HYED PROGRAMME	* The programme have limited funds for e.g. developing educational materials * Shortage of trained manpower due to structural adjustment and braindrain * Educational materials are sometimes wrongly used. They are distributed without telling how to use them	* No money available * Restricted time for the lessons. The children are only 3,5 hour a day at school
RECOMMENDED IMPROVEMENTS	* Staff should be well trained in HE * The staff should be able to apply all educational methods at appropriate times * Pitso must be used in the initial stages and be followed by group-discussions, homevisits etc. * Educational material should be made available for field use	/
ADVICE FOR COLLEAGUES	* Hyed should be well planned * Know the people you are going to work with * Prepare appropriate materials * Use a combination of several education methods * Staff should be well trained in communication skills and how to use different materials	* In water and sanitation projects it is important to cooperate with several schools
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-25	Q-26
NAME OF THE PROJECT	School Health Action Project for primary schools in Sigor Division	Cholera Campaign
PROJECT AREA	West Dorot Kenya	Okposi, Ohaozara Local Govt, Imo State
PROJECT OBJECTIVES	To reduce the incidence of communicable diseases among the school going population and communities in the neighborhood of the school	To stop the spread of cholera within Okposi town/ community
COVERAGE	60.000 persons	250.000
STARTING DATE FINAL DATE	1989 1991	october 1979 december 1979
TYPE OF WS IMPROVEMENTS	* Construction of Pit latrines and refuse pits * Tree planting * Maintenance of compound cleaning * Spring protection	* Provision of potable water through the installation of handpumps, the introduction of boiling water and filtration * Construction of toilet facilities
HYED OBJECTIVES	* Improvement of community understanding of the programme * Motivation of community to action * Promotion of programme sustainability * Effective behaviour change	* To improve the hygiene habits of the people * To provide enough and good drinking water * To eliminate promiscuous defecation within the community
DESCRIPTION OF THE HYED PROGRAMME	Hyed is organized in phases. The different phases address different issues but all geared towards solving the priority health problems in the area. Hyed is implemented by different sectors such as ministries of health and education and NGO's. The target groups are school children, mothers, VHW's. They in turn communicate the same to other community members	A detailed survey of the area concerned with a view identifying factors that would militate against the programme. Formation of health committees within the community. Organization of lectures at centers already agreed upon. Visit to strategic sample premises or compounds. Practical demonstrations on purification of water and latrine building. Evaluation visits to know the extent of assimilations of the programme.
STRONG POINTS OF THE HYED PROGRAMME	* Participatory planning (implementing agencies and beneficiaries) * Community based organization * Regular monitoring and follow up * Proper timing, not inconvenience to the beneficiaries * Catalytic role of the implementing agency	* Well trained, knowledgeable and enough personnel * A study of the community concerned with a view to covering the area systematically * Hyed period must be at a time when a greater part of the community would be reached, avoiding adverse seasons * Adequate provision of money to take care of materials, equipment and incentives
BOTTLENECKS OF THE HYED PROGRAMME	* Transfer of trained personnel e.g. trainers of trainers * Limited financial resources * Political instability * Integration of domestic and other duties to hyed -> time constraints	* Inadequate trained staff for hyed * Short supply of materials and limited organizational ability of personnel * Inadequate knowledge of customs/taboos of the target groups * No recognition of various target groups within the community * Poor finances to produce materials and equipments and encourage staff * Programme was timed during the farming period and market days -> poor response
RECOMMENDED IMPROVEMENTS	* Involvement of communities in designing the hyed materials * Strengthening the capacities of the community to manage and sustain hyed	* Constant education of the target group * Provision of facilities e.g. adequate water and good sanitation * Introduction of good hygiene habits
ADVICE FOR COLLEAGUES	see the strong points	* Proper planning before setting off for the programme * Involve the target group in all stages * Information must be correct and authentic * Facilities must be within the resources of the target group * The customs, taboos of the people must be taken note of and all pressure and influential groups must be included
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-27	Q-28
NAME OF THE PROJECT	DJAM	Gelekele Integrated Water Supply and Sanitation
PROJECT AREA	Lagdo Lake, Northern Province, Cameroon	Kenya
PROJECT OBJECTIVES	* Surveillance of schistosomiasis * Health education related to schistosomiasis transmission	* Improvement of health
COVERAGE	± 15.000	3000 people
STARTING DATE FINAL DATE	1986 1990	january 1989 planned 1992 extended to 1994
TYPE OF WS IMPROVEMENTS	/	* Rainwater harvesting * Pit-latrine construction
HYED OBJECTIVES	* To deliver a minimal educative message to communities at medium/high risk of schistosomiasis. Prevalence > 20%	* To induce positive changes in hygiene practices
DESCRIPTION OF THE HYED PROGRAMME	First and epidemiological and socio- economic survey. After that the formation of a health team. The team developed the HE/minimum message. Than the implementation of the HE. After the HE has been implemented an evaluation is conducted.	This changes can be achieved through: * Community public meetings * School hygiene lectures to school pupils * Community selected volunteers taught in seminars and workshops usually one week long
STRONG POINTS OF THE HYED PROGRAMME	* The unique and essential point of the HE is to design an efficient evaluation process before implementing the programme * Collection of information about the cultural background and perceptions in relation with health + illnesses * Health problems as perceived by the target group and monitored by epidemiologist should be matched together in order to define priorities.	* The project beneficiaries themselves felt the need for positive changes in hygiene practices * They asked for training of agents within the community * Hyed or at least the awareness of disease occurrence and the links thereof to human behaviour need to be introduced before the actual construction is started * Hygiene education is linked to the provision of physical facilities
BOTTLENECKS OF THE HYED PROGRAMME	* Lack of resources to pay an expert in the field of medical anthropology * Lack of desire of the health team to really evaluate what has been done	* Financial constraints in getting expert inputs which cost money even when locally available e.g. transport, allowances * Community involvement especially mothers to attend "away workshops" is an added burden to the community especially when the community is not properly mobilized
RECOMMENDED IMPROVEMENTS	* Better monitoring of what is really done in the community	* Relevant teaching aids should have been produced
ADVICE FOR COLLEAGUES	* Identify the real problems * Time spent in the conception of the programme is nothing compared to time lost to repair the flaws of a bad conceived programme * You will commit a lot of mistakes, be conscious of this and try to correct them	* Listen to the community even when they seem to be ignorant. Often they have a reason for every act or behaviour * Improve on the communities strong points. Not just introducing what you think is good for them
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-29	Q-30
NAME OF THE PROJECT	Servicios Integrados en Huaycán	Campaña contra el colera en Ate Vitarte Sub projecto Modulos Basicos para Comedores Populares
PROJECT AREA	Distrito de Ate Vitarte, Lima, Peru	Distrito de Ate Vitarte, Peru
PROJECT OBJECTIVES	* Organization and mobilization of the community of Huaycan * Participation in the planning and implementation in all the measures taken to improve the quality of health, sanitation and nutrition	To decrease the incidence of people with cholera through improvement of the sanitary conditions and hyed
COVERAGE	± 70.000.000	± 5040 people
STARTING DATE FINAL DATE	november 1986 October 1989	May 1991 December 1991
TYPE OF WS IMPROVEMENTS	* Two wells for common use * Facilities for waste disposal * Common water storage tank	* In the "comodores populares" awareness raising of the importance of clean water storage containers * According to their wishes, each commodore get a waterstorage container
HYED OBJECTIVES	* Improved quality of drinking water * Stimulation of proper latrine use * Safe (solid) waste disposal * Development of non-conventional sanitation facilities on basis of demonstration objects	* A proper use of the storage containers * How to make the water potable * The use of clean water for food preparation * To prevent contamination through food, water and utensils
DESCRIPTION OF THE HYED PROGRAMME	To make the water drinkable and the elimination of excreta and waste were the priorities in the programme. IDEAS provide the materials and the educational set up. The hyed consist of a theoretical and a practical part. The hyed was given to 3 Unidades Comunales de Vivienda and was followed by other UCV's. Emphasis was also put on the participation of women.	The programme was organized by the Central Distrital de Comedores Populares de Ate Vitarte. Not more than 40 persons attended the education sessions. Each group received two sessions. The lessons were developed in discussion with the target group. A follow up was also planned. During this follow up each comodore was visited.
STRONG POINTS OF THE HYED PROGRAMME	* Use of well known organizations in the target area * A combination of practical and theoretical hyed methods	* A good organized target group * Priority was given to lower the incidence of cholera * The used methods were very attractive * A very participative method was used and it was practical applicable * It was clear when the educators were planned to come for follow-up etc. * The programme was based on felt needs of the comodores
BOTTLENECKS OF THE HYED PROGRAMME	* There was no visible relationship between clean water and the prevalence of diarrhoea * Besides lack of clean water the living conditions of the target group were also very unhealthy * The ministry of Health stopped the donating calcium chloride and gave sodium chloride which is dangerous	* The follow up was not included in the programme but for sustainability it must be planned every now and then
RECOMMENDED IMPROVEMENTS	* The messages must get equal emphasis * Collect enough money to implement the hyed * Use different types of educational methods include posters and videos * The methods must be fully understood by the target population	* To develop an follow up programme with new messages
ADVICE FOR COLLEAGUES	* Realize the programme in intensive cooperation with the organizations in the target group * Give information and education about subjects which are interesting for the target group * When it is possible use mass media to improve the impact	* Use proper techniques and well constructed improvements * Choose the technique in consultation with the target group and respect their advice and comments * Link the hyed to something that contribute to convenience of the target group
ADDITIONAL INFORMATION		

INFORMATION SOURCE	Q-31	
NAME OF THE PROJECT	Community water and health project	
PROJECT AREA	Cajamarca and La Libertad department in Northern Peru	
PROJECT OBJECTIVES	* Through the provision of potable water, sanitation and appropriate He and promotion, an improvement of health	
COVERAGE	42.000 rural inhabitants	
STARTING DATE FINAL DATE	1989 1992	
TYPE OF WS IMPROVEMENTS	* Potable water distributed by a system of pipes to every household * Domestic pitlatrines installed in every household	
HYED OBJECTIVES	* Participating communities have instituted regular HE and preventive practices	
DESCRIPTION OF THE HYED PROGRAMME	Project in every community has a 18 months of presence. During the first 8 months project personnel advice the two promoters selected by the communities. The promoters are well trained. Next 6 months are the monitoring phase and the promoters are expected to perform their duties (hyed and HE). The last 4 months all weak points that have been detected are brought to a workshop to be discussed with the promoters.	
STRONG POINTS OF THE HYED PROGRAMME	* Make the community aware of how you can get a disease and how they could protect them against these illnesses * Make community members adopt hygiene practices by having persons form the communities to train them * Make the association of promoters responsible for the training of new promoters and let them take part in the monitoring of the promoters * The 3 phases and their timing are appropriate to the communities * The existence of a scale in every community facilitate the monthly meetings * None of the participating	
BOTTLENECKS OF THE HYED PROGRAMME	* Get financial resources to continue expanding the project benefits to other communities	
RECOMMENDED IMPROVEMENTS	* Improve the project by reporting and information system in order to provide more and more accurate information for the participants	
ADVICE FOR COLLEAGUES	* Have communities participating actively in the project in all the activities and continuously motivating them	
ADDITIONAL INFORMATION		

INFORMATION SOURCE	I-1	I-2
NAME OF THE PROJECT	Village water reservoirs, archdiocese of Tamale	Kanpur/Mirzapur project
PROJECT AREA	North Ghana	Kanpur and Mirzapur in India
PROJECT OBJECTIVES	* Improvement of the water quality * Increasing the water quantity * To bring water closer to the people	* To clean up the river Ganges
COVERAGE		For both cities 300.000 people
STARTING DATE FINAL DATE	1987 1994	1986 still going on
TYPE OF WS IMPROVEMENTS	* The provision of waterdams	* The provision of sanitation, sewage, drainage, drinking water and the collection of household refuse
HYED OBJECTIVES	* Prevention of Guinea Worm infection * Community Participation in all phases of the programme * Stimulation of the VHW and TBA to go to health education training	* Public Health and Community Participation * The inhabitants of a certain district have to take over the full responsibility of the project
DESCRIPTION OF THE HYED PROGRAMME	Animatoren provide the hyed, sometimes in cooperation with local people. They used several methods as songs, role playing, story telling and slides. Not only hyed but also information about other health subjects. Two weeks after the hyed, the animatoren visit the villages again and repeat the message and observe the impact of the hyed.	The implementation of the hyed was done by existing organizations e.g doctors, nurses, teachers etc. Also 400 caretakers of the pumps (two per pump) were involved in the hyed. Each group received a specific training. After the implementation, an evaluation of the impact of the project was conducted.
STRONG POINTS OF THE HYED PROGRAMME	* People liked to go to the hyed * The hyed message was given in many different ways * The hyed was given to small groups * The local people were asked to give examples from their own experiences * The hyed was a combination of doing (provision of clean water) and hyed	* The education (material + programme) adapted to the target group. * Attractiveness of the education * The use of different materials and channels * Pretesting of the materials * Showing a direct link between illnesses and unclean water
BOTTLENECKS OF THE HYED PROGRAMME	* People didn't understand the poster because of (visual) illiteracy and illnesses of the eyes * Local women were selective in whom they educated and whom not	* In the beginning resistance of the government * Attention could also be paid to income generating activities and education for women
RECOMMENDED IMPROVEMENTS	* To use more local animators * To give the hyed more adapted to different groups of people * To take into account the different tribal backgrounds of the people	* Let the community evaluate the results themselves. So they can see what the effect is of the behaviour change. They can see themselves that the recommended behaviour is worth doing
ADVICE FOR COLLEAGUES	* Convenience is very important, the most important reason why people use clean water was convenience * Take the time for the hyed programme Changing behaviour takes a lot of time * Try to get insight in local beliefs about guinea worm (how people could get it, prevent it etc)	* Get an insight in which things went wrong and which went good. Try to readjust the wrong things. * Provide income generating activities * Adapt the education programme and the materials to the target group * Give the target group tools to solve their problems * Ask yourself what would make you changing your behaviour. Don't expect irrealistic things from others
ADDITIONAL INFORMATION	Used method: Freire	

INFORMATION SOURCE	I-3	I-4
NAME OF THE PROJECT	The education programme was on initiative of the interviewee	Mechi Hill Irrigation and related development programme.
PROJECT AREA	Palawan. The Philippines	Mechi, Nepal
PROJECT OBJECTIVES		
COVERAGE	± 600 people	After 4 year at least 1000 women involved in the programme.
STARTING DATE FINAL DATE	1987 still going on	1987 1997
TYPE OF WS IMPROVEMENTS	* Provision of clean water * Provision of latrines	* Provision of a gravity flow drinking water supply system
HYED OBJECTIVES	* To give information and education * To improve the self-esteem of women	* Giving hyed to the beneficiaries of the drinking water system * Improving the quality and sustainability of the ws system through education * To enlarge the social strength and status of women
DESCRIPTION OF THE HYED PROGRAMME	First an inventarisation of the felt needs and problems. After that, by means of self selection, the female community health workers were chosen. These CHW receive a one week training from a midwife and a dietitian. The follow up was done in the villages. After the training the CHW's have to give the information to the other women in the villages.	First a base line survey in two villages. After that a selection of 2 a 3 women per area as leader women for sustainability, when the project leave the area. They attended a one week training course. After the training they had to give the information to other women. The leader have to practice the learned skills in their own houses. They are also supposed to discuss the learned skills with 15-20 women of their wards They could get support from assistants.
STRONG POINTS OF THE HYED PROGRAMME	* The programme was based on the problems and direct needs. * It didn't try to change everything * Questions and solutions came from the people themselves (self-esteem) * Positive reinforcement of the proposals of the target group * The use of existing training curricula, made in the Philippines * The use of different methods, keep attention + enjoy the women * Drawings made by the women and were adapted to their lives	* Good communication between I-4 and her counterpart * The leader women for sustainability * Especially the agricultural section functioned very well, the women realized even some profits of selling the vegetables
BOTTLENECKS OF THE HYED PROGRAMME	* Not so much support from the government * In the first phase of the programme the several desks didn't work together * The donor didn't provide enough time to achieve behaviour change * The donors were very keen on visible and measurable results.	* Bad infrastructure and remote areas * The obligation to use the governmental trainingcentre, which was not so good * Very few integration and coordination between the social and technical section * The assistants were not so motivated and earned not enough, they miss the advantages of living in Katmandu * Because of corruption their wages were not paid regularly
RECOMMENDED IMPROVEMENTS	* Take enough time for an intensive preparation	* In the first phase, work only with the social section to prepare the women properly
ADVICE FOR COLLEAGUES	* Let the local people do it all themselves. Your role is on the background * Always ask yourselves what is wrong with a behaviour, when it doesn't harm anybody don't change it	* Take the time to look around and to prepare yourself, to know the people, situations and circumstances * Base the programme on the needs of the target group * Design your own programme, goals and structure beforehand * Try to get motivated colleagues
ADDITIONAL INFORMATION	Used method: Freire	

INFORMATION SOURCE	I-5	I-6
NAME OF THE PROJECT	Emergency relief aid in Senegal. After that, it became a dam building project	Projecto piloto participação comunitaria
PROJECT AREA	North Senegal	North Moçambique
PROJECT OBJECTIVES	* Irrigation system * Electricity/waterpower station	* Provision of wells in combination with participation of the target group
COVERAGE		Provincia Cabo Delgado, Moçambique
STARTING DATE FINAL DATE	± 1972 still going on	1985 still going on
TYPE OF WS IMPROVEMENTS	* Provision of wells * Provision of a waterdam in the estuary of the river	* Provision of safe (drinking) wells in rural areas
HYED OBJECTIVES	* General conscious raising of the effects of the dam * (Adult) Literacy project * After that also hyed and health education	* Promoting hyed as well as within the department of Health as outside the department * Developing educational materials * Teaching hyed to nurses and teachers
DESCRIPTION OF THE HYED PROGRAMME	Eduction was given about the effects of the dam. Also literacy training courses were given. Especially the women became aware of their underdog position and try to alter this. The women were teached how to grow vegetables. They became aware of other things and asked for information about several health topics (bottom up). A doctor with the aid of a theater group provide information and education	Two weeks training of animadores. The training consisted of a theoretical as well as a practical part. It was mainly a methodological training course on how to give hyed. The animadores had to train They learned to use several methods and materials. The animadores had to give the information to the villagers. They could use a booklet with practical information how to do and plan hyed. In the villages a group of people is responsible for the well and hyed.
STRONG POINTS OF THE HYED PROGRAMME	* Use and cooperate with local people and language * A mix of the traditional knowledge and the western knowledge * Conscious raising and after that, the programme was based on the local needs and demands * Much emphasis on the identity of the target group	* Hyed was made pleasant and amusing * Good cooperation between the technical and social section * Use of already existing networks and organizations of (wo)men * Very practical and definite training course * Provision of a step to step booklet for the animadores how to plan and implement a hyed. They know exactly when to do what and what steps need to be taken at what time
BOTTLENECKS OF THE HYED PROGRAMME	* Nomadic population-> an instable target group * Lack of coordination between the government and the villages * Dole out through the aid of donor organizations * The educators were male volunteers. They moved often to the city, to find better jobs	* Pressure from the donor organizations to drill a certain amount of wells each year * No appreciation from the government for the lower status jobs e.g. the animadores
RECOMMENDED IMPROVEMENTS		* Write everything down what has been done. Others can use that information. They don't have to reinvent the wheel of hyed.
ADVICE FOR COLLEAGUES	* Try to develop integrated programmes, as well as an education as a profit making component * First take into account the social aspects and after that the economical aspects * Take the time to become better acquainted to the target group, the local situation etc * Be aware of that there is not one target group but several groups in one community * Make use of the local people, they know the situation and habits, they speak also the same language	* Give some kind of incentives to the animadores to motivate and appreciate their jobs * Take care for support and supervision for the animadores * Take the time to listen what one can tell you, look around in a village and talk to the target group. Try to get an impression of how the people live and how their situation is and what their needs are. * Pay attention to the people and care for them. * Learn the local language
ADDITIONAL INFORMATION		

INFORMATION SOURCE	I-7	I-8
NAME OF THE PROJECT	Water, Sanitation and Health Education Project	Village Handdug Well Project
PROJECT AREA	Western Province of Zambia	4 provinces in South Darfur, Soedan
PROJECT OBJECTIVES	Construction of improved ws for both the rural and urban population of the six districts in the province	* Provision of 120 handdug wells in the target area * Participation of the target group
COVERAGE	15% of the 600.000 inhabitants of the province	120.000 people in about 92 villages
STARTING DATE FINAL DATE	1984 still going on	1990 intended final date 1994, now half 1992
TYPE OF WS IMPROVEMENTS	* 800 wells for rural communities * Water provision for urban areas	* Provision of 120 handdug wells within 4 years of time, one well per village
HYED OBJECTIVES	* The 'teacher' presents the material in order to help the 'students' to express and create, to obtain a bottom up approach.	* Collection of water in clean and covered jerrycans * Use of one special jerrycan to get water from the well * Prevention of a dirty well rope * Storage of the water in such a way that the children couldn't touch it * Keep a lid on the jerrycan
DESCRIPTION OF THE HYED PROGRAMME	Construction of a CEP team attached by various departments. The CEP team visited the identified villages 4-5 times before and during the provision of the water supply. Stimulation of the habitants to chose a water committee	Training of a team in communication and education techniques. At village level two committees were chosen: 1 participation raising committee and 1 VHC. This team trained the VHC's and the villagers In the afternoon the VHC's were trained and in the evening the villagers
STRONG POINTS OF THE HYED PROGRAMME	* Well chosen extension staff * The members had received a training course in the UK as an incentive * The extension staff had the same cultural background as the target group * Multidisciplinary approach * Good cooperation between the technical and the health section * All materials were locally designed	* Local authorities paid for the trainees. This raised a feeling of responsibility and ownership * Cooperation of people who are already working within the ministry of Health -> use of existing structures * Cooperation of women in the VHC's * A good follow-up system
BOTTLENECKS OF THE HYED PROGRAMME	* Not much faith in the credibility of the government * Very bad economical situation * Problems with paying for water * There was already enough water available, but it was not always clean water, but sometimes more convenient and cheaper to obtain * Difficulties in promoting the new, alternative bottom up approach	* Both Ministries (Health + Water) were not used to cooperation * Difficult to get women in the VHC's * Hyed a long time after the wells were installed * People were not used to work in groups * There was no existing social structure * Lack of materials and infrastructure * Lack of good working conditions of the people and bad salary for them * Clean water wasn't a priority for the target group and the Ministry of Health * Lack of time * Lack of good equipped staff
RECOMMENDED IMPROVEMENTS		* Awareness raising on all governmental levels, local, regional and national * Participate with the target group * Don't implement hyed in cooperation with the Ministry of Water
ADVICE FOR *COLLEAGUES*	* Give hyed in a way which appeal to the target group and which is closely linked to their daily live * Select carefully the members of the extension staff * Base the messages on the real needs of the target group * Make always appointments when you want to visit a village * Pretest the educational material	* A good follow up and support of VHC's * More wells per less villages * Hand over the responsibility to the local people * Try to raise awareness of the importance of hygiene behaviour * Use the marketing approach * Involve enough people to realize a participative approach * Make use of existing institutions
ADDITIONAL INFORMATION	Used method: SARAR of PROWWESS	

INFORMATION SOURCE	I-9	I-10
NAME OF THE PROJECT	Pilot Project, Participative Projects	Rural water for health project
PROJECT AREA	Sierra Leone	North West Province of Zambia
PROJECT OBJECTIVES	* Stimulation of the people to organize themselves * The people have to start an activity * The selection of grouppromoters	* Relief project for water supply, in a very dry period.
COVERAGE	300 people	
STARTING DATE FINAL DATE	1986 still going on	± 1970 (> 1988 Hyed) still going on
TYPE OF WS IMPROVEMENTS	/	* Provision of wells
HYED OBJECTIVES	/	* Hyed concerning the use and maintenance of the wells
DESCRIPTION OF THE HYED PROGRAMME	The people could voluntary organize themselves and develop activities. These groups were trained and supported by grouppromotors, who are living and working in the villages. The group received a monthly training and a workshop. Everything was discussed and decided by the groupmembers. Used methods were booklets, roleplaying etc	Watercommittees were installed and were trained. The villagers were also trained in 5 hyed sessions before the well was constructed and 7 afterwards. Four months later 7 new hyed sessions. Between times unexpected visits to control the maintenance of the well. Try to reach a high level of participation. Use of several educational methods
STRONG POINTS OF THE HYED PROGRAMME	* A fixed grouppromoter * During the training memory aids were used * The training achieve both conscious raising and practical tools to improve the situation * An expatriate person include in the team because he sees local customs different * Fixed appointments for the group-discussions	* The project members had the courage to learn from the made mistakes * To do the hyed in cooperation with a theater group * To do the hyed in cooperation with local people (language, habits) * Training in the villages and not extern * Combined training session for ± 5 committees for exchanging experiences * An extern training session for the staff raise more awareness for the hyed section of the project
BOTTLENECKS OF THE HYED PROGRAMME	* Lack of participative skills of the staff * No study was done of the target group, who was poor or rich etc * Few support from the donor organization * The Ministries were not involved in the programme. So sustainability is questioned * It is very difficult to find trained staff members	* Conflicting interests between the project goals and the hyed goals * The hyed was never based on a community diagnosis * The donorproject have goals which could never reach sustainability * Many (economical) problems in Zambia
RECOMMENDED IMPROVEMENTS	* Take care for support of the group promoters	* Don't donate to much because of the danger of doling out * Use locally affordable material and ideas
ADVICE FOR COLLEAGUES	* In the beginning of the programme you have to support the target group ± every week * Discuss throughoutly with the staff how to implement the programme * Discuss with the target group what, for them, realistic goals are * Collect information to evaluate the progress * Take time to discuss and listen to the target group * Know exactly what your role is in the project * Take the time to select and built up the staff	* Take care that the local people can take over the project after finishing * Hyed programmes have to last a long time at least 10 year, when you want to reach sustainability * Study what the capacities and capabilities of the target group are and based the programme on that info * Pretest the educational material * Use local materials and locally developed methods * Start with listening and looking around, what are the problems and needs of the target group * Don't accept everything the local authority and donors decide
ADDITIONAL INFORMATION	Used method: SARAR of PROWWESS	Used method: Freire

INFORMATION SOURCE	I-11	
NAME OF THE PROJECT	Projecto de Manutencao e Animacao no dominio das aguas rurais	
PROJECT AREA	Guinea Bissau	
PROJECT OBJECTIVES	* Introduction of a decentralized maintenance system for handpumps	
COVERAGE	Entire population of Guinea Bissau	
STARTING DATE FINAL DATE	1987 1993	
TYPE OF WS IMPROVEMENTS	* To set up a maintenance structure for the handpumps on village level	
HYED OBJECTIVES	* Prevention of contamination of the groundwater by cleaning the surroundings of the pumps	
DESCRIPTION OF THE HYED PROGRAMME	In each area an "area engineer" was employed. After a training he received a bicycle and a toolbox. Later engineers on village level were also trained. They were part of the water committee. The water committee took care of the maintenance of the pump. The villagers are also informed about the responsibilities of the water committee and the engineer. Posters were used as educational material. To safe money the posters were colour printed in the Netherlands	
STRONG POINTS OF THE HYED PROGRAMME	* Educational material was locally designed * The material was pretested * A new approach was designed to implement the education sessions more participatively	
BOTTLENECKS OF THE HYED PROGRAMME	* The educators didn't like to go in the villages in the evening * The presentation of video or slides was more important than the messages * When you can only visit the villages in the evening it was not possible to visit more than 2 villages * No integrated programmes e.g. schools and health centers * Not enough time to alter behaviour * Lack of cooperation and integration between the responsible Ministries	
RECOMMENDED IMPROVEMENTS	* Start on Ministerial level * Take care for incentives for the maintenance engineers (In this project the engineers got a bicycle as incentive but they couldn't afford the maintenance) * Take care for a adequate follow up and support for the villagers	
ADVICE FOR COLLEAGUES	* Cooperate with local teachers, VHW's or nurses for sustainability * Take enough time to reach the hyed goals * Take care of an adequate evaluation method	
ADDITIONAL INFORMATION		

INFORMATION SOURCE	C-1	C-2
NAME OF THE PROJECT	Village Water Supply Programme	Community Water supply and Sanitation Programme
PROJECT AREA	Rural Botswana	Nepal
PROJECT OBJECTIVES	* Provision of piped ws with a good quality of drinking water * To increase both the quantity and quality of (household) water * Improving the health status	* To improve the health situation of the rural people who received piped water supply * To obtain a higher acceptance and status for women
COVERAGE	± 10.000	
STARTING DATE FINAL DATE	1971 (hyed 1984) /	1976 /
TYPE OF WS IMPROVEMENTS	* Provision of piped water supply in the villages	* Provision of piped water supply * Communal tap wells
HYED OBJECTIVES	* Awareness raising in villages on how to handle and use water hygienically * To improve the health status and the quality of life	* Promoting personal hygiene * Promoting household hygiene * Promoting environmental hygiene * Installation of a sanitation committee
DESCRIPTION OF THE HYED PROGRAMME	A national hyed campaign was designed. Several methods and materials were developed and used. The hyed was given on several levels, from national to personal. Three messages were spread keep the water clean, use more water for personal hygiene and keep to standpipe water	The staff consists of two sanitation women workers and one supervisor. In each ward is a sanitation committee on voluntary basis. The SC received an annual training of the SWW. The training consists of several subjects. Problems of the SC can be discussed and solved. The SC gives education sessions to the women. After every session a short evaluation has been done.
STRONG POINTS OF THE HYED PROGRAMME	* The health teams were very much involved in their work * Despite of a short time of preparation the campaign was properly designed and implemented * No bureaucratic constraints * A great freedom for the coordinator * It achieved attention and support * An integrated approach and participation of several ministries * Household water quality survey -> direct adaption and evaluation * Women were involved in the hyed	* The hyed was based on the felt needs and problems of the target group * Participation of women, their opinion was taken into account and the programme was planned accordingly * The programme was planned on times which are most convenient for the target group * An instruction booklet was designed which appeared to be useful and applicable * A lot of evaluation was done and the programme was altered when necessary
BOTTLENECKS OF THE HYED PROGRAMME	* Short term contracts for the coordinators * It took a long time to find an understudy for the coordinator * Lack of transport facilities	* Education is not enough, the living conditions must also be improved * Too many messages for the planned time * Bad cooperation with the nepalese government and the donor organization * The poorest women were very hard to reach, also due to the caste system * The planners didn't take always into account some inconvenient days for HE
RECOMMENDED IMPROVEMENTS	* Realistic contract periods * Close cooperation between the counterpart and the coordinator during all phases of the programme * Allocation of a 4 wheel drive car * Involving teachers in the hyed	* Women have to be adequately and regularly supported and paid. * Not so many objectives but less and clear objectives that could be evaluated
ADVICE FOR COLLEAGUES	* Plan enough time for behaviourchange * Conduct a community diagnosis before designing the hyed * Coordination and cooperation at all levels (ministerial to individual) * Plan an annual review for monitoring and evaluation purposes * Assess the effectiveness when the programme is going on for sometime * Ensure that the educational material is locally designed and pretasted and being used in the right way	* Before the hyed is implemented at least one tapstand must be build for demonstration purposes * Use different educational methods to bring over the same message * Selection of the SWW depends of their enthusiasm. They must know what their work consists * For the purpose of evaluation conduct a baseline study and set clear and measurable objectives
ADDITIONAL INFORMATION		

INFORMATION SOURCE	C-3	C-4
NAME OF THE PROJECT	Urban Sanitation Improvement Team	PHC with Water Supply and Sanitation Programme
PROJECT AREA	Lesotho	Remote Qabane Valley, Lesotho
PROJECT OBJECTIVES	* To develop appropriate latrine designs that were effective, affordable and cultural acceptable	* Provision of safe, reliable and convenient water systems * The installation of improved sanitation facilities * The encouragement of improved hygiene practices * To add information to national data sources
COVERAGE	Urban population of 168.000 people	27 villages, 5000 people
STARTING DATE FINAL DATE	197? 1988	1972
TYPE OF WS IMPROVEMENTS	* Latrine provision in urban areas	* Construction of water supply systems utilizing self-help labour and eventually providing back-up for village level managed operation and maintenance of the system
HYED OBJECTIVES	* Encouraging hygiene practices * Encouraging proper use and maintenance of the latrines * Motivation of groups with no or other latrines to build VIP latrines * Promoting child health practices	Different programmes dealing with: sanitation, village water supply, VHC's, ante-natal clinics, family planning, breast feeding, smoking, alcohol abuse, tuberculosis, leprosy and sexually transmitted diseases
DESCRIPTION OF THE HYED PROGRAMME	Because the team was very small it was impossible to work closely and participatively with the community. The team tried to mobilize agencies and field workers who have been working with the communities. Some families were used as examples for other families in their villages. The use of several education methods.	The HE division is staffed by 13 professionals. The HED is more a service organization helping other programmes to meet their objectives. Every day a 15 minutes radio programme was broadcasted. The HED trained nurses, teachers and extension workers. Several education materials were used. The HED had assisted in the training of > 1500 VHW's
STRONG POINTS OF THE HYED PROGRAMME	* Emphasis placed on HE and communication which has enabled a small team to have a significant impact * The use of as many local resources as possible	* VHW's appear to be good channels for health education
BOTTLENECKS OF THE HYED PROGRAMME		* Hyed was not a governmental priority * Materials were sometimes produced by other agencies. * Lack of well trained staff * Need for more office space and a proper recording studio * The work of the VHW's was not appreciated by the villagers
RECOMMENDED IMPROVEMENTS		* The hospital should first deliver the new ideas to the people, because it is much more respected than the VHW's * That goes for the authority of the chief too, he could add weight to the message and thereby improving the chance of its acceptance
ADVICE FOR COLLEAGUES	* Promote actions which are realistic and feasible for the target group * Build on existing ideas, concepts and practices * Repeat the message using several methods * Use existing methods and channels of communication * Entertain and attract the community * Use demonstration to show the benefits of the recommended alterations * Provide opportunities for dialogue and discussion	* Involve as many actors as possible in HE with the main focus on teachers and VHW's * Conduct a preliminary KAP and socio-economic study * Pretest all the used materials * Provide some kind of incentives to the trained VHW's
ADDITIONAL INFORMATION		

INFORMATION SOURCE	C-5	C-6
NAME OF THE PROJECT	Rural Potable Water Institutions Project	Care/ Bolivia Child Survival and Rural Sanitation Project
PROJECT AREA	Rural population of Kasserine, Tunesia	Departments of Chuquisaca, La Paz, Oruro Potosi and Tarija
PROJECT OBJECTIVES	* Improving the health of the target population * Increased productivity of them	* To decrease the incidence of death and illnesses among the children < 4 in Bolivia's rural communities
COVERAGE	± 50.000 people	59.000 people in 200 rural communities
STARTING DATE FINAL DATE	1987 1991	august 1986 august 1990
TYPE OF WS IMPROVEMENTS	* Provision of improved access to potable water for undeserved rural populations * Provision of latrines, showers or other water related installations	The project had 3 integrated components: * The provision of health services + HE * The provision of potable water and sanitation facilities * Commun. organization and participation
HYED OBJECTIVES	* To plan and implement the hyed component for the project * An inter-ministerial team holding the responsibility for programmatic decisions and field work on a regional level	* 90% of the mothers with children < 4 should know when and how to rehydrate * 75% of the children <4 should have been correctly rehydrated * 80% of the children > 9 months and < 5 should have been immunized * 200 permanent community-level health programmes should be functioning * 70% of the population should be using iodized salt or iodine capsules
DESCRIPTION OF THE HYED PROGRAMME	The 10 educators were recruited from several ministries. They were trained in basic hyed techniques. The educa-tors trained VHW's and teachers. They have to support all ws+s activities. The educators had to design new educational materials. Emphasis was put on the participation of women	Health Promoters were selected by their communities. An on the job training was provided. The trainers (nurses) stayed in the villages for about 20 days a month. Mothers' clubs are the primary organizational vehicles for the health component of the project.
STRONG POINTS OF THE HYED PROGRAMME	* Increased knowledge of teachers and students regarding w+s, personal and household hygiene * Some teachers provided community hyed and reinforced the VHW's work * Some teaching aids as puzzles and games proved to be very successful * Flexibility in project design and budgeting can lead to other activities and materials	* The results confirmed that integration was workable and advantageous * The latrine component was extremely successful and popular * On the job training of health promoter * The people like to go to the HE * The programmes were based on the interests of the women * The project accomplished the streng-thening of community organizations
BOTTLENECKS OF THE HYED PROGRAMME	* Lack of transport * No adequate incentives for the educ. * The tasks of the educators were too many -> not enough time for hyed * Continue guidance to ensure that all the planned activities took place * Lack of support of community leaders * No formalized structures for hyed	* Sometimes it lasts over 4 years before the water provision was installed, this lowered the motivation of the target group to participate * The presence of more than 1 NGO in the community can influence participation and effectiveness
RECOMMENDED IMPROVEMENTS	* Preliminary community diagnosis * Reported changes should also be evaluated through household observations * It is important to create a network for sustainability * A clear internal structure of staff	* Women tend to work better with women * More cooperation between different (funded) projects in the same area * Realistic evaluation criteria * Provision of handwashing facilities * Pots with lids should also be available for clean storage of water
ADVICE FOR COLLEAGUES	* Before designing new material an inventory of existing materials should be done	* All counterparts must be equally involved in all phases of the project * The project should run for > 7 years * The project design should leave room for community participation * HE should reach both women and men * Make inquiries to identify the most suitable time/format/style of the HE * Income generating element(s) should be part of the HE for sustainability
ADDITIONAL INFORMATION		

ANNEX III

RESULTS OF THE QUESTIONNAIRES (n=31)

What do you consider to be the strong points of the hygiene education programme ?

*	The hyed was based on a community diagnosis	13
*	Well chosen education methods (attractive, practical and understandable)	13
*	Local people were the educators and staff members	10
*	Participative education methods were used	8
*	Already existing organizations and personnel were used	8
*	Enough financial resources were available	8
*	The programme was properly designed and implemented	7
*	Measures were taken to obtain sustainability	7
*	The staff was well trained and qualified	7
*	Good cooperation between the social and technical section of the project	6
*	Support and cooperation from governmental organizations was received	6
*	Evaluation and monitoring was done	6
*	Women played an important role in the programme	6
*	Achieved an increased awareness and consciousness of the target group	6
*	The training sessions were held in the village/area	5
*	The behaviour change was made possible (enabling factors)	4
*	Adequate incentives and support for the staff were provided	3
*	Project had his own staff, no organizational problems	2

What problems and bottlenecks do you face in the hygiene education programme ?

*	Lack of well trained staff/problems with staff	16
*	Community was not/did not feel involved in the programme	15
*	Problems with planning (timing/logistical)	13
*	Lack of enough financial resources	13
*	Lack of cooperation between field and organizational level	10
*	Inappropriate hyed method was chosen	8

*	Lack of cooperation/integration between the social and technical section	7
*	Not enough time was planned	6
*	Lack of support and incentives for the staff	6
*	Difficulties due to the role of women	6
*	Difficulties in reaching the poorest people	3
*	No evaluating and monitoring has been done	2

How would you like to improve or change the hygiene education programme ?

Should be:

*	better cooperation and integration between the social and technical section	8
*	based the hyed programme on a community diagnosis	8
*	worked more closely with the target group	8
*	developed a monitoring and evaluation system	7
*	better cooperation between the field and the higher decision levels	6
*	well trained and qualified staff available	4
*	provided support and incentives for staff members	3
*	used different education methods	3
*	focused on a small amount of hyed messages per meeting	2
*	involved more women in the programme	2
*	learned from information of similar projects	2
*	used more already existing organizations and personnel	2
*	available enough financial resources	2
*	provided also income generating activities	1
*	made a better planning	1
*	appointed more local people as educators and staff members	1
*	pre-tested the education material	1
*	given more practical information	1
*	more hygiene education at schools	1
*	education material available	1

What advice do you have for your colleagues on how to make a hygiene education programme successful ?

* Base the hyed programme on a community diagnosis 19
* Work intensively with the target group 11
* Plan/develop carefully the hyed programme 8
* Make behaviour change possible (enabling factors) 5
* Obtain good cooperation and integration between the social and technical section 5
* Try to get support from all the governmental levels 4
* Train the staff thoroughly 4
* Use different education methods 4
* Provide some kind of incentives and support to the staff 4
* Pre-test the education methods/materials 4
* Make use of existing organizations and personnel 3
* Regularly evaluate and monitor the programme 3
* Take measures to obtain sustainability 3
* Learn from similar programmes 2
* Provide also income generating activities 2
* Plan enough time to obtain the goals 2
* Make the hyed session pleasant and attractive 2
* Provide opportunities for practical demonstration 1
* Intensively involve women in the hyed 1
* Start with listening and looking around in the communities 1
* Learn the local language 1
* Do not interfere in subjects beyond hyed 1
* Do not impose any ideas 1
* Enter the village as a team 1

RESULTS OF THE INTERVIEWS (n=11)

What do you consider to be the strong points of the hygiene education programme ?

*	Hyed was attractive and pleasant for the target group	5
*	Hyed was adapted to the target group	5
*	Different education methods/materials were used	4
*	Good cooperation between the social and technical section of the project	4
*	Locally designed material was used	3
*	Some kind of measures were taken to obtain sustainability	3
*	The education methods/materials were pre-tested	2
*	Use of local education methods and language	2
*	The information was practical applicable	2
*	There was a combination of water provision and hyed	2
*	Hyed was based on a community diagnosis	2
*	Already existing organizations and personnel were used	2
*	The staff was carefully chosen	2
*	The training sessions were held in the villages/area	1
*	Income generating activities were also provided	1
*	Combined training sessions for about five watercommittees (opportunities for experience exchange)	1
*	Questions and solutions came from the target group themselves	1
*	The educator had the same cultural background as the target group	1
*	Hyed was given to small groups	1
*	People were locally paid	1
*	Women were involved in the hyed	1
*	Participative education methods were used	1
*	Memory aids were used	1
*	Some kind of incentives and support for the staff was provided	1
*	There was a fixed group promoter	1

What problems and bottlenecks do you face in the hygiene education programme ?

*	Lack of cooperation and support from the responsible Ministries	9
*	Lack of cooperation and integration between the social and technical section of the project	7
*	Some kind of problems with the local staff	4
*	Lack of well trained/qualified staff	4
*	Lack of incentives and support for the staff	4
*	Not enough time was planned to obtain behaviour change	3
*	Inappropriate hyed method was chosen	3
*	Many economical problems in the country	2
*	No community diagnosis was conducted	2
*	No measures were taken to obtain sustainability	2
*	Lack of materials/infrastructure	2
*	Nomadic target group	1
*	People were not used to work in groups	1
*	To much aid was given	1
*	Problems with paying for the water provisions	1

How would you like to improve or change the hygiene education programme ?

Should be:

*	used participative education methods	3
*	used local material, ideas and persons	3
*	paid more attention to incentives and support for the staff	2
*	taken more time for preparation	1
*	started with women only	1
*	more awareness from all governmental levels	1
*	started at governmental level	1
*	no working relationship with the Ministry of Water	1
*	taken more time for preparation	1
*	taken into account the characteristics of the target group	1
*	taken more notice of the tribal backgrounds of the target group	1
*	not that much donations because of the danger of doling out	1

What advice do you have for your colleagues on how to make a hygiene education programme successful ?

*	Local people must be involved in development and implementation of the hyed	7
*	Start with listening and looking around in the communities	6
*	Set realistic goals before implementation	5
*	Take care for support and incentives for the staff	5
*	Adapt the hyed to the target group	4
*	The promoted behaviour/provisions must be based on a community diagnosis	3
*	Evaluate and monitor the programme regularly	3
*	Choose very carefully the staff members	3
*	Use participative education methods	2
*	Provide also income generating activities	2
*	Pre-test all the education methods/materials	2
*	Take into account that the target group consists of several smaller target groups	1
*	Make appointments for visiting the community	1
*	Cover less villages but support them more intensive	1
*	Focus the message only on harmful behaviours	1
*	Use the marketing approach	1
*	Make use of existing education methods/materials	1
*	Learn the local language	1
*	Know what your role in the project is	1
*	Do not accept everything the authorities say	1

RESULTS OF THE CASE-STUDIES (n=6)

What do you consider to be the strong points of the hygiene education programme ?

*	Use of already existing organizations/personnel	3
*	Women were involved in the programme	3
*	Well chosen education methods (attractive, practical and understandable)	3
*	The hyed programme was properly designed and implemented	2
*	An integrated approach(project/ministerial level) was used	2
*	Monitoring and evaluation was conducted	2
*	Hyed was based on a community diagnosis	2
*	The hyed achieved attention and support	2
*	No bureaucratic constraints	1
*	The programme was very flexible and could be altered according to the wishes of the target group	1
*	The training sessions were held in the villages/area	1
*	The project accomplished the strengthening of community organizations	1
*	An instruction booklet was very useful	1
*	Different education methods were used	1
*	The project accomplished the strengthening of community organizations	1
*	The staff was very motivated	1
*	The coordinator had a great freedom	1

What problems and bottlenecks do you face in the hygiene education programme ?

*	Problems with planning (timing logistical)	5
*	Lack of well trained and qualified staff	3
*	Lack of incentives and support for the staff	3
*	Bad cooperation between the field and higher decision levels (governmental/project)	2
*	The coordinators had short term contracts	1
*	Lack of formalized structures for hyed	1
*	Bad cooperation between the social and the technical section of the project	1

* The presence of more than 1 NGO in the area 1
* The poorest people/women were hardly not to reach 1
* Education was not enough also the living conditions must improve 1

How would you like to improve or change the hygiene education programme ?

Should be:

* based the hyed on a community diagnosis 1
* worked with women to reach other women 1
* done household observation to control the reported changes 1
* taken some measures to obtain sustainability 1
* a clear internal structure of staff 1
* more cooperation between similar projects in the area 1
* defined realistic evaluation criteria 1
* made the change possible (enabling factors) 1
* worked with women to reach other women 1

What advice do you have for your colleagues on how to make a hygiene education programme successful ?

* Try to obtain good cooperation, participation and coordination at all levels 5
* Conduct a community diagnosis to base the hyed programme on 4
* Use existing communication methods and channels 3
* Use demonstration to show the benefits of the recommended changes 2
* Use different education methods 2
* Pre-test the education methods/materials 2
* Plan enough time to obtain behaviour change 2
* Set clear, visible and measurable goals 2
* Plan monitoring and evaluating activities 1
* Carefully select the members of the staff 1
* Income generating activities should also be provided 1
* Entertain and attract the community 1
* Provide some kind of incentives and support for the educators 1