National Hygiene Promotion Strategy

Nigeria

National Hygiene Promotion Implementation Approach

- **Description:** The above flow chart depicts the description of the main steps, through which the hygiene promotion strategy was formulated. The strategy was informed by a situation analysis. The steps illustrate how the strategy is linked with the implementation guidelines for schools, communities, and health centres. For human resources, the guidelines leads to the development of training manuals for teachers, volunteer hygiene promoters (VHPs), LGA WASH Team and CHEWs and training of master trainers/ ToTs. The ToT will lead to the preparation of action plans for implementation of the hygiene promotion strategy at each level, which will be monitored by the respective designated people at each of the levels. At the end of the year an evaluation will be conducted to understand the gaps and once these are established, recommendations for course correction will be established. Combined implementation logic to help with understanding the intervention at community level

and in schools targeting minimum result of supervised group handwashing (GHW), are attached as **Annexure- VI** .

CONTENTS

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List of Abbreviations and Acronyms

ARI	Acute Respiratory Infections
BCC	Behaviour Change Communication
CAP	Community Action Plan
CBOs	Community Based Organizations
CHEWs	Community Health Education Workers
CLTS	Community Led Total Sanitation
CtC	Child to Child
CtP	Child to Parent
DHS	Demographic and Health Surveys
EHCs	Environmental Health Clubs
EU	European Union
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
GHD	Global Handwashing Day
GDP	Gross Domestic Product
HP	Hygiene Promotion
IEC	Information, Education and Communication
FMoE	Federal Ministry of Education
FMoEnv	Federal Ministry of Environment
FMoH	Federal Ministry of Health
FMWR	Federal Ministry of Water Resources
IRC	International Resource Centre
IYS	International Year for Sanitation
JMP	Joint Monitoring Programme
KAP	Knowledge, Attitude & Practice
KII	Key Informant Interview
LGA	Local Government Area
LGEA	Local Government Education Authority
LSBE	Life Skill Based Education
M&E	Monitoring & Evaluation
MDG	Millennium Development Goal
NAIRA	Official Currency of Nigeria
NGOs	Non-Government Organizations
NTGS	National Task Group for Sanitation
ODF	Open Defecation Free
PHCs	Public Health Centres
PPP	Public Private Partnership
PTA	Parents Teachers Association
RUWASSA	Rural Water Supply & Sanitation Agency
SBMC	School Based Management Committee
SLTS	School Led Total Sanitation
STGS	State Task Group for Sanitation

STH	Soil-Transmitted helminthes
SUBEB	State Universal Basic Education Board
UNDP	United Nations Development Fund
US$	United States Dollar
UN	United Nations
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
VIP	Ventilated Improved Pit
VHPs	Volunteer Hygiene Promoters
WASH	Water, Sanitation and Hygiene
WASHCOMs	Water, Sanitation & Hygiene Committees
WHO	World Health Organization
WinS	WASH in Schools
WSP	Water and Sanitation Program of World Bank

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Glossary

Advocacy:
A continuous process for strengthening the programme interventions through increasing the level of commitment to improve policies and implementation related to Water, Sanitation and Hygiene (WASH) in Communities, Primary Health Centres (PHCs) and in all Primary Schools. Advocacy further encompasses raising resources through formulating arguments in favour of the programme (hygiene promotion and sanitation) and to be communicated through various media (print and electronic) and interpersonal channels to various targeted groups at various intervals and programme cycle.

Attitudes:
Preferences, biases, age old taboos and subjective assessments that influence thinking of one to act or respond in a typical manner. Attitudes lead people to like or dislike something, or to consider things good or bad, important or unimportant, worth caring about or not worth caring about.

Baseline/bench mark study or survey:
It is a study/survey carried out prior to programme implementation (Hygiene Promotion and Sanitation) that provides information on key indicators, such as latrine coverage and use, practice of good hygienic habits and reasons for barriers towards change in behaviour. Baseline/bench mark study helps to understand the impact of programme interventions through subsequent evaluation activities.

Child to Child (CtC) approach:
It is a hygiene promotion approach based on the belief that children can be highly influential in improving the health of others, especially with regards to raising hygiene awareness and practices of younger children and siblings. Hygiene promotion in schools is based on this approach, where by senior pupil support their juniors in adopting new hygienic behaviours.

Child to Parent (CtP) approach:
A hygiene promotion approach based on the belief that children can be 'agent for change' and influential in improving the health of others, especially with regards to raising hygiene awareness among parents and other members of the family.

Civil Society:
Those individuals and organisations who are not part of the government structure but working for the cause and development of the society through community organisations, informal groups, non-government organisations, voluntary agencies, small scale independent contributors, private sector, media organisation and professional bodies.

Community Led Total Sanitation (CLTS):
An approach to collective community decision for completely eliminate open defecation by using sanitation ladder for safe disposal of excreta and attempt to achieve open defecation free (ODF) status.

Community Participation:
It aims to promote the active involvement of all sections of a community in project planning and decision making. It aims to encourage people to take responsibility for the process and outcomes, both short and long term, of a project. Merely involving people for contributing labour, equipment or money to a project cannot be called active community participation.

Critical times:
In connection to hand washing, this generally means washing hands with soap after defecation, handling children's faeces or cleaning their bottoms or disposing faeces, and before eating, feeding/breast feeding children, cooking and handling food or water.

Enabling Environment:
Attitudes, policies, and practices including financial instruments, formal organization, community organizations and partnership, which together support and promote needed changes in hygiene behaviour, practices and access to technologies for safe water and safe disposal of excreta.

Helminth Infections:
Intestinal worm infections.

Empowerment:
It is a process of facilitating and enabling people to acquire new skill, knowledge and enhance capacity and capabilities to implement, monitor hygiene promotion and sanitation related interventions for better results and outcomes.

Environmental Health:
It is a broad term that encompasses water and sanitation interventions as well as such issues as air and noise pollution. Environmental health services are defined by the World Health Organization as: *"those services which implement environmental health policies through monitoring and control activities. They also carry out that role by promoting the improvement of environmental parameters and by encouraging the use of environmentally friendly and healthy technologies and behaviours".* The Environmental Health Profession had its modern-day roots in the sanitary and public health movement. Many countries have EH officers who may be recruited to the team either as core delegates or as field officers.

Environmental Sanitation:
A range of interventions designed to improve the management of excreta, waste water, drainage and solid waste in a community.

Excreta:

Faeces and urine.

Faecal-oral route:
The route by which disease-causing organisms (pathogens) excreted in the faeces of infected humans (or animals) enters the human body through the mouth. Such organisms may be carried from faeces to mouth via contaminated fingers, flies, field (soil),fluids (water) or food (refer to 'F diagram').

Formative research:
Research carried out prior to programme implementation to obtain information with which a hygiene promotion programme can be designed.

Garbage Pit (for bio-degradable items):
A pit dug out in a community to throw bio-degradable household waste or community waste, such as kitchen leftovers, vegetable waste, papers, animal excreta etc. The pit is covered with a layer of soil, once it is filled then in 6-12 months it becomes organic manure.

Garbage Pit (for none bio-degradable items):
A second pit dug out in a community to dispose of non-bio-degradable items, such as metallic parts, broken glasses, plastic/PVC items and nylon/polythene bags. Once pit is full then cover it by soil layer and leave it.

Groundwater:
Water found below ground level in the sub-soil.

Groundwater Table:
The level at which the subsoil is saturated.

Hardware:
The physical infrastructure for WASH programme like latrines, stands for hand washing with soap, water points (hand pumps, protected dug wells, solar motorized bore hole, water tanks, pipes) drainage, wastewater disposal and solid waste disposal facilities. The terms Software and Hardware are frequently used to refer to different components of WASH programme. The software refers to the community aspects of the intervention i.e. how people use the hardware facilities. While engineers and technicians may be responsible for the construction of water systems and sanitation facilities, but they always have the way that these facilities are used and maintained. In the same way the hygiene promoters also have a role to play in ensuring that feedback on the appropriateness of design of the facilities is incorporated into the programme. Some feel that the term 'software' has negative connotations but if we continue with the computer analogy, the hardware is of little use without innovative software programmes!

Health:
It is a state of complete physical, mental and social well-being, and not merely the absence of disease or sickness. It is a fundamental human right and attainment of the highest possible level of health is a most important worldwide social goal whose

realization requires the action of many other social and economic sectors in addition to the health sector. (World Health Organization -WHO)

Hygiene:
Personal and household practices that serve to prevent infection and keep people and environments clean. Examples of hygiene practices include hand washing with soap, bathing and management of stored water in the home, all of which aim to preserve cleanliness and health. WHO defines hygiene as 'the conditions and practices that help to maintain health and prevent the spread of diseases.

Hygiene Education:
All activities and provision of education aimed at raising awareness and conveying knowledge of the links between good hygiene practices and health. It also includes rendering of information to persuade people to maintain good hygiene and prevent water and sanitation related and other infectious disease. Often it is used to communicate appropriate knowledge and understanding related with water and sanitation related diseases as well as adoption of hygienic behaviours among the targeted audience(s). But it is not necessary that disseminated knowledge may help to convert it to the practices of an individual, family or community members.

Hygiene promotion:
Systematic and planned approaches to persuade the extensive acceptance and adoption of safe hygiene practices in order to reduce diarrhoeal and other WASH related diseases. Hygiene promotion focuses on behaviour change to maximise the benefits of improved water and sanitation facilities. Sharing of information, mobilization of communities and pupil and finally provision and maintenance of essential materials (soap, safe water etc) and facilities for hygiene practices are key factors for hygiene promotion. It begins with and is built on what people know, do and want.

Knowledge:
Developing of an understanding on any specific topic/subject after getting a range of information from various sources. For example, a facilitator of hygiene promotion might explain how water-borne diseases are transmitted and then illustrate that drinking unsafe water can cause diarrhea.

Life Skills:
Capacity and capabilities for adopting and positive behavior that allows individuals to deal efficiently with difficulties and challenges of everyday life. In particular, life skills are a group of psycho-social competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a hygienic, healthy, and productive manner.

Life Skills based hygiene promotion:
An approach to creating and maintaining good hygienic behaviours and practices through the development of knowledge, attitudes, especial skills related with hygienic practices, using a variety of learning experiences, with an emphasis on

participatory methods. It should enable a child/pupil to make positive decisions and take actions to promote and protect health and hygienic conditions for themselves and for others and further impart and promote good hygienic behaviours, which should travelled from generation to generation.

Monitoring and Evaluation:
Monitoring is a process to observing the progress of project over time; it provides timely information for ensuring that progress, quality, and effect of processes and procedures are maintained. Evaluation is a periodic assessment of programme effectiveness, efficiency, sustainability and Impact. Evaluation establishes the worth of the programme. It focuses on whether a project is being implemented as intended, examines how the project operates, and addresses problems in service delivery and if necessary then lead to course correction to ensure planned impacts and outcomes..

Morbidity:
The incidence of ill health.

ODF:
Open defecation free – an aspiration in total sanitation approaches.

Participatory methodologies:
Participatory approaches aim to build confidence, make decision-making easy and enable people to learn from each other. Methods, materials and procedures that persuade the active contribution of an individuals in a group process, regardless of their age, sex, or economic or educational background are essence of participatory methodologies.

Parent Teacher Association (PTA):
PTA is an organization that promotes and organizes strong working relationships among parents, teachers, and schools, in support of students and also in support of WASH, especially hygiene promotion.

Pathogen:
A bacterium, virus or other microorganism that can cause disease.

Pit Latrine:
Latrine with at least one metre deep pit for collection and de-composition of excreta and a passage for liquid to the surrounding soil into the pit.

Pour-flush Latrine:
Latrine that depends for its operation of small quantities of water, poured from a container/bucket to flush away faeces from the point of defecation.

Program Communication or Communication for Development (C4D):
The process of identifying, segmenting, and targeting specific groups and audiences with particular strategies, messages, or capacity building/training programs; it involves reaching them through various mass media and interpersonal channels, both traditional and non-traditional.

Soakage Pit:
A pit dug out for safe disposal of waste water and is filled with various size of gravels (bigger one in down side and smaller one at top) and connected to a small pipe to accept waste water at regulated way.

Social marketing:
An approach, which uses marketing principles to achieve social benefits, such as changes in attitudes and behaviours, which are deemed to be good for targeted audiences.

Social Mobilization:
It is a process for bringing together all possible social partners, stakeholders, allies to identify and determine indicators for necessary interventions by raising awareness, demand for particular development objective.

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SECTION-I

1. BACKGROUND AND SITUATION ANALYSIS:

- Nigeria has an estimated population of 178 million, of whom 45 per cent are below 15 years, and its annual population growth rate is around 3.2 per cent. As a result, the country's population is expected to double by 2035[1]. The country consists of 36 states, a Federal Capital Territory (FCT) and 774 local government areas (LGAs), each with significant degrees of autonomy. In all, estimated around 150 primary schools (both public and private) are located in every LGA.

- Economic growth in Nigeria has not been equitable. An estimated 54 per cent of the population lives below the poverty line (43 per cent urban, 64 per cent rural), and 90 per cent of the poorest people live in the northern region. Households in the northern region and in the lowest income quintiles have substantially less access to services. Of the urban population, 27 per cent is food insecure, compared to 44 per cent of the rural population. Socio-cultural barriers still impede many healthy household practices; the rate of exclusive breastfeeding is just 15 per cent, and only 49 per cent of babies are delivered by skilled attendants[2].

- Regarding access to safe water and sanitation, wide regional variations exist in the country, the South-East zone has the highest access to water (69 per cent) but the lowest access to improved sanitation (18 per cent)[3].

- Globally 32 per cent of the world's population, i.e. 2.4 billion people, lacked improved sanitation facilities, and 663 million people still used unimproved drinking water sources[4]. Thus, insufficient access to safe water and sanitation provisions, along with poor hygiene practices, make enormous number of children die and ill every day, and affects their cognitive development.

- As per JMP-2015[5], in Nigeria only 29 per cent population (33% Urban and 25% Rural) have access to improved sanitation facilities and 34% rural population still defecate in open and 30% indulge in other unimproved sanitation. JMP 2015 suggests that only 8% of the rural population have facilities at home for handwashing with soap.
- Diarrhoeal diseases are the second leading causes of death in children under five years old. These diseases are both preventable and treatable. Each year diarrhoea kills around 760 000 children under five. A significant proportion of diarrhoeal diseases can be prevented through safe drinking-water and adequate sanitation and hygiene.

[1] UNICEF, Nigeria CPD 2014-17
[2] UNICEF, Nigeria CPD 2014-17
[3] UNICEF, Nigeria CPD 2014-17
[4] WHO/UNICEF led Joint Monitoring Programme (JMP 2015) for water supply and sanitation

[5] WHO/UNICEF led Joint Monitoring Programme (JMP 2015) for water supply and sanitation

Globally, there are nearly 1.7 billion cases of diarrhoeal disease every year. Diarrhoea is a leading cause of malnutrition in children under five years old. About 17% of childrens death annually are due to inadequate WASH and 88% of diarrhoeal diseases are caused by unsafe WASH interventions[6].

- Diarrhoea is the second leading cause[7] of mortality among Nigerian children under five years of age, after pneumonia. It is frequently related to the consumption of contaminated water and to unhygienic practices in food preparation and disposal of faeces.

- Various global studies suggest that merely washing hands with soap after defecation and before eating, can reduce over 42-47% diarrhoeal cases among young children.

- Due to poor sanitation and hygiene, Nigeria annually incurs about US$3 billion or 455 billion Naira in 2012[8] (with December 2015 exchange rate around 594 billion Naira) economic loss. This sum is equivalent of 1.3% of the national GDP. Out of US$ 3 billion economic loss, US$2.5 billion is lost each year only due to premature deaths, mainly children under five years of age in Nigeria[9].

- A report in the year 2015, prepared by Federal Government of Nigeria[10] on epidemiological mapping of Schistosomiasis and Soil Transmitted Helminths (STH) in 19 states and the FCT of Nigeria, revealed that all 19 states and FCT were endemic for one or both diseases with an overall prevalence of 9.5% for schistosomiasis and 27% for STHs. The prevalence of infection was significantly higher in males than in female children for both diseases. STHs was more prevalent among the younger age group (5-10 years) while schistosomiasis was more prevalent among the older age group (11-16 years). Two per cent of pupils surveyed were co-infected with both diseases.

- In Nigeria, since the introduction of Community Led Total Sanitation (CLTS) programme in 2008, a significant progress has been made for spreading the sanitation coverage and over 13,000 communities were ODF (claiming and certified)[11] and sanitation coverage is further accelerating but significant sustainable hygienic behaviour change has not been noticed among the community member.

- In Nigeria, over 80,000 primary schools with estimated over 22 million[12] pupil (with estimated annual increase of 3.2 per cent additional pupil, in 2015 over 26 million pupil may be in primary schools) are a readymade network for spreading the

[6] World Health Organization
[7] Nigeria Nutrition and Health Survey (NNHS) 2014
[8] US Dollar to Naira exchange rate of 2012
[9] World Bank –WSP March 2012
[10] Federal Ministry of Health, Nigeria – May 2015
[11] Open Defecation Free (ODF) until September 2015
[12] Nigeria digest of education statistics (2006-10), Federal Ministry of Education, Nigeria

messages of adopting the hygienic behaviours by the community members along with children.

- Around 54 per cent primary schools in Nigeria have some kind of access to water source (including stream as a source)[13], but sanitation facilities in primary schools are either lacking or in pathetic situation. In less than 10% schools there are some kind of sanitation facilities. Similarly, majority of schools have no boundary wall, thus WASH facilities at schools are prone to be misused by others.

1.1 Hygiene practices in Nigeria:

- In Nigeria, for many years, hygiene promotion was part of the WASH campaign conducted from time to time. Since 2008, specifically with the introduction of CLTS approach hygiene education was imparted to communities at various stages through participatory approaches and besides emphasising on latrine construction equal importance was given to adoption of various hygiene behaviours. In many states, various campaign for awareness creation were held but general view was that awareness campaigns did not result to convert knowledge into practices.

- A survey in 2014 -15, on Knowledge, Attitude and Practices (KAP), conducted by UNICEF, Abuja[14] in six states of Zamfara, Katsina, Jigawa, Kaduna, Bauchi and Benue found that on an average people have high level of knowledge (over 50%) about the health benefits from hand washing with soap.

- Survey further revealed that around 82% of people prefer to wash their hands (not necessarily with soap) before eating meals, but only 53% people wash their hands with soap after defecation. In Jigawa 33% and in Katsina only 43% people wash their hands with soap after defecation.

- The practices of not washing hands with soap after cleaning a childs bottom is quite alarming as only around 14% people practice this, but in Jigawa only 9%, in Zamfara only 6.5% and in Kaduna 30% practice it

- Before preparing/serving food on an average only 17% (in Bauchi 9%, Jigawa 8% and Zamfara 7%) wash their hands with soap. Before feeding child on an average only 18% people wash their hands with soap in the six surveyed states.

- Although the above mention data was from six states, but more or less, the situation is not much better in other states too. Many states with riverine areas report cholera cases every year, as defecation near or in stream/river is quite prevalent. Generally, this happens, because the concept of “good hygiene leads to good health” has not yet been understood by members of communities.

[13] Nigeria digest of education statistics (2006-10), Federal Ministry of Education, Nigeria
[14] Survey conducted by UNICEF, Nigeria 2014-15

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2. WHY EMPHASIS ON HYGIENE PROMOTION

- Merely constructing water and sanitation facilities does not help to improve the health of people, it needs to be combined with sustainable good hygienic practices. There are enough evidences that despite availability of safe water and sanitation facilities, people suffer from water and excreta related diseases.

- It is an established fact, that unsafe water and in-sanitary conditions cause diseases. Water and excreta related diseases are many types and those are classified in groups. An infectious disease is one, which can be transmitted from one person to another or sometimes from insects/animals. Usually when human excreta mix with drinking water or contaminate a household or community, then people get sick and as a chain reaction they infect others. Children are more prone to that type of infections and fall sick quickly. It is necessary to understand the type of diseases, people get due to water contamination as well as when excreta mixes with food and water.

  - **Water related diseases** may be divided into two categories, firstly those which are caused by a biological agent of diseases (a pathogen) and secondly those which are caused by some chemical substances in water. The ***first group*** may be called the 'water related infections' and include some of the greatest causes of diseases in developing countries/ regions including Nigeria (for instance diarrhoeal diseases). The ***second group*** is related with 'Diseases caused by chemical contamination of water', such as fluorosis (caused due to excess fluoride levels in drinking water); arsenical keratosis (caused due to excess level of arsenic in drinking water) and infantile methaemoglobinaemia i.e. blue baby (born) - caused due to high level of nitrate in drinking water.

  - **Excreta related disease** is related to human excreta, meaning urine and faeces (excreta/stool), which are the source of many infections. The spread of major infections and parasitic diseases such as typhoid, dysentery, hepatitis, cholera and giardiasis are due to biological contamination of drinking water. All such diseases are caused by pathogens or pathogenic organisms, which are microscopic living organism such as bacteria, viruses, helminth and protozoa.

2.1 Classification of water related diseases[15]:

- Water Borne Diseases can be broadly classified into following categories, based mainly on the routes taken to transmit them.

  1. Water- borne diseases
  2. Water –washed diseases
  3. Water-based diseases

[15] Adopted from sanitation in schools, UNICEF, Dushanbe, Tajikistan

4. Insect vector diseases

1. **Water- borne route:** When pathogen (disease causing agent) infested water is consumed by a person and on completion of the pathogen's incubation period (infectious stage of its life cycle), person gets sick. These diseases are typhoid, cholera, diarrhoea, dysentery and few others.

2. **Water –washed route:** When for personal hygiene purpose water is not used in adequate quantity then diseases like skin sepsis, scabies and fungal infections of the skin as well as infection of eyes occurs. These infection can be reduced with increasing the volume of water.

   Those who do not take bath, do not wash their hair or do not change clothes regularly may suffer from water-washed infection caused by lice and mites, they may also suffer from fever transmitted by body lice.

3. **Water-based route:** When a person drinks water, which contains pathogen (disease causing agents), which spend part of their life cycle in aquatic surroundings get schistosomiasis and guinea worm (eradicated in Nigeria).

4. **Insect vector route:** When diseases are spread by insects, which breed in water and cause diseases like Malaria, Filariasis (Elephantiasis) and Dengue.

Water related diseases can be classified as under (Indicative list)

Category	**Infection**	**How these are related with water**	**Preventive strategy**
Water-borne route	Diarrhoea, Dysentery, Typhoid, Cholera, Giardiasis, , Hepatitis-A, Poliomyelitis	Faeces of a person suffering from the disease* get into water	Improve quality of drinking water Prevent casual use of the unhygienic sources
Water- washed route	Infectious skin and eye diseases Louse-borne infections and relapsing fever	Inadequate washing of body/hands	Increase water quantity for (wash/clean well) use Improve personal hygiene practices (take daily bath, wash hairs regularly and wear clean clothes)
Water-based route	Guinea worm** (ingested) Schistosomiasis (penetrating skin)	Disease causing pathogens grow in water	Control cyclops and filter water through a fine cloth mesh to remove larvae/Cyclops Disinfect /boil water
Water related route	Malaria Filariasis (Elephantiasis) Dengue fever	Mosquotes breed in stagnated water/waste water Mosquotes breed in fresh stagnated water	Do not allow water to stagnate and destroy breeding sites. Cover the body as much as possible. Use bed-nets
*****Besides water, can also spread through food, dirty nails **Eradicated in Nigeria			

2.2 Classification of excreta related infections[16];

- Excreta-related infectious diseases are related to human excreta (faeces and urine). All such diseases are caused by pathogens or pathogenic organisms, which are microscopic living organism such as bacteria, viruses, helminth and protozoa.
- Excreta related infection are usually classified as:-

1. **Faecal-oral infection (non-bacterial):** Some of these infections, caused by viruses, protozoa and helminths, can spread very easily from person to person whenever personal and domestic hygiene is not ideal. Changes in excreta disposal methods are unlikely to have much effect in these kinds of infections/ incidence unless accompanied by widespread changes in personal cleanliness, requiring substantial improvements in water supply and housing, coupled with major efforts in health and hygiene education and promotion. Improvements in excreta disposal will have certain degrees of influence on various faecal-oral diseases.

   Faeces- to- mouth infection: These infections are usually transmitted directly. For example: A child, who has worms and who forgot to wash his hands with soap, after defecation, offers his friend a biscuit with same hand, his finger, still dirty with his own faeces are covered with hundreds of tiny worm eggs (so small they cannot be seen). Some of these worm eggs stick to the biscuit. When his friend eats the biscuit, he swallows the worm eggs, too. As a result, soon that friend will also have worms. His mother may say this is because he ate too many sweets. But no, this is because he ate shit.

   Amoebae: These are not worms, but they are parasites that can be seen only with a microscope. The stool of an infected person has many of these tiny parasites. Because of poor sanitation, they get into the source of drinking water or into food, and other people become infected. Many healthy people have amoebae without becoming sick. However, amoebas are common cause of severe diarrhoea or dysentery (diarrhoea with blood) especially in persons already weakened by other sickness or poor nutrition. Less commonly, amoebas cause painful, dangerous abscesses in the liver.

2. **Faecal – Oral infection (bacterial):** Bacteria cause the transmission of many diseases. They are persistent and can multiply if they find suitable substrate (food). Besides, in person-to-person transmission route, it can occur through contamination of food, crops or water sources with faecal material. Some of the pathogens in this category also passed in the faeces of animals and birds and can be transmitted to the community having improved sanitary facilities and hygienic practices. Often as seen in riverine areas, where people defecate in the river/stream and in the absence of any other water source, people collect water for drinking and cooking from there and when without boiling/treating people drink water, then they get various kinds of diseases.

3. **Soil-Transmitted Helminths (STH):** This category contains the soil-transmitted helminth (STH) whose eggs are passed in faeces. They are not

[16] Adopted from sanitation in schools, UNICEF, Dushanbe, Tajikistan

immediately infective to human and undergo a period of development (usually in moist soil). If latrine is poorly maintained and the floor becomes soiled, it can become focus for transmission.

The eggs of STH can survive for months between hosts. Any faecal material that has not been adequately treated must not reach the soil for re-use.

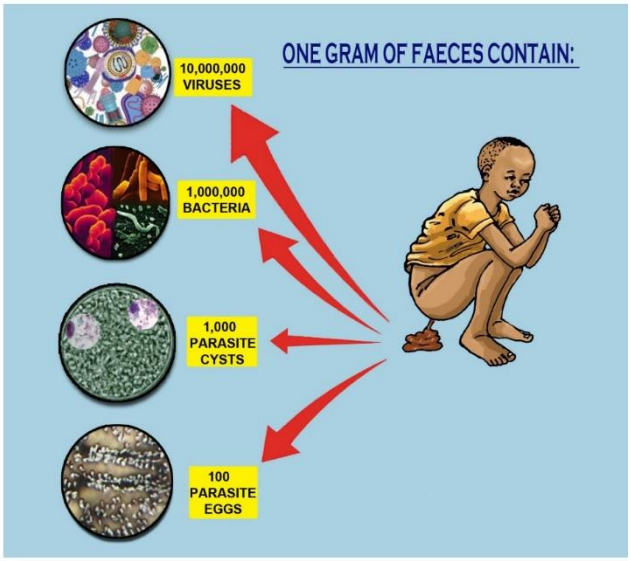
4. **Water-based helminths:** These helminths need an aquatic host or hosts to complete their life cycles. They then re- infect man through the skin or when insufficiently cooked fish, crabs, crayfish or aquatic vegetation are eaten. Appropriate excreta disposal method can be adopted to control them by preventing untreated excreta from reaching water in which the aquatic hosts live.

5. **Excreta- related insect vectors:** These are infections, which can be spread by excreta related insect vectors and these are mosquitoes, flies and cockroaches. They carry pathogenic organisms on their bodies and in their intestinal tracts. They breed in exposed excreta and flooded pit latrines.

Classification of excreta related infections (Indicative list)

Category	**Infection**	**Transmission route**	**Major control measures**
Faecal-oral (non-bacterial)	Diarrhoea, Amoebic dysentery, Hepatitis A, Poliomyelitis Giardiasis, Entrobiasis	Person to person contact; Domestic contamination	Domestic water supply; Improved housing ; Provision of hygienic toilets; Health/hygiene awareness
Faecal-oral (bacterial)	Typhoid, Paratyphoid Diarrhoea, Dysenteries, and, E. Coli diarrhoea, cholera.	Person to person contact; Domestic contamination; Crop contamination	Domestic water supply; Improved housing; Provision of hygienic toilets; Health/hygiene awareness; Excreta treatment prior to land use/discharge.
Soil transmitted helminths (STH)	Ascariasis, hookworm,	Yard contamination; Field contamination	Provision of hygienic toilets; Keeping the floor of toilets clean; Excreta treatment prior to land use.
Water-based helminths	Schistosomiasis Clonorchiasis	Water contamination	Provision of hygienic toilets; Excreta treatment prior to land use/discharge; Control of animals harbouring infection; Consumption of sufficiently cooked food.
Excreta-related insect vector	Filariasis	Breeding of insects in faecal contaminated sites	Elimination of potential breeding sites Use of mosquitoes net

- Overall harmful organisms transmit excreta related human diseases through agents of many important infections escape from the body in the excreta and then eventually reach to others; and unhygienic disposal of excreta encourages breeding ground for insects, flies, cockroaches and mosquitoes, which also acts as agent for spreading diseases.



- **One gram of faeces contain:**

Many people do not know that human excreta is full of viruses, bacteria, parasite cysts and parasite eggs and even one gram of excreta contains 10,000,000 (10 Million) viruses; 1,000,000 (One million) bacteria; 1,000 parasite cysts and 100 parasite eggs[17].

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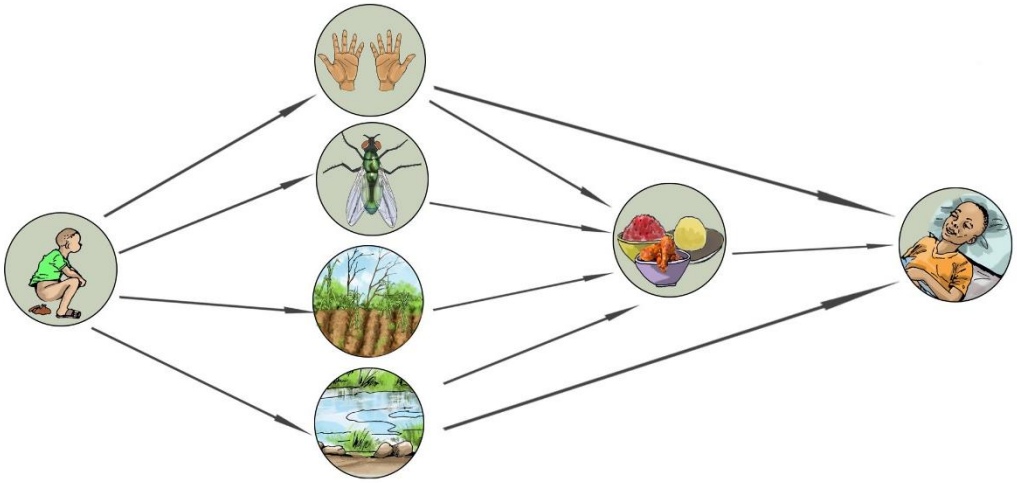
[17] WHO/UNICEF

3. DISEASE TRANSMISSION ROUTES (F DIAGRAM)

For easy understanding regarding the route of these diseases are explained in the below diagram, that how diseases are transmitted from one person to another. **It is like eating shit and drinking shit** (**See F-Diagram**)

- Disease transmission occur across following routes:
    I. **Fingers** (excreta sticks to hands, fingers and under the nails)
    II. **Flies** (flies, cockroaches sit on excreta and then on food)
    III. **Fields** (excreta goes to field and then unwashed raw vegetables eaten)
    IV. **Fluids** (excreta mixes with drinking water)



F - Diagram: Disease Transmission Routes

- There is a general thinking that children's excreta is harmless and with this notion generally it is not handled safely, particularly by mothers, as often it is seen that mothers do not wash their hands with soap after cleaning the children bottom or disposing of children excreta. This causes many excreta related diseases and children are most vulnerable to them. It is important to make people / mothers/ caretakers understand that children's excreta is equally harmful as that of adults.

- To prevent the incidence of disease it is important that hygienic practices must be adopted, which will break any or all of the routes of transmission of micro-organisms from excreta (faeces).

- As human excreta is the biggest cause for spreading many diseases, so it is necessary that excreta should be safely disposed of and it should not remain exposed. This means the construction and use of sanitary latrine, is the best way of safe disposal of excreta. In the above-mentioned **F-diagram** it is easy to put barriers on various routes to prevent the occurrence of diseases.

- It is most important that to stop the occurrence of disease with hardware (construction of latrine) interventions clubbed with software interventions (hygienic practices). In the F-diagram we can see the barriers put into the Faecal-Oral routes of disease transmission.

- **Primary barriers (Constructing facilities – hardware aspects)** are:

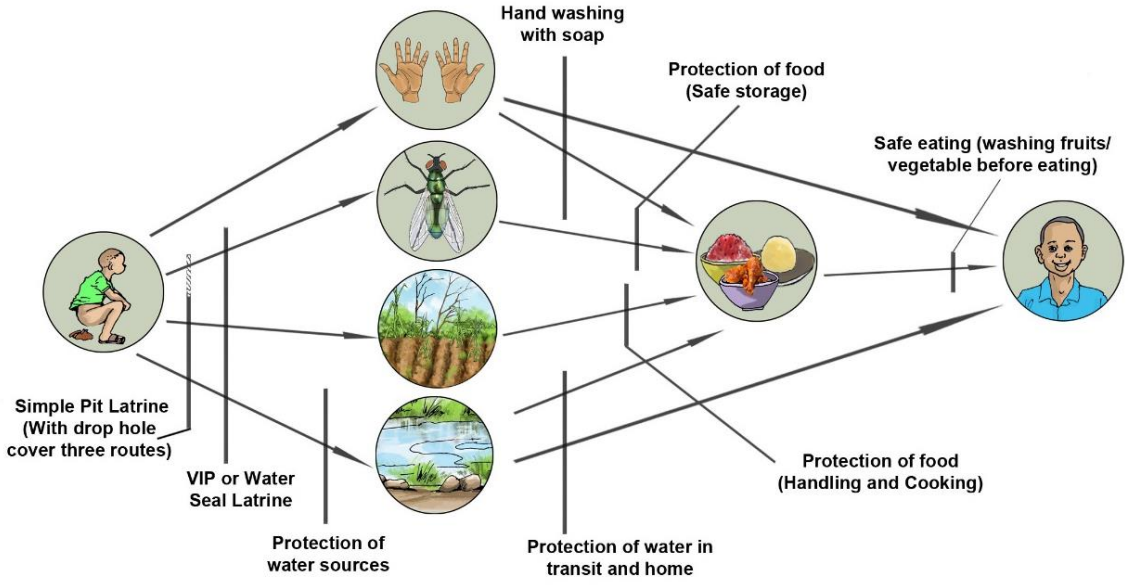
  I. Lined pit latrine (barricade two routes) with cover on drop hole (barricade three routes);

  II. VIP or Water seal latrine (barricade three routes);

  III. Protection of water source (barricade a route which causes contamination of water).

- **Secondary barriers (Promoting Hygiene Practices –Software aspects) are:**
  I. Hand washing with soap <u>after</u> defecation, cleaning children excreta and disposing of children excreta; Hand washing with soap <u>before</u> eating and feeding/breast feeding.
  II. Protection of food (through safe storage, covering it).
  III. Protection of food (through handling and cooking) and safe eating (washing fruits and vegetables before eating them raw).
  IV. Protection of water at source, in transit and at home.

- It is evident that hygiene behaviour has a critical influence on the transmission of faecal diseases at various stages and can prevent it by creating barriers.



***Barriers* on Disease Transmission Routes**

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SECTION-II

3. WHAT IS HYGIENE PROMOTION?

- **What is hygiene:** The word hygiene is derived from the Greek word *hygieinos* meaning healthful, or relating to health. As we use it, the term hygiene is the 'practice of keeping oneself and one's surroundings clean, especially in order to prevent illness or the spread of disease'[18]. Implementers of Water, Sanitation and Hygiene (WASH) programme generally recognize that people need to behave in a hygienic manner to protect water supplies and ensure that sanitation facilities are used properly.

- **What is hygiene education:** Generally, hygiene education is about developing, increasing, enriching people's understanding and imparting knowledge by informing/educating them or raising their awareness level about the links between bad or undesirable hygiene practices and bad health. For decades development programmes/ agencies assumed and thought that educating people or merely distributing related IEC materials, will result in adopting the hygienic behaviours by targeted segment of the society. But that has had not happened. Behavior change for adopting good hygiene practices is a complex process and unless there is 'felt need' for it, no one adopts new hygienic behaviours.

- **What is hygiene promotion:** It is a much wider concept than hygiene education. It is an umbrella term, which uses to cover a range of strategies which aim to improve people's hygiene behaviour and so prevent the spread of water and sanitation related diseases. It builds upon certain evidences such as what people know, do and want and therefore focuses on specific indicators for planned and systematic interventions to support targeted audience to take action to avert water and sanitation related sickness, and to best use the benefits of safe water and sanitation facilities.

- Many studies have suggested that the impact of good hygiene practices on sanitation - related diseases could be as great as that of the actual provision of sanitation facilities. Successful hygiene promotion is widely believed to be one of the most valuable tools to decrease the diarrhoeal diseases. Life skill based hygiene practices are a way to inspire participation and empower children and communities. Despite this noticeable knowledge, hygiene promotion is still often given far less emphasis than installing traditional water supply and sanitation facilities, as donors look for physical and financial progress of the WASH program.

- Hygiene Improvement Framework (HIF) states that hygiene improvement takes place including overall health benefits to every section of community when following three things are in place:-
    a) Hygiene Promotion
    b) Improved access to hardware for WASH
    c) An enabling environment

[18] *Boot and Cairncross, 1993*

- Hygiene promotion is about putting in place a process whereby people (children, women and men) effect and sustain a hygienic and healthy environment for themselves. This is done by creating barriers to prevent agents of transmission of diseases and by lessening the main risky hygiene practices. Safe disposal excreta and hygiene behaviour are essential for the dignity, status and wellbeing of every person, rich or poor, irrespective of whether they live in rural areas, small town or urban centres.

- Primary barriers to diarrhoeal and other water-related disease transmission include both physical infrastructure including household sanitation and hygiene practices, such as station for washing hands with soap after touching/handling excreta. Experience has shown that sustained improvements in access to sanitation and sustain changes in hygiene behaviours require an appropriate enabling environment (of policy, organization, finance, management and accountability)

Hygiene Promotion[19]

- Is the planned and systematic preventive measure and attempt to allow people to take appropriate action to avert water and sanitation related diseases, and provides a practical way to facilitate community participation and accountability.
- Is vital to a successful WASH intervention. Effective hygiene promotion is based on dialogue and interaction with affected communities while working in partnership with them.
- Merges beneficiary knowledge/insider (what do people know, do and want) with outsider knowledge (e.g. the causes of diarrhoeal diseases, communications and learning strategies)
- Includes (but is not exclusively) the delivery of information and learning opportunities regarding perspectives of personal and environmental hygiene, including safe water facility, safe excreta disposal, drainage, solid waste disposal and vector control.
- Provides the crucial link between people in the community and the technical interventions during all stages of a project cycle.
- Has a narrower focus than health promotion, but both try to empower people to take action to prevent illness.

[19] Adopted from Ferron s., 1998

- The main areas of focus for hygiene promotion programmes are:
  - Appropriate use and maintenance of sanitation facilities;
  - Safe disposal of excreta (including faeces of infants and small children);
  - Hand-washing with soap after defecation, before eating food, before feeding/breastfeeding children;
  - Safe water for drinking, safe storage and safe handling; and
  - Control of flies and other insect vectors

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5. OBJECTIVES OF HYGIENE PROMOTION STRATEGY IN NIGERIA

- In Nigeria, there have been various hygiene related interventions made in the past through HIF, hygiene education and by using various media and channels. However, that did not yield desirable results as was expected. Even after launching of CLTS in 2008, a tremendous progress was made to achieve ODF villages but that success did not reflect in hygiene related behavior changes.

- As hygiene promotion has emerged a key and vital intervention to get the benefit from water and sanitation facilities, it also helps to acquire knowledge to understand the relationship between good health and good hygiene. It has a short, mid and long term objectives as defined under:

No.	Short Term	Mid term	Long Term
1.	To make people understand the need for change in existing hygiene behaviours.	To make people understand the relationship between good health and good hygiene and maximum number of targeted population adopt good hygienic practices. To support people to acquire new hygienic behaviours and they become advocate for it and motivate others to do so.	To support people to sustain newly attained hygienic behaviours and then pass -on to the next generation by the family.
2.	To explain the links between the good health and good hygiene practices.		
3.	To make people understand the need for construction of a household latrine.	To empower the people to proudly use household latrine by every member of the family and children's excreta is also disposed of, in it.	To support people to understand the need for up-gradation of their existing latrines to new technologies, especially to water seal latrines.
4.	To reduce occurrence of diarrhoeal cases as soon as targeted audience start adopting new hygienic behaviours.	To support the reduction in diarrhoeal cases and also under five year age child mortality.	To support an individual, families and community as a whole to maintain the sustainable high standard of hygienic practices.
5.	To make pupil understand the importance of hand washing with soap.	Pupil understood the importance of hand washing with soap and they sustain this practice lifelong.	Hand washing with soap practice is passed from generation to generation.
6	Introduction of Child (school pupil) as agent for change.	Child recognized as agent for change.	Overall child at the helm of affairs for hygiene related behavior practices.
7.	To make people understand the importance of safe water, use of protective source and danger of using raw	To empower the people to use water from safe source or make drinking water safe (by boiling or treating) before consuming it.	People's health improves and decrease in diarrhoeal and cholera cases noted.

	water from un-protective sources.		
8.	To make people and specially pupil and children understand the importance of good personal, food and home hygiene.	People, specially pupil and children adopt good personal hygiene behaviours like regular nail clipping, daily bath, wearing clean cloths, wearing shoes, slippers while moving out of the house or using latrines. All cooked food always covered, house are cleaned daily and kept well ventilated.	Pupil and children adopt new personal hygiene behaviours in their day to day routines and pass on to next generation.
10.	To make people understand the importance of environmental sanitation and clean surrounding. Also use of garbage pits in the community.	People keep their community environment clean and use community garbage pits.	Adopt environment cleanliness as part of their routine life and pass on the same habit to the next generation.

- The above mentioned objectives shall be converted to **SMART** objectives **(S-Specific, M-Measurable, A-Achievable, R-Realistic, T- Time bound)** while preparing action plan for implementation of hygiene promotion activities at each project LGA level/ School level.

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6. PROCESS OF CHANGE IN NIGERIA:

- A process of change on adopting hygiene behaviours by targeted audiences will follow when following principles are adhered to:

Principles to the Change Process in Nigeria[20]		
1.	**Maximising public and**	All concerned ministries, especially FMWR, FMoH, and FMoE were widely consulted and inclusiveness promoted. Federal and State

[20] Adopted from sanitation and hygiene programming guidance –WHO/USAID

	private benefits	governments will retain the responsibilities for delivering public policy outcomes (such as safe guarding health of Nigerian citizens, especially children and women). Those representing communities, Schools such as WASHCOMs, VHPs, PTAs, SBMCs, Teachers, Pupil, Parents, Households, village heads, religious and natural leaders must show discipline and participatory approach to help implementers to achieve all objectives (Short, Mid and Long –term) of adopting good hygiene behaviours and better health for all.
2.	**Achieving Equity**	Ensure the voice of the 'un-served' or "hard to reach", "marginalized groups" is heard in the process, including individuals and organizations not currently part of the "formal" system of service delivery. It is mandatory for the WASHCOMs, VHPs that they should through VDCs or otherwise reach to the 'hard to reach', poor and marginalized households to ensure that they are part of the change process within the community.
3.	**Building on what exists and is in demand**	Participants and all stake holders, including, institutions (RUWASSA, LGA, SUBEB ,LGEA), Communities, and Schools must be aware of the existing situation of sanitation and hygiene practices and represent it accurately in the programming process, which includes action plans for implementation at all levels particularly during benchmark/ baseline data collection, Monitoring and Impact evaluation.
4.	**Making use of practical partnership**	Communities and stakeholders (RUWASSA, SUBEB, LGA WASH team, LGEA, WASHCOMs, VHPs, CHEWs, Teachers, Pupil etc) remain to be patient when developing the programming partnership by recognizing that it will be hard to reach to the sustainable targets and then maintain them.
5.	**Building capacity as part of the process**	During the implementation process many stakeholders will be trained (such as Head Teachers, Teachers, EHCs members, Pupil Groups, WASHCOMs, VHPs, LGA WASH Team, LGEA, CHEWs).There is a need to create mechanisms for transferring ideas from the field to the programming process and vice versa. (In the process many more stakeholders will have enhanced capacity through experience). A pool of master trainers will be created in the country for various interventions as per the implementation guidelines for each institution/ community. If programming change are too difficult in some regions/states or LGAs, then to start with smaller scale interventions, which would be more achievable

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7. HYGIENE PROMOTION STRATEGY IN NIGERIA

- In Nigeria, since 2008 Community Led Total Sanitation (CLTS) is being implemented and a good progress has been made for construction of household latrines and provision of safe water sources but significant sustainable hygienic behaviour change has not been noticed among the intervention community member. Even the simplest hygiene practice such as 'washing hands with soap after defecation and before eating food or feeding/breast feeding children is not observed by a large chunk of population in the country. Since families and communities have not adopted good hygiene

practices, thus children are also deprived of that practices, because they learn behaviours from their families.

- In Nigeria over 80,000 primary schools with over 22 million[21] pupil are a readymade network for spreading the messages of adopting the hygienic behaviours by the community members along with children. Nigeria has about 178 million population and out of it estimated 45% population is less than 15 years of age, hence focusing on children as agent for change is vital.

A. Thus, overall Hygiene Promotion strategy will include following:

1. **High visibility of hygiene promotion activities:** Make visible all hygiene promotion activities and hygiene practices (Example: installation of tippy tap type - no/low cost systems for group hand washing practices in schools, markets, religious places and foot operated tippy taps in each household);
2. **Child at the centre of hygiene promotion:** Make child/pupil as agent for change; Give children prominence for adopting new hygienic behaviours and make them catalyst for others behaviour change. (even in communities, main focus will remain on child, as 45% of Nigeria's population are below 15 years of age)
3. **School children as effective communicators:** Motivate children/pupil to carry and disseminate hygiene messages to their families and among community members;
4. **Children/pupils as observers and monitors:** Encourage children/pupil to observe hygiene behaviour of their family members and others in the respective community and accordingly communicate with them. Children shall be good monitors to notice process of behaviour change within their own families and of their neighbourhoods.
5. **Hygiene promotion everywhere:** In a particular area/ ward, for a good result and impact hygiene promotion activities must be launched simultaneously in communities, schools, health centres and market place.
6. **Active involvement of media:** Media will have a vital role in building up the atmosphere in favour of hygiene promotion efforts. Although entire media and its channels will have a key role to play as good inter- personal dialogue will help people to understand the reason for the change through mobilization of a community/schools pupils and electronic media (Radio and Television), social media (Face Book, Twitter, WhatsApp, Instagram, SMSs and similar other platforms) and traditional media will support the cause taken up at grassroots for behaviour change.

[21] Nigeria digest of education statistics (2006-10), Federal Ministry of Education, Nigeria

7. **Active involvement of religious, traditional and natural leaders:** Since religious, traditional and natural leaders have high level of reputation among the communities, thus they will be requested to address the needs for adoption of new hygiene behaviour.

8. **Active involvement of women and youth groups:** For propagating, practicing and monitoring hygiene promotion activities, women and youth (youth groups) will be involved for grassroots activities.

9. **Hygiene promotion will be done in phases:** To start with, limited number of risk behaviour will be promoted in phase - I and when community members attain those behaviours and sustain it then only other risk behaviours will be taken up in phase - II. Duration between phase-I and phase-II shall be, on average six months from the date of CLTS triggering. In other cases, where triggering has already been done, or communities claimed ODF or certified ODF, in that case also phase-I process will have duration of six months from the date the intervention is made through schools or in communities through WASHCOMs, VHPs or CHEWs. (Phase-I, II and III duration details has been described in a table below)

   During phase – I, hygiene promotion emphasis will be on following three areas:-

   i. **Hand washing:** Hand washing with soap **after** defecation, after cleaning child's bottom and after handling of children excreta;

      Hand washing: Hand washing with soap **before** eating food and before feeding/breastfeeding children; (better hygiene through hand washing, food protection and domestic hygiene leads to a reduction of child diarrhoeal cases up to 33%[22]. However in a few cases/countries reduction in children diarrhoeal cases has gone up to 44 – 45%)

   ii. **Excreta disposal:** Use of latrine by all members of a family and no open defecation in any circumstances. Disposing of children/infants faeces into a latrine; (studies show that safer excreta disposal led to a reduction of child diarrhoeal cases up to 36%),

   iii. **Safe drinking water:** Safe handling of drinking water – keep it covered, no dipping of fingers and boiling/treating if collected from unprotected source. (Improved drinking water supply/ consumption led to a reduction of child diarrhoeal cases up to 15-20%)

[22] All figures in per cent are from WELL fact sheet.

- **During phase – II, emphasis will be on the following areas, besides areas covered under phase-I (in some cases both phase – I and phase – II can overlap):-**
    i. Food and home hygiene
    ii. Solid and liquid waste disposal
    iii. Environmental hygiene
    iv. Other issues pertaining to personal hygiene including mandatory use of footwear by all children.

- **During the third phase – III, the focus will be on sustainability, so that all new hygiene behaviours attained during phase –I and II must be sustained for at least two years, so that those behaviours become permanent habits and can be passed from generation to generation.**

10. **Creating benchmark (See Annexure-I) :**Some kind of systematic benchmark on existing hygiene and sanitation practices will be created, wherever 'Hygiene Promotion *in* and *through* Schools' programme will be launched. Other places also some benchmark data will be generated through WASHCOMs and VHPs.

11. **Creating a pool of human resources:** To implement the hygiene promotion strategy a huge pool of master trainers will be required in the country to impart training to teachers, VHPs, WASHCOMs, school inspectors, LGA WASH team members and others. Thus, specific training modules will be created and ToT will be arranged in the country.

12. **Menstrual Hygiene Management (MHM):** MHM in primary schools and communities will be an integral part of an overall hygiene promotion in Nigeria. It will be first introduced in communities and then to primary schools.

13. **Hygiene promotion in emergency situations:** Hygiene promotion in any type of emergency in Nigeria is an integral part of overall hygiene promotion interventions. Special efforts will be made to promote good hygiene practices among Internally Displaced Persons (IDPs) and also to people affected by cholera.

B: Phase-wise schedule for HP interventions and duration for completion:

PHASE-ONE INTERVENTIONS (In geographical areas of all existing project LGAs and in newly added LGAs)		
Interventions areas activities	**CLTS Status**	**Maximum duration for completion of phase-I activities and intervention.**
a) Hand washing with soap **after** defecation, after cleaning child's bottom and after handling of children	Triggering initiated	Six months from the date of CLTS triggering;
	Already triggered, Claimed or Certified ODF	Six months from the date of interventions made through

excreta; **Hand washing** with soap **before** eating food and before feeding/ breastfeeding children; **b)** Safe Excreta disposal including children excreta; **c)** Safe drinking water, including consumption, transportation and handling;		schools or in communities through WASHCOMs or VHPs;
	Not triggered, triggering, initiated, already triggered, ODF claimed or certified;	Six months from the date of interventions of "Hygiene Promotion in and through Schools";
	Not triggered, No CLTS interventions, No WASHCOMs, No VHPs;	One year from the date of interventions in the catchment schools, where "Group Hand Washing" is introduced;
	Not triggered No CLTS interventions, No WASHCOMs, No VHPs;	One year where trained CHEWs will be responsible to make interventions in the communities;

PHASE –TWO INTERVENTION

Interventions areas activities	**CLTS Status**	**Maximum duration for completion of phase-II activities and intervention.**
a) Food and home hygiene **b) Solid and liquid waste disposal** **c) Environmental hygiene** d) **Personal hygiene related issues including mandatory use of footwear by all children.**	All ODF claimed or certified communities and also all communities involved in Phase-I interventions of the Hygiene Promotion.	Maximum six months with or without over-lapping with Phase-I activities /interventions; All interventions through WASHCOMs, VHPs, CHEWs and through Schools.

PHASE –THREE INTERVENTION (SUSTAINABILITY PHASE)

Interventions areas activities	**CLTS Status**	**Maximum completing duration of phase-II activities and intervention.**
All activities listed under Phase-I and II and intensive monitoring by LGA WASH team, LGEA (school inspectors), WASHCOMs, VHPs, School teachers, pupil, CHEWs and media.	All ODF claimed or certified communities and also all communities involved in Phase-I interventions of the Hygiene Promotion.	Maximum two years with or without over-lapping between Phase-I and II activities /interventions; Mainly intensive monitoring by LGA WASH team, LGEA (school inspectors), WASHCOMs, VHPs, School teachers, pupil, CHEWs and media.

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8. KEY APPROACHES FOR HYGIENE PROMOTION IN NIGERIA

- The aim of the hygiene promotion in Nigeria is to motivate people to change their behaviour to lessen high-risk hygiene practices and to create, use and maintain the appropriate sanitation facilities. This change has to be voluntary, and will only take place, if people have felt need for it, and they want to change. Participation and partnership is thus the key to adoption of new hygienic behaviours and success of the hygiene promotion efforts.

a) **Initiate hand washing with soap activity:** When the felt need for change or

reason for adoption of good hygiene practices is lacking among the targeted audience, then the overall effort of the interventions usually go to waste. Thus, as a part of key approach initiate only hand washing with soap at critical times activity for a social status symbol among targeted audience, may be pupil, mothers, women and others. This could be the entry point to target three key areas of phase – I interventions as spelled out under the strategy. Link schools as status symbol, which have Group Hand Washing facilities and they involve pupil for daily practice. Similarly, link installation of foot driven tippy taps at each household level with status and prestige of each household. Then as per strategy initially a few essential risk practices to be targeted for behaviour change in Nigeria. This is linking between health benefits of adopting a good hygiene practice with social status of an individual, family and a community as a whole.

b) **Targeting specific audiences:** These include primary, secondary and tertiary audiences **(See Annexure - II)** like primary school pupil, mothers, mother-in-laws, children, older siblings, fathers, village elder/natural leaders, religious leaders or women groups and youth clubs (if any). One needs to identify who is involved in child-care, and who influences them or takes decisions for them.

c) **Ascertain the reasons for changed behaviour:** While observing and monitoring a process of behaviour change of an individual, family member, a family as a whole or a community as a whole for adoption of better hygienic practices, the people should be facilitated to state the motives for the adoption of the hygienic practices. This approach will help to understand, whether people have new practices for social reasons or for the benefits of better health of family members especially children. By working with the target groups/audiences, it is easy to find out their views on the benefits of good hygiene practices. This provides the basis for life skills, timely information, motivational strategy and specific tasks to pupil, women groups, mothers, motherin-laws, VHPs for observation and sustainable monitoring. Results from this approach will help to scale the approach, as well as strategy for hygiene promotion. **(See- Annexure –III).**

d) **Complex behaviour change processes:** Since behaviour change is a complex process **(See Annexure-IV and V)** and it does not change overnight, it is necessary to continue efforts to persuade the target audience to try the behaviour first and then climb the ladder for change. Two-way continuous information - flow is necessary, for developing the understanding among target groups for the intended behaviour change. It will be a continuous process at least until the year 2022 or until the completion of institutionalization of the hygiene promotion efforts with-in a community, LGA, state and national level.

e) **Positive messages for hygiene promotion:** Positivity is a representation of

creativity, when people are in a good mood and not depressed then they learn best, and they listen for a long time, if they are entertained. Interventions, which attempt to frighten or threaten the targeted audience, are usually not accepted by people. Thus, media needs to be sensitized accordingly and all campaigns to be taken up in positive notes.

f) **Pinpoint appropriate media/channels of communication:** It is necessary to work on cost effective mix of media channels of communication. The media strategy must be developed as per targeted audience practices and patterns in terms of how they communicate and which media channel they listen to or watch. Although inter-personal media will be the most effective tool to communicate with community members, individuals and pupils, including reaching the family members through pupils, VHPs, WASHCOM members and religious leaders, but use of electronic media (TV and radio will give a boost to the efforts done at the grassroots level. For example, how many of them listen to the radio (including which radio station) or watch which television channel, attend which social or religious functions, listen to youth peers or learn from school? Traditional and electronic media are easier to use in this context. The social media is becoming popular among young people in Nigeria, but mainly in urban areas , however within a few years and in a phased manner social media will play a pivotal role in spreading awareness about adoption of good hygiene practices. Several media and channels giving the same messages can reinforce one another. There is always a trade-off between reach, effectiveness and cost of using a particular media or channel. Mass media reaches many people cheaply, but their messages are soon forgotten. For example a message on radio may reach thousands of people simultaneously, but this is only limited to awareness creation (if heard properly) and just by listening to that message no one will change his/her behaviour, reinforcement of information from other media/channel is a must. In Nigeria almost all states have a number of FM stations and many are very popular, similarly at the national level, Radio Nigeria, Voice of Nigeria, BBC Hausa are popular, besides a few other FM stations. These will be made partners at national level as well as state level to broadcast regular programme of hygiene promotion on a weekly basis. Federal Radio Corporation of Nigeria will also be made a prominent partner to run the awareness campaigns in the country. The forthcoming BBC language radio such as BBC Yoruba, BBC Nigerian Pidgin and BBC Igbo will be very helpful to reach maximum number of people. The Federal Government of Nigeria owned television channel NTA, which has presence in all 36 states and FCT will be very effective to convince the target audience to participate in the hygiene promotion campaign.

g) **MHM to be introduced in schools with consent from community members:** Since MHM in schools and communities is an integral part of hygiene promotion strategy, therefore a specific approach is needed for its implementation. It will be better to first introduce the subject in

communities, where CLTS and hygiene promotion interventions have been planned. Once the behaviour change in MHM areas are noticed, then as per relevant policy of Ministry of Education be introduced in the catchment primary schools.

h) **Hygiene Promotion in emergencies:** There are many kind of emergencies often erupts in various parts of Nigeria, such as, it could be Internally Displaced Persons (IDPs) in Borno and some adjoining states, or cholera outbreak in number of states (including some in Southern and Eastern areas), floods or droughts (due to climate change). In these scenarios the hygiene promotion will be taken up as a comprehensive dissemination of selected hygiene messages through various available media and channels. Messages shall be priorities on the areas as mentioned under phase-I on page 30 of this strategy.

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SECTION-III

9. PATHWAYS FOR IMPLEMENTATION OF HYGIENE PROMOTION ACTIVITIES –in Phases and LGAs wise

- Mainly three institutions will be targeted to achieve comprehensive results from various interventions ‘in and through schools’, ‘community’ and ‘in and through health facilities’. Separate guidelines have been prepared to achieve hygiene related behaviour change practices among school pupils, individual community members and those who utilize health facilities. The guidelines are in-line with the hygiene promotion strategy, where high visibility, child as the catalyst and easy flow of information among targeted population have been emphasised.

- The phases of implementation have already been discussed in Chapter -7. Same will be applicable while making interventions ‘in and through schools’ and in the ‘communities’. Specific training will be imparted to the teachers, head teachers and school inspectors for easy and simplified implementation on the basis of daily life skill based activities by involving pupil. Similarly comprehensive training will be imparted to VHPs, WASHCOMs, LGA WASH Team, LGEA and CHEWs for easy implementation of hygiene practices by every individual member of the community.

- Implementation of hygiene promotion, will also be in line with National Road map for ODF status of Nigeria by the year 2025. The ODF targets for Nigeria have been

spread over 11 years, starting from year 2015 to 2025. The country is expecting to achieve the universal goal of 100 per cent sanitation much ahead of targets of Sustainable Development Goals (SDGs) of 2030.

- Through this hygiene promotion strategy and implementation guidelines, it is expected that extensive hygiene promotion activities in Nigeria, in and through schools and in communities will generate an environment in favour of the enhanced sanitation coverage and may result in achieving CLTS targets early, because children are likely to play a key role of catalysts/motivators not only for hygiene related behaviour change but also for construction of household based sanitation facilities.

- In Nigeria, by the year 2025, an estimated 118 million people living in estimated 24 million households[23] will be targeted for ODF status. Initial targets set under the national Road map are:-

    i. During 2016-19, five million population each year;
    ii. During 2019-21, 10 million population each year;
    iii. During 2022- 24, 25 million population each year; and
    iv. Estimated 13 million populations in 2025.

- The time-line for 100 per cent sanitation coverage under national Road Map for ODF status of Nigeria is by the year 2025. Similarly, 100 per cent hygiene related good practices under phase-I, II and III, as mentioned in chapter -7 shall be achieved by the year 2022

- It is possible, that hygiene promotion implementation will be conducted much faster than constructing toilets, as children are expected to pick up good hygiene behaviour quickly and will likely support their family members to adopt new hygiene practices.

(i) **<u>Year 2015</u>:** Preparedness, including formulation and finalization of hygiene promotion strategy. Defining and finalizing various implementation guidelines including (a) hygiene promotion *in* and *through* schools (b) hygiene promotion in communities and market place (c) hygiene promotion in health facilities (d) guidelines for hygiene campaigns, advocacy and commemoration of special days (e) training of LGAs WASH consultants from 11 states - six under SHAWN and five under EU projects (f) introduction of Group Hand Washing in a few schools (g) finalisation of new IEC materials in the form of flash cards and flip charts.

(ii) **<u>Year 2016</u>:** Initiation phase including finalization of training manuals, capacity building, conducting ToTs, master trainers, training of LGEA, LGA WASH teams, teachers, head teachers, WASHCOMs, VHPs, CHEWs. Implementation of phase-I activities of hygiene promotion along with or without triggering in 70 project LGAs under SHAWN (40+30) in six states

[23] Nigeria road map for ODF by 2025

and 28 project LGAs under EU in 14 states. Overall 98 project LGAs comprising estimated 10800 schools, where Group Hand Washing will be introduced. That means over 3 million pupils shall be daily washing their hands with soap by the end of their academic year 2016-17. Around 15 schools per project LGA shall be selected to implement HP in and through schools, totalling estimated 1470 schools.

(iii) **Year 2017:** Initiation of phase I and II activities in 150 new LGAs, while phase –II will also be continued in earlier 98 LGAs and these LGAs (98) will proceed to phase-III activities for consolidation and institutionalization of hygiene related good practices. Overall 150 new LGAs comprising an estimated 16,500 schools, where Group Hand Washing, will be introduced. Thus by the end of the academic year 2017-18, an estimated 27,300 schools will be involved in daily Group Hand Washing activities. That means over 8 million pupils shall be washing their hands daily with soap. Around 15 schools per LGA shall be selected to implement HP in and through schools, totalling 2,250 schools. **A one month comprehensive media campaign on the need for hand washing with soap at critical times will be conducted.**

(iv) **Year 2018:** Initiation of phase-I and II activities in 175 new LGAs, while phase –III will also be continued in 248 LGAs (98+150), 98 earlier LGAs and 150 LGAs introduced in the year 2017. By the end of 2018, the 98 LGAs will have completed phase-III activities of consolidation and institutionalization of hygiene related good practices. Overall a total of 175 new LGAs comprising an estimated 19,250 schools, is where Group Hand Washing will be introduced. Thus by the end of the academic year 2018-19, an estimated 46,550 schools will be involved in daily Group Hand Washing activities. That means about 14 million pupils shall be washing their hands daily with soap. Around 15 schools per LGA shall be selected to implement HP in and through schools, totalling 2625 schools.

(v) **Year 2019:** Initiation of phase-I and II activities in 180 new LGAs, while phase –III will also be continued in 325 LGAs (150+175), 150 LGAs introduced in the year 2017 and also in 175 LGAs introduced in the year 2018. By the end of the year 2019, the 150 LGAs will have completed phase-III activities including consolidation and institutionalization of hygiene related good practices. Overall in 180 new LGAs comprising estimated 19,800 schools, Group Hand Washing will be introduced. Thus by the end of the academic year 2019-20 an estimated 66,300 schools will be involved in daily Group Hand Washing activities. That means that over 19 million pupils shall be washing their hands daily with soap. Around 15 schools per LGA shall be selected to implement HP in and through schools, totalling 2,700 schools. **Additionally, a one month comprehensive media campaign for construction of sanitation facilities at each household level and in public**

places will be launched. AMid-term evaluation of the interventions will also be undertaken for course corrections (if any).

(vi) **Year 2020:** Initiation of phase-I and II activities in remaining 171LGAs, while phase – III activities will also be continued in 355 LGAs (175+180), 175 LGAs introduced in the year 2018 and also in 180 LGAs introduced in the year 2019. By the end of the year 2020, the 175 LGAs will have completed phase-III activities including consolidation and institutionalization of hygiene related good practices. Overall in 171 remaining LGAs comprising estimated 18,800 schools, where Group Hand Washing will be introduced. Thus by the end of academic year 2020-21 an estimated 85,150 schools will be involved in daily Group Hand Washing activities. That means that over 25 million pupils shall be washing their hands daily with soap. About 15 schools per LGA shall be selected to implement HP in and through schools, totalling 2,565 schools.

(vii) **Year 2021:** All 774 LGAs in Nigeria, covered under hygiene promotion interventions along with all primary schools, estimated at 85,100 schools also covered under daily Group Hand Washing activities involving over 25 million pupils will be covered . Phase - III activities will continue in 351 LGAs (180+171), 180 LGAs introduced in the year 2019 and also in 171 LGAs introduced in the year 2020. By the end of the year 2021, the 180 LGAs will complete phase-III activities including consolidation and institutionalization of hygiene related good practices. 3000 schools will be selected to implement HP in and through schools. **A one month comprehensive media campaign on hand washing with soap, safe disposal of excreta and safe handling of drinking water will be conducted.**

(viii) **Year 2022:** All 774 LGAs in Nigeria shall continue with the good hygiene practices. And each house hold in the country shall have hand washing stations either in the form of foot operated tippy taps or permanent stations. The 171 LGAs introduced in the year 2020 shall be completing the phase - III activities including consolidation and institutionalization of hygiene related good practices. 3000 new schools will be selected to implement HP in and through schools.

Table XX in next page explains the targets by year until 2022:-

Year and Phase-wise implementation of hygiene promotion activities in Nigeria from year 2015 to 2022

Year	Activities	No. of LGAs for phase-wise activities[24]			No. of schools implem-enting 'HP in and through schools' (15 per LGA)	No. of new Schools under daily GHW[25] at the end of year	Estimated No. of Pupils involved in daily GHW at the end of year
		Ph - I ½ **year**	Ph-II ½ **year**	Ph-III[26] **2 year**			
2015	Preparedness						
2016	Training manuals, Capacity building, ToTs, trainings of LGEA, LGA Wash Team, Teachers, Head Teachers, WASHCOMs, VHPs, CHEWs. Implementation of Hygiene Promotion activities and monitoring.	98[27]	----	-----	1470	10800	Over 3 million
2017	Capacity building , training, implementation and monitoring	150	98 + 150	98	2250	16500	Over 8 million
2018	Capacity building , training, implementation and monitoring	175	175	**98** + 150	2625	19250	Over 14 million
2019	Capacity building , training, implementation and monitoring. Also mid-term evaluation for course correction (if any)	180	180	**150** + 175	2700	19800	Over 19 million
2020	Capacity building , training, implementation and monitoring	171	171	**175** + 180	2565	18800	Over 25 million
2021	Enhanced monitoring and consolidation	----	----	**180** + 171	3000		
2022	Enhanced monitoring and consolidation	----	----	**171**	3000		

[24] Phase-wise activities as per Chapter-7

[25] Group Hand Washing

[26] No of LGAs (Bold and underlined) will be completing phase-III**.**

[27] 70 project LGAs under SHAWN (40+30) in six states and 28 project LGAs under EU in 14 states

	Total	774 LGAs	774 LGAs	**774 LGAs**	17610[28] Schools	85150 Schools	25 million pupils involved in daily GHW

10. HUMNAN RESOURCE REQUIREMENT AND CAPACITY BUILDING:

- According to the implementation plan mentioned in the previous chapter, it will take a minimum of seven years (from the year 2016 to 2022) to reach all 774 LGAs in the country and over 85,000 schools for daily Group Hand Washing (GHW) activities involving over 25 million pupils. There is a huge financial and human resource implication to implement and sustain the hygiene promotion in Nigeria for an overall behaviour change and adoption of good hygiene practices by each of the citizens of the country.

- As the interventions will be participatory and on the basis of partnership, assuming that the Pupils, PTAs, parents, SBMC, WASHCOMs, VHPs play a pivotal role in promoting the phase - wise hygiene promotion in key areas, on a daily basis and also get involved in observing and monitoring key behaviour changes oat individual, family and community levels as a whole, thus the financing burden on the programme may come down drastically. Also, for daily Group Hand Washing activity in schools - parents, PTAs and SMBC shall take full responsibility for providing required number of tippy tap stands as well as soap on regular basis. However the main financial burden will be on training of master trainers and subsequent training in each year.

Total trained manpower required in the country for HP implementation between 2016-22:

#	Nature of training	Targeted trainees	Calcu-lation	Total Number trained	Duration of training
1.	Training of teachers for daily GHW	One teacher per school from 85150 schools	85150 X 1	85150 teachers	Half day at ward level
2.	Training of teachers for HP in and through schools	2 teachers+ 1 head teacher (=3) per school from 17610 schools	17610 X 3	52830 teachers	4 days residential
3.	Training of LGEA for monitoring	2 school inspectors	774 X 2	1548 LGEA inspectors	2 days residential
4.	Training of LGA WASH team for training of WASHCOMs and VHPs	1 UNICEF consultant + 2 more staff	774 X 3	2322 LGA WASH team	4 days residential
5.	Training of CHEWs for	10 CHEWs per LGA	774 X	7740	4 days

[28] From the year 2023 onwards, HP *in* and *through* schools must be introduce in a minimum of 10,000 schools every year, so that all the schools in the country shall be covered by 2029-30. Since huge trained manpower (master trainers and others) will be available in the country by 2020, thus it will be possible to take –up 10,000 schools per year.

	interventions in community and monitoring		10	CHEWs	residential
6.	Training of SUBEB and Ruwassa along with LGA WASH team and LGEA	1 SUBEB + 2 from Ruwassa (all 36 states + FCT)	37 X 3	111 from states	4 days residential
7.	Master trainers (ToTs) for training of teachers	4 each from 36 states + FCT	37 X 4	148 master trainers	4 days residential
8.	Master trainers for LGA WASH team, LGEA and CHEWs	6 each from 36 states + FCT	37 X 6	222 master trainers	4 days residential
9.	Master trainers for training / sensitization of media (electronic, print and traditional)	Two from each state + FCT	37 X 2	74 master trainers	2 days residential

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- Training of IT professionals will be required for running social media campaigns through WhatsApp, Facebook, Twitter, Instagram and some similar platforms. The actual requirement will be determined in the year 2017 onwards, as expected that by that time, the momentum in hygiene promotion will be generated in the country.

- The above mentioned training requirement will be split on a yearly basis, and according to project LGAs to be taken up in each year for hygiene promotion interventions as spelled out in the implementation plan in the previous chapter. For example in the first year (2016) if 10,800 teachers need to be trained in 98 LGAs for daily Group Hand Washing activity, then training will be spread over six months – meaning that 18 schools per month per LGA at ward level for half a day in a month. This training can be imparted by WASH ward officer in consultation with LGA WASH consultant and LGA WASH Coordinator. In six months' time all the schools (approximately 110 schools per LGA) will have trained teachers for installing and carrying out daily Group Hand Washing activities involving estimated (110 schools X 300 pupils average) 33,000 pupil per LGA. This means that in the first year 98 LGA X 33000 pupil = 3.23 million pupil will be involved in the daily Group Hand Washing activities without incurring any substantial cost, as it will be implemented with assistance and support from parents, PTAs, SMBC, and under PPP mode. Possibly soap companies can be brought in as partners for regular supply of soaps.

- **Example for first year, i.e. 2016**

Targeted schools/each month/each LGA** (1)	Total spread period for training in each LGA (duration of one training is half a day in a month) (2)	(1) X (2)	Total No. of schools per LGA (3)	Total No. of teachers per LGA (4)	Total No of LGA (98) X total Number of schools/teachers (110) (5)
18 schools	6 months	18 X 6	108 schools	108 teachers	98 X 110 = 10780 teachers trained or

		= 108	(rounded off to 110 schools)	(rounded off to 110 teachers)	schools covered

**** If any LGA has more than 110 schools then per month more schools must be added, it could be 30-35 schools per month/LGA. But training of one teacher from each school of one LGA needs to be completed with-in six months period.**

- The above plan will continue on yearly basis until the year 2022.

- For implementation of "Hygiene Promotion *in* and *through* Schools", minimum 15 schools per LGA/per year must be selected in consultation with LGEA. Three teachers (2 teachers + 1 head teacher) per school must be selected before the annual break each year and they need to be trained for four days before opening of school after the annual break, so that they shall start the implementation of programme right from the beginning of academic year by forming or re-forming EHCs and other groups.. Over all 45 teachers will be trained at each LGA level by the master trainers. The number of schools per LGA can be increased up to 20 -25 or even 30 schools, if LGAs geographical area is large and numbers of schools in the LGA are more than 110 schools.

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11. ROLE AND RESPONSIBILITIES OF STAKEHOLDERS

- Hygiene Promotion interventions does not stand alone, it is a part children health, education and overall development of the child. Thus, there is a need to develop partnership among various stakeholders from the national level to the community and school level. Partnership s with organisations such as:-

  a) National Task Group for Sanitation (NTGS) - State Sanitation Task Groups (STGSs);
  b) Federal Ministry of Water Resources – Ruwassa, LGA WASH Team;
  c) Federal Ministry of Education –SUBEB, LGEA;
  d) Federal Ministry of Health – PHCs, Health facilities and CHEWs;
  e) Federal Ministry of Information – NTA (TV News), Federal Radio Corporation of Nigeria;
  f) Federal Ministry of Environment;
  g) Civil society organizations, including NGOs (International, National, State level and local) and CBOs;
  h) SBMC, PTAs. Parents, women groups, youth clubs and faith-based groups;
  i) Religious groups;
  j) Donor agencies (Multilateral and bilateral) – DFID, EU and others;
  k) International organization - UNICEF, WATERAID, WSSCC and others;
  l) Private sector, including private companies and foundations, soap manufactures at national and state level, Jerrycan, water bottle and string manufactures;

m) National level training institutes (for teachers, CHEWs) and research institutions;
n) Media (Electronic, print, traditional and social) at national, state and local level.

- The partnership among various stakeholders will help for effective interventions for hygiene promotion through participatory approaches. The partnership at various levels will help for the sustainability of the programme and also to make hygiene promotion in Nigeria as a people's movement. Besides, it will help to address the key gaps during implementation through periodic interaction under the leadership of NTGS at the national level.

- An enabling environment through FGN policies and committed political will with adequate funding from donors and International organization for construction of WASH facilities (water and sanitation) in schools and health centres will help to accelerate the pathways for adopting the good hygiene behaviours by the citizens of Nigeria.

- The most important aspect is which nodal ministry will own the hygiene promotion programme in Nigeria. Technically, Federal Ministry of Water Resources (FMWR) is the ministry in-charge of implementing water and sanitation (CLTS) programme in the country through RUWASSA, thus basic responsibility of hygiene promotion interventions remains with the FMWR. However, under the strategy all primary schools will be targeted for carrying out daily Group Hand Washing with soap activities in the country along with a detailed life skill based "Hygiene Promotion *in* and *through* Schools" intervention in selected schools of each project LGA. Since primary schools are directly working under SUBEB and LGEA, thus the Federal Ministry of Education becomes responsible at national level for 'hygiene promotion in and through schools', besides all other intervention in schools for the benefit of pupil and their family members..

Who does what and how long?

Stakeholder /Partner	Roles and Responsibilities					
	National Level	**State Level**	**LGA Level**	**Community level**	**School level**	**How Long**
FMWR	Policy development, engagement with partners, donors, multilateral /bilateral organization, ToTs, monitoring, coordination with NTGS;	Implementation of water + sanitation (CLTS) through RUWASSA, Training for CLTS, hygiene promotion, Yearly action plan;	Implementation of water + sanitation (CLTS) through WASH LGA team, yearly action plan;	CLTS triggering by LGA team, training of WASHCOMs, VHPs, monitoring;	Providing water and sanitation facilities – hardware, also support HP and daily GHW activity;	Until 2025
FMoE	Policy development on daily GHW and HP in & through schools, Coordination with FMWR and NTGS;	Action Plan development through SUBEB for daily GHW and HP in & through schools, Coordination with RUWASSA;	Action Plan development through LGEA for daily GHW and HP in & through schools; Overall supervision for implementation of all HP related activities in schools, Intensive monitoring by school inspectors, Coordination with LGA WASH team;	In consultation with LGA WASH team - Observing involvement of teachers and pupil under HP through schools;	Assuring daily GHW in all schools of a project LGA and life-skill based activities in the selected schools; Monthly monitoring and sharing with LGA WASH team;	Until 2029
FMoH	Policy development linking HP with childhood related diseases (WASH) and IMR. Also linking HP with nutrition and control of STHs;	Identifying and focusing mal-nutrition sensitive areas, Dirrahoel infection, cholera endemic and STHs related sensitive areas	Supporting PHCs and health facilities on HP issues. Deputing CHEWs for HP in areas for HP interventions in the communities, where schools interventions or CLTS has not started;	Training and sensitizing relevant groups (women, youth, others) at community level for HP and CLTS activities;	Supporting daily GHW activity in each school, Periodic check on STGs and overall adoption of Hygiene habits by pupils;	Until 2025

FMoEnv	Policy development on house and community based pollution, safe disposal of non-bio degradable items including polythene bags etc;	Support states to implement policy relevant to HP and better environmental practices;	Support better environmental practices for , safe disposal of non-bio degradable items including polythene bags etc;	Support communities through LGA WASH team for, safe disposal of non-bio degradable items including polythene bags etc;	Help schools to adopt good practices for better environ-ment;	Until 2025
FMoI	Policy development for HP through electronic, print, traditional and social media for regular awareness creation programme;	Support training and sensitization of relevant electronic, print and other media for regular media campaigns on periodic basis;	Support media to do LGA level success stories and disseminate through electronic, print and other media;	Support media to interview relevant individuals, families or community members, who have changed their hygiene related behaviours and disseminate that through relevant media and channels;	Support media to document pupil and teacher's experience on HP and good hygiene practices and disseminate that through relevant media channels;	For- ever on regu-lar basis
NTGS	Have periodic meeting and assess HP interventions at schools and in communities, Overall keep a watch on HP related national level developments;	Support STGSs for smooth implementation of HP interventions	Support monitoring through STGSs and other stake holders	Support monitoring through STGSs and other stake holders	Support monitoring through STGSs and other stake holders	Until required
UNICEF	Provide technical and financial support, provide resource persons for developing relevant training and other modules;	Provide financial and technical support, including resource persons for ToTs;	Provide technical support through WASH consultant, including resource persons for ToTs;	Support triggering of CLTS, WASHCOM and VHPs training, monitoring and observation of behavior change practices;	Support daily GHW activity, HP in& through Schools, monitor-ring in-consultation with LGEA/ school inspector on HP related interventions;	Until 100% of objectives achieved.

WaterAid, WSSCC	Provide technical and financial support and other relevant support required by FGN;	Provide financial and technical support, including resource person for ToTs;	Provide technical support through WASH consultant, including resource person for ToTs;	Support triggering of CLTS, WASHCOM and VHPs training, monitoring and observation of behaviour change practices;	Support daily GHW activity, HP in& through Schools, Also suppot monitor-ring at grassroots;	Until 100% of objectives achieved.
Donors	Increased financial Aids, until every Nigeria adopt good hygiene practices.	_____	_____	_____	___	Until 2030
Civil Society, NGO, CBOs	Must build up an environment in favour of HP, which can be turned to people's movement in Nigeria for adopting good hygiene practices;	Help states to build up an environment in favour of HP, which can be turned to people's movement in a state for adopting good hygiene practices;	Support LGAs to build up an environment in favour of HP, which can be turned to people's movement in a LGA for adopting good hygiene practices;	Support Communities to build up an environment in favour of HP, which can be turned to people's movement in respective communities for adopting good hygiene practices;	Support school to build up an environment in favour of HP, which can be turned to pupil movement in respective areas for adopting good hygiene practices;	Until 100% achievem ent of good hygiene practices;
SBMC, PTAs. Parents,	-----	------	------	Discuss and decide how to support schools as a medium to promote HP in communities; support, Motivate community members for acceleration of adopting good hygiene practices;	Support schools for daily GHW activities, HP in & through Schools by providing relevant materials and soap on regular basis;	Until every-one adopt good hygiene practices
Women groups, youth clubs and faith-based groups;	-----	-----	------	Support all efforts for HP in community	Support all efforts for HP in schools	Until every-one adopt good hygiene practices
Religious leaders	Support all efforts for	Support all efforts for HP in a	Support all efforts for HP in a	Support all efforts for	Support all efforts	Until

	HP at national level	State	LGA	HP in community	for HP in schools	every-one adopt good hygiene practices;
Private sector including soap and Jerry can manufacturers	Commitment to support No of schools for provision of soap and Jerrycans on regular basis	Commitment to support No of schools for provision of soap and Jerrycans on regular basis	Commitment to support No of schools for provision of soap and Jerrycans on regular basis	Commitment to support No of communities for provision of soap and Jerrycans on regular basis	Commitment to support No of schools for provision of soap and Jerrycans on regular basis	Until 100% adoption of good hygiene practices achieved.
National Level training and research institution	Commitment to impart HP training to teachers and CHEWs as institutionalized basis in Nigeria	-----	-----	----	----	As per demand
Media	Electronic (TV and radio) and print media must build up an atmosphere at national level in favour of HP in the country through doing various programmes on national level channels by radio and TV and also through articles in various newspapers;	Electronic (TV and radio) and print media must build up an atmosphere at state level in favour of HP in through doing various programmes on state level channels by state radio and TV channels and also through articles in various newspapers;	Electronic (TV and radio) and print media must visit project LGAs and interview with relevant officials on progress of HP and how people are involving themselves in the programme; Similarly goof articles need to be published in local newspapers to support the HP initiatives;.	Electronic (TV and radio) and print media must visit communities and interact with community members, pupil, families and also observe how people are motivated to change their hygiene related behaviour; Good features shall be created by electronic media . Also print media do the same;	Electronic (TV and radio) and print media must visit schools and see that how pupil are involved in HP activities and how pupil became the change ffor agent for their family members and their neighbours; Also print media do the same;	Continue until 2030

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12. STRATEGIC COMMUNICATION FOR HYGIENE PROMOTION:

- The basis of hygiene promotion is the use of strategic communication from the beginning untill the objectives are achieved. Also, the basis of effective strategic communication is appropriate and timely interventions for key indicators generated from qualitative and quantitative methodologies (KAP surveys, baseline data, structured observations etc.). Thus, entire communication interventions shall be based on evidence.

Elements of strategic communication:

1) Advocacy
2) Social Mobilization
3) Programme Communication
    i. Communication for social and behaviour change - Risk communication
    ii. Communication for immediate interventions - Outbreak Communication

1) Advocacy

- Advocacy for hygiene promotion interventions is a continuous process at multi levels aimed at influencing policy decisions and attitudes of various stake holders (at national, state, LGA and local level). Advocacy will help to 'act/ take-decisions' to hygiene related short and long term risks, including cholera outbreaks or Avian flu or Ebola type pandemics.

- Sustained and regular advocacy will help to raise awareness about hygiene related risks among different audience segments and also among experts, media and civil societies.

- Advocacy also suggests specific solutions to various indicators emerging out of formative research/ studies/ survey especially related to hand washing with soap as well as related to Knowledge, Attitudes and Practices (KAP) about hygiene practices etc.

- Advocacy at the community and local level can help educate leaders (religious, political), influential people, opinion leaders, teachers, women group, WASHCOM members etc to motivate people to adopt good hygienic behaviours.

2) Social Mobilization

- Social mobilization is a comprehensive planning approach that emphasizes coalition building and community action, like meeting of community members for CLTS triggering.
- Social mobilization is a broad scale movement to engage people's participation in achieving a specific goals, like increasing the sanitation coverage in Nigeria and adoption of good hygiene behaviour. It involves all relevant segments of society including decision/policy makers, opinion leaders, professional groups, religious leaders, natural leaders, communities and individuals.

- It is a planned decentralized process that seeks to facilitate change for development through adoption of good hygiene behaviours.It takes into account the felt needs of the people, embraces the critical principle of community involvement, and seeks to empower individuals and groups for action.

- It is the process of bringing together all feasible and practical inter-sectoral social allies to raise people's awareness related with hygiene promotion and to strengthen community participation (observing, monitoring, reporting about improving hygiene practices) for prevention and control of WASH related diseases.

3) Programme Communication

- Communication is a process whereby information is enclosed in a package, then channeled and imparted by a sender to a receiver via some media/medium (electronic, print, traditional and social). The receiver then decodes the message and gives the sender a feedback.

- Programme Communication objectives particularly related with Social and Behaviour Change Communication (SBCC) for hygiene promotion can be best be achieved if effective two-way communication is practiced rather than just limiting to the one - way communication i,e distribution of leaflets, flyers, posters or simply airing the messages through electronic media (Radio and Television). Inter-personal communication is considered as most effective way to communicate for behavior change for hygiene promotion and related issues.

- It is generally seen and felt that acquisition of knowledge does not automatically convert to practice, unless there is a felt need for it. Thus, the communication package must be focused and weaved around the felt needs of the targeted people/ community (on the basis of evidences), rather than the felt need of the sender(s)/implementer..

a) **Social and behavior change communication (SBCC)** for risk communication shall be carried out through mix of various media and channels. As said earlier, the inter-personal communication, which is a two way communication, is the most effective way to communicate with target audiences with the help of IEC tools (flash cards, flip charts, posters, cartoon booklets or similar tools. Besides,

films, documentaries, video spots, audio clips, etc. shall also be used while addressing a gathering or socially mobilized community members). The grassroots based traditional media is also very effective if message is woven through entertainment and attractive in presentation with little input of comedy. The whole idea is to emphasize on Edutainment.

The use of electronic media (Radio and Television) are the best, if used for building an atmosphere in favour of particular campaign (i.e. hand washing with soap or construction of latrines etc). Both radio and television have wider reach to the masses and easy to communicate with them but both have certain weaknesses. As messages broadcast from radio are audible, thus retention is limited, unless same messages have been given at the grassroots either through social mobilization process or in some other way through inter-personal communication. In that way message from radio work as re-enforcement and also help in building atmosphere in favour of interventions. A message telecast from television has more retention than the radio due to colourful visuals. However, the timing of the broadcast/telecast of messages along with radio/television channel(s) is more important as targeted audience should be able to listen or view the programme. It should not have happen that when programme is aired then target audience is not free to listen or view it. In Nigeria, NTA is popular channel of television and is viewed all over the country and also have state specific programme aired through it. It can easily be made partner for hygiene promotion, besides, other popular television channels at the state level. Similarly radio channels needs to be chosen on the basis of its listeners profile and range.

Print media (Newspapers) in Nigeria is either based in Lagos or in Abuja and it is important to build up partnership with a few of them, so that they write regular column on periodic basis on importance of hygiene promotion and role of various stakeholders. This will help to support advocacy at the FGN level as well as at states level. Also, it will help to attract new donors for the programme.

b) Outbreak Communication is a kind of communication held during emergencies arising out of civil war, earthquakes, floods, movement of IDPs, epidemic/pandemic, (Cholera, Ebola, Avian Flu, Zika fever type) outbreaks in Nigeria. This communication could be an announcement of outbreak (i.e. cholera), precautions (washing hands with soap, use of latrines, handling of safe drinking water, food hygiene etc.) to be taken by targeted audiences. Besides, what government would be doing to mitigate the suffering of the affected population. Various type of IEC material related with hygiene practices would be a good intervention to make people aware of danger of unhygienic conditions and unsafe drinking water and unsafe food. Under the outbreak communication the most important thing is to appoint one spokesperson for the FGN, state level spokesperson and UN agencies spokesperson. ‘Trust’ is the basic ‘hallmark’ of outbreak communication thus targeted audience needs to be told the factual situation.

- The elements of strategic communication to be applied in Nigeria at national, state, LGA, community and school level with variety of media and channels for effective implementation of hygiene promotion in the country. Each of the element of strategic communications is described in a table below:-

Elements of Strategic Communication	**National Level**	**State Level**	**LGA Level**	**Community and School Level**	**Media/ channels**
Advocacy	- With FGN (Ministries) Policy development for enabling environment; -With Donors for more funding; -With NTGS for active support of partners; -With national level media for regular focus on hygiene promotion.	- With Governors /Deputy Governors for timely release of funds (Government share); Also release of operational funds for LGA WASH team and LGEA; - With state level media for regular focus on hygiene promotion; -With SUBEB and RUWASSA for timely and effective interventions of HP activities in LGAs, communities and schools.	-With LGA chair-person for overall coordi-nation of HP activities in the LGA; Also release of monthly opera-tional funds; - With all elected represent-tatives for overall support to the HP programme.	- With community leaders, religious leaders for an overall support to the HP; -With women and youth groups; -With head teachers of schools.	-Use inter-personal media mainly to do advocacy at National, State and all other levels; -Advocacy kits as a tool (with evidence base data) shall be developed for sharing at all levels for effective advocacy; -Motivate media at all levels to promote importance of hygiene practices.
Social Mobilization	- Prepare partners at national level to mobilize	-Prepare partners at state level to mobilize	-Prepare partners at LGA level to mobilize pupil,	-Mobilize communities at local level for CLTS	-Motivate media (especially electronic media) for build

	pupil, people for celebration of 'Global Hand Washing Day'.	pupil, people for celebration of 'Global Hand Washing Day'.	people for celebration' Global Hand Washing Day.	triggering; -Mobilize communities to support daily GHW activities in schools; - Mobilize pupil, people for celebration of 'Global Hand Washing Day'.	up an environment for social mobilization grassroots to undertake latrine constructions as well as adoption of hygienic practices.
SBCC	At National level, build up the capacity of master trainers to implement the HP programme in communities, schools, health facilities; Also build up capacity of national level media (with evidence – data) for becoming partner in promoting the HP; Develop Advocacy kits with authentic data, pix, videos, testimony (audio and visual) for importance to be given to HP;	At Statel level, build up the capacity of master trainers to implement the HP programme in communities, schools, health facilities; Also build up capacity of statel level media (with evidence – data) for becoming partner in promoting the HP; Develop Advocacy kits with authentic data, pix, videos, testimony (audio and visual) for importance to be given to HP;	At LGA level, build up the capacity of master trainers to implement the HP programme in communities, schools, health facilities; Also build up capacity of LGA level media (with evidence – data) for becoming partner in promoting the HP; Develop Advocacy kits with authentic data, pix, videos, testimony (audio and visual) for importance to be given to HP;	At local level in communities and at schools extensive IEC tools (print, electronic, social) must be used to communicate with pupil and community members to make them understand the risk by continuing with unhygienic behaviours as well as danger from open defecation or unsafe disposal of excreta and also consumption of untreated water procured from unprotected sources.	Traditional media, must be mixed with new media (use of Information Communication Technology –ICT).

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13. LINKAGES BETWEEN HYGIENE PROMOTION STRATEGY and Guidelines for "hygiene promotion *in* and *through* schools" and "hygiene promotion in communities"

- The "National Hygiene Promotion Strategy" in Nigeria, recognises the child as an 'agent for change' and emphasises on 'high visibility of hygiene promotion activities', along with implementation in phases and on a yearly basis to achieve universal coverage by 2022 in the country. A set of separate detailed guidelines has been prepared to implement hygiene promotion, which includes guidelines for (i) Hygiene promotion "*in* and *through*" Schools (ii) Hygiene promotion in communities and market places (iii) Hygiene promotion in health facilities (iv) Guidelines for media campaigns and commemoration of special days.

- These guidelines are basically step by step approaches to implement hygiene promotion and sanitation activities in various possible scenarios in the country. The guidelines underlying the importance of direct relationship between catchment schools and communities on adoption of new hygiene behaviours of targeted audiences. To start with, daily "Group Hand washing" has been recommended in all primary (over 85,000) schools in the country, to be covered in seven years, so that catchment communities shall be impacted and motivated to adopt the practice of hand washing with soap at critical times, besides other good hygiene practices.

- The guidelines propose an interaction between school teachers, pupils, parents, PTAs, WASHCOM, VHPs and other community members in order to generate an environment in favour of complete coverage of sanitation by building household latrines under the Community Led Total sanitation (CLTS) and helping to form the child friendly environment in schools, households and in the community, which may result in better health for the children and reduced child mortality

- Life skill based activities practiced daily by pupils in schools for adoption of new and improved hygienic behaviours are the basis of these guidelines. The guidelines consider the child as "agent for change" with the expectation to motivate others in the family for adopting good hygienic behaviours and thus galvanizing the whole community towards accelerating the behaviour change processes.

- As explained in the strategy that high visibility of hygiene promotion activities, be in schools or in communities, this is expected to galvanize the targeted population to adopt new behaviours. In the process, the intensive interaction between PTAs, parents, SBMC members within schools for installing minimumstandards in every school (two stands per class) for daily

‘Group Hand Washing’ will not only give a boost to the visibility aspect, but will generate curiosity for adoption of new hygiene behaviour and will have much greater impact when community member watch hundreds of pupils washing hands with soap together daily. Construction of foot operated jerrycan type tippy tap in each household of the community will also ensure the visibility of hygiene promotion programme as well as benefits of hand washing with soap.

- Hygiene promotion strategy describes short, medium and long term objectives based on expected outcomes and it also suggests adopting these objective as SMART objectives, while making action plans at LGA or community/school level. Besides, strategy explained in detail the various aspects including why and how phase-wise activities in some areas of hygiene promotion to be carried out. The pathways to implementation explained the number of LGAs to be covered on yearly basis, so that all 774 LGAs in the country shall be covered by the year 2022. The human resources needs for the whole country, roles and responsibilities of each of the partners from national to community level have been described along with how the strategic communication will help to achieve the objectives. In the guidelines the same principle is adopted and ‘who does what and how’ is outlined in detail. Besides this, the yearly action plan, segregation of activities related with each domain of hygiene, how to accelerate interaction between schools and communities has also been explained in details.

- “Hygiene Promotion *in* Schools” provides an effective setting for learning good hygiene habits which can lead to lifelong habits. Pupils also eagerly pass on hygiene information to their family members and neighbours. In-fact, “Hygiene Promotion *in* Schools” interventions will work as catalyst for change in improved sanitation practices and good hygiene habits in the community. This approach is not confined to the classrooms, it paves the way for “Hygiene Promotion *through* Schools”, thus provides outreach potential. The schools practicing good hygiene and sanitation are catalysts for community-wide behaviour change. This model puts the pupil at the centre of a social movement towards improved health. The children who get the messages reach out to peers, siblings and also to the community with the message of the importance of hygiene practices.

- Children’s impact on family decision-making in the wider water, sanitation, and hygiene (WASH) sector has been particularly apparent in the context of Community-Led Total Sanitation (CLTS) interventions. Children have been found to play several roles in ending open defecation, including: awareness raising, collecting baseline information, developing indicators, disseminating information, and influencing their parents to build toilets. Children have also been successfully trained to deliver sanitation knowledge to adults.

- To strengthen the hygiene and sanitation related bonds between the school and its catchment communities it is proposed under the guidelines to carry out a

number of activities either jointly or by community members. Activities like observing ‘hygiene day’ once in a month by the community and schoosl will strengthen the bond between community members and pupils. The KAP survey and procession by pupil in the community will give more confidence to children to play a participatory role in promoting hygiene behaviour and ODF coverage.

- As explained in the strategy, the initial interventions will be limited to key high risk areas related with (a) transmission of contaminations through hands (b) transmission of contamination /infection through excreta/children faeces and (c) Transmission of contamination through drinking water. While in next phase, behaviours related with other domains of hygiene will be taken up and in final phase the emphasis will be on consolidation for the sustainability of adopted hygiene practices.

- The role of religious leaders, natural leaders and village elders has been encompassed in the guidelines, thats how they will be approached by school teachers as a way of starting hygiene promotion activities in the community through support from schools and pupils.

- The hygiene promotion strategy linkages with guidelines are specifically related with the need for human resources and developing a pool of master trainers for various trainings for hygiene promotion in the country. The guidelines will form the basis to develop training modules for each of the trainings suggested in the strategy.

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14. MONITORING AND EVALUATION

- Monitoring and evaluation (M&E) is a vital component of hygiene promotion interventions. It helps to identify the pace of change in hygiene related behavior or adoption of good hygiene behavior.

- Usually for monitoring and evaluating behavior change **survey** are used. In which, a comprehensive set of questions, observations and focus group discussion guidelines for use at national/state level surveys as well as in LGAs and project area the surveys are carried out.

- In this strategy the emphasis is on the children's role for hygiene promotion among their peers, siblings, family and community members. Thus the **children's monitoring module** will be more useful for periodic monitoring. In which, children will play a key role through a tool, which will be developed as a part of the teacher's training module. A tool will be drafted and finalized during ToTs (through input from the field). This tool will be the major monitoring tool to be used by pupils at school and in communitys through simple observation checklists, survey questions etc.

- Similarly, monitoring at the community level must be done by WASHCOM members, (if WASHCOM are not constituted, then school teachers in consultation with community elders must take the monitoring task). A tool will drafted as part of the training module for hygiene promotion in the community and the same will be finalized during ToTs. Participatory monitoring techniques involving community members in assessing changes in hygiene practices will be very effective. This does not only increase community ownership but also allows them to identify solutions for encouraging adoption of good hygienic practices and safeguards sustainability of improved hygiene behaviour.

- Baseline data created by pupisl in the catchment communities will be helpful to determine changes in people's behaviour on a yearly basis.

- Regular monitoring of the activities held should be considered part of the record-keeping duties of WASHCOMs, School Teacher(s), person designated at PHCs. It is necessary that they also conduct self-assessments in terms of their own performance as a facilitator.

- LGEA staff (school inspectors) will be responsible for monthly monitoring for daily 'Group Hand Washing' and 'Hygiene Promotion *in* and *through* Schools' on regular basis. A proforma will be developed for them as part of teachers training module. Also schools inspector will share the monitoring data with the LGA WASH team, so that a comprehensive progress report shall be generated at each LGA level, to be shared with SUBEB and RUWASSA.

- **Evaluation**: A mid- term evaluation must be carried out by an external agency after two years of implementation of hygiene promotion activities in schools and in communities. A good evaluation will look into Process, Impact and Outcome of the hygiene promotion interventions.

Monitoring – Who does What

Monitoring areas	By whom in Schools	By whom in Communities	By whom in Health Centres	By whom in Market place
Overall Implementation	Monthly monitoring by School Inspectors on prescribed Proforma**	Monthly monitoring by WASHCOMs or Teachers/ community level volunteers on prescribed Proforma**	Monthly monitoring by Health Centre's in-charge on prescribed Proforma**	Monthly monitoring by Market committees on prescribed Proforma**
Installation of water, sanitation facilities, tippy taps for GHW and household based foot operated jerrycan type tippy taps.	By school inspectors, as part of overall implementation	By WASHCOMs or Teachers/ community level volunteers as an overall implementation	By health centres in-charge	By market committee
Daily Group Hand Washing practice in schools	By head teacher and representative of PTAs/ parents group	Not applicable	Not applicable	Not applicable
Peer to Peer and CtC	By six group members of pupil formed in schools	Observed by VHPs, WASHCOMs and children's and noted down in the register available with WASHCOMs.	Not applicable	Not applicable
Pupil to parents and family members	By children only, who in-turn report to six groups formed in schools. Groups in turn report to teacher in-charge and same is documented.	Observed by VHPs, WASHCOMs and children's and noted down in the register available with WASHCOMs	Not applicable	Not applicable

Installation and functioning of foot operated jerrycan type tippy tap by each household and in market place	Not applicable	By WASHCOMs on fortnightly basis. Note down progress in register available with them	Not applicable	By market committees
Phase-I related three HP activities	By six groups of pupil and in turn reporting to teacher(s)	By WASHCOMs/VHPs and noting down in register available with them	By health centre in-charge	By market committees

** Proforma to be drafted as part of teacher's training module/ Community training module

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Annexure -I

Creating benchmark for hygiene promotion Interventions

- Human behaviour is in the spotlight for hygiene promotion programme. At the beginning of a programme we need to investigate what behaviours are posing health risks and so should be addressed by hygiene promotion activities. At the end, we need to assess what changes in behaviour have occurred that are beneficial to health. Accordingly, it is necessary to know, which target group has what understanding about the behaviour change towards adopting hygienic practices. These include:-
  - Which specific practices are placing the health of children and families at risk?
  - What are the social, cultural and economic barriers to influencing those at risk to changing their current harmful practices or developing new practices?
  - What or who could motivate the adoption of new practices?
  - Who should be the audience groups of the communication initiative?
  - What to prevent the spread of the disease?
  - How can we communicate with these groups most effectively?

Indicators emerging from above mentions points will form the basis for interventions and also for the evaluation. Messages should we impart to persuade our audience groups to adopt good practices

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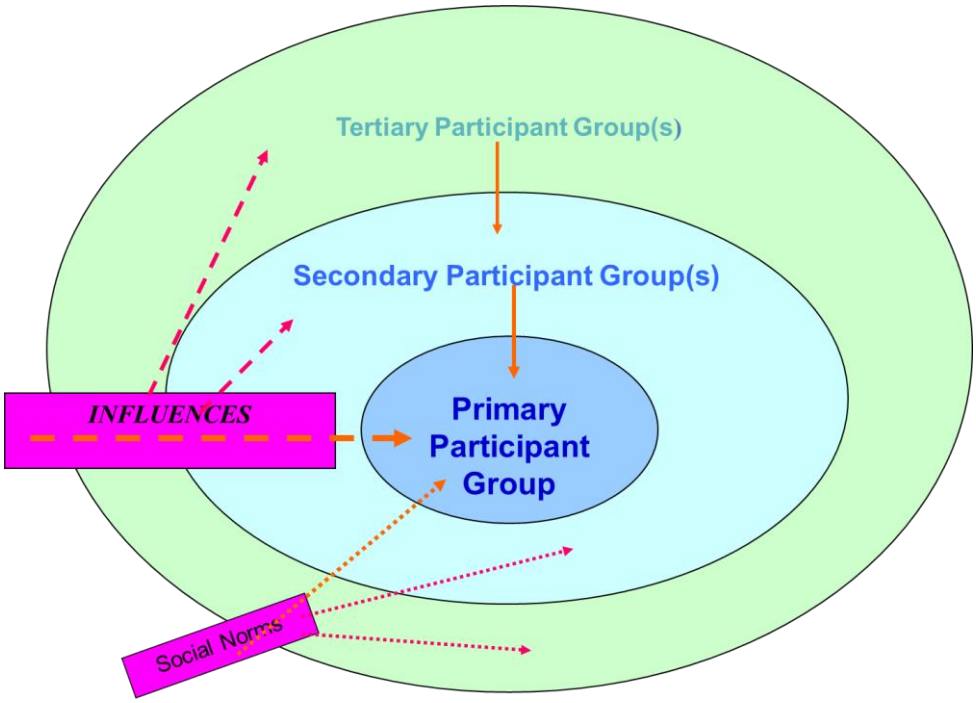
Annexure-II Audience segmentation in Nigeria:

- **Primary participants:** Who are they? and why we are targeting them? They are the individual, families and all members of a community (irrespective of their wealth quintal, educational background and social status). We will target them for behaviour change because they are at the helm of any sociological structure. They consist of:-
  - Children (both boys and girls, Parents),
  - Mother-in laws,
  - School children,
  - Families,
  - Community members



- **Secondary participants:** People who render any kind of support (direct or indirect) to a community and they have some kind of influence on the members of a community, are called secondary participants. They consist of:
  - Village elder(s), (both male and female)
  - Religious leader,
  - Health workers (CHEWs and nurses),
  - Teachers, head teachers,
  - LGEA staff,
  - LGA WASH team
  - Local shopkeepers.

- **Tertiary Participants:** They are the people, who administer the LGAs, State government and Federal government and relevant to the concern department and areas of interventions. They consist of:
    - FMoE, FMoH, FMWR, FMoEnv
    - State Governors, Deputy Governors
    - Elected representatives from that area, Politicians of that area,
    - State RUWASSA and SUBEB
    - LGAs chairperson,
    - NTGS
    - Donors
    - International organizations, Multi and Bi-lateral organizations

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Annexure -III

Behaviour development and change model

- The behaviour development and change model[29] reflects the influence of the "immediate environment" of parents, family, friends and community leaders and influentials. Research and experience have provided enough evidence to support the fact that interpersonal communication provides a major influence on beaviour change and development. Interpersonal communication is a function of an individual's wider social environment such as culture, religion, health and education systems, news and entertainment media.

- The behaviour development model reflects these two influences. The wider environmental factors are placed on the outer circle, encompassing all, while immediate environment – family, peers, community are in the centre of the model.

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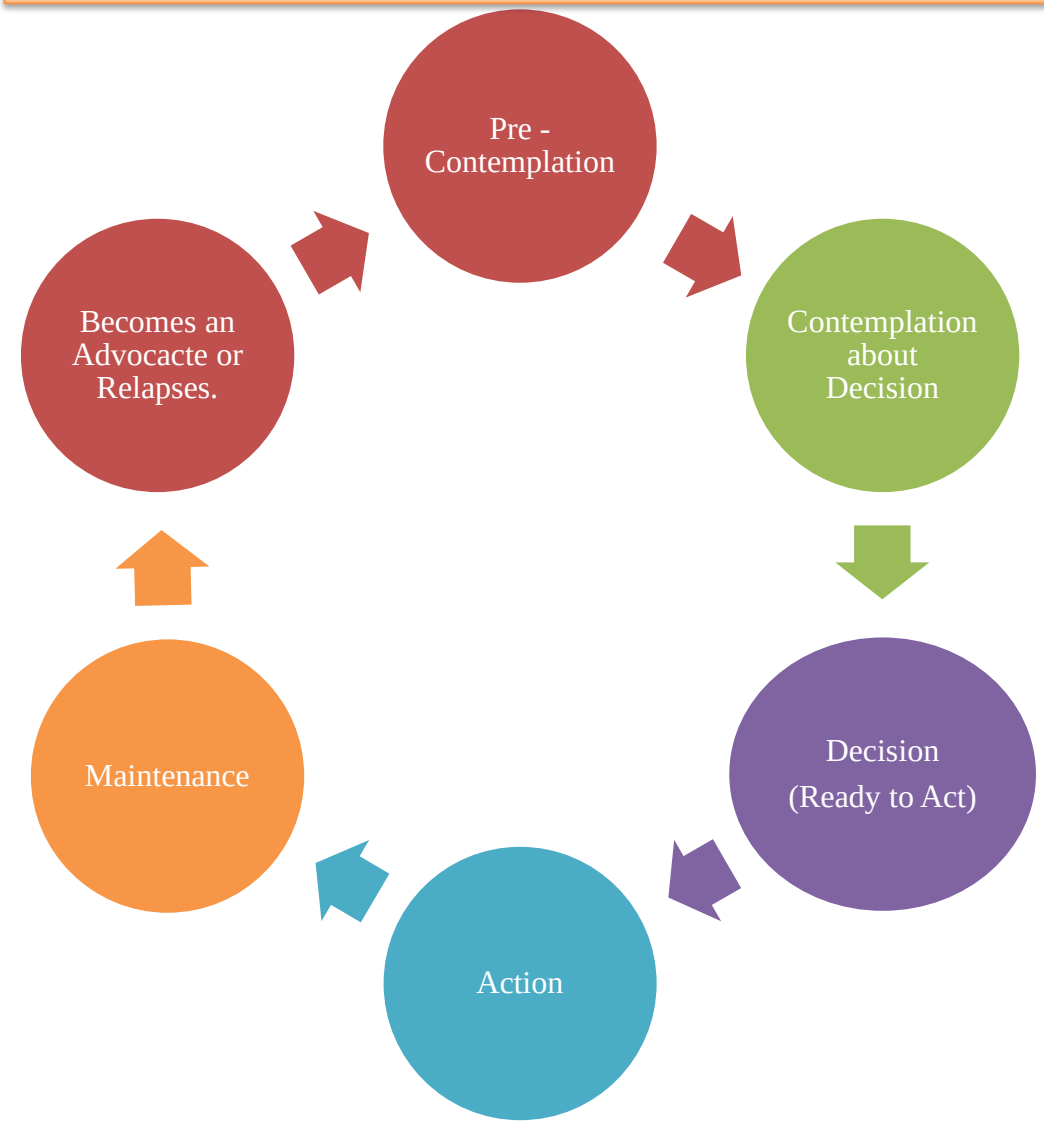
[29] UNICEF-Penang:McKee, Neill; Manoncourt, Erma, Chin Saik Yoon et al. (2000) – Involving People Evolving Behaviours

Annexure-IV

Behaviour Development Stages –Flow Chart



Behaviour Development Stages, Definitions and *Generic Indicators*

Annexure-V

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Becomes an Advocate or Relapses</td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="2">Maintenance</td><td>Tells friends about it urging friends to take action OR
Stops practicing the behaviour</td></tr>
<tr><td></td><td></td><td></td><td>Action</td><td colspan="2">Continuing recommended actions or repeating recommended practices.</td><td>Encourages friends, neighbours to practice the behavior Or

Goes back to previous behaviour</td></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3">Decision (Ready-to-Act)</td><td rowspan="3">Trying it out the information or behaviour; Implementing specific actions</td><td rowspan="3">- States that s/he her/himself is satisfied practicing the recommended behaviour</td><td rowspan="3">- Continues practicing the behaviour
- Expresses satisfaction with her/his performance</td><td rowspan="3"></td></tr>
<tr><td rowspan="2">Contemplation about Decision</td><td rowspan="2">Perceives risks and knows about benefits</td><td rowspan="2">- Practices the recommended behaviour
- Seeks reassurance that s/he is practicing the recommended behaviour correctly
- Asks for advice on practicing the behaviour</td></tr>
<tr><td rowspan="2">- States that s/he her/himself is satisfied practicing the recommended behaviour
-Confirms that this practice is solving the problem or addressing the issue correctly.</td></tr>
<tr><td>Pre-Contemplation</td><td colspan="2">Doesn’t know completely but has heard</td><td rowspan="3">- States that s/he wants to solve the problem, control the issue, practice the behaviour
- States that s/he knows how to solve the problem, control the issue
- States that s/he knows how to overcome obstacles in practicing the behaviour
- States that behaviour is consistent with social norms
- May seek approval from peers and/or change agents to act.
- May inform peers and/or change agents</td></tr>
<tr><td>Doesn’t know about problem, hasn’t thought about the issue</td><td>- Discusses the issue with friends and neighbours.
- States how the issue affects the community
- States the advantages to self and/or community of controlling</td><td>- States the steps necessary to improve the situation.
- Demonstrates the practices necessary to control the issue
- States what the further questions or unresolved matters are,
- States the sources needed to find the answers.</td></tr>
<tr><td>- States the issue in every day terms.
- States how the issue might affect her or his life

- States that s/he is looking at (e.g. Hand Washing after defecation) in a positive way but MHM in a negative way.</td><td colspan="2"></td></tr>
</table>

			that s/he is going to act				

Annexure- VI

Combined Community and Group Hand Washing Interventions at School