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Local Government Division, Policy Support Unit

Sector Development Plan (FY 2011-25)

Water Supply and Sanitation Sector in Bangladesh

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National Hygiene Promotion Strategy by Thematic Group on Hygiene and Sanitation

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National Hygiene Promotion Strategy 2010

1. *Background*

For most developing countries including Bangladesh sanitation and especially hygiene promotion remains one of the most challenging areas confronted in the development sector. This is because, for it to become an effective sector, it requires the development of an effective public sector strategy in an arena which is dominantly private and where results are only achieved when the household makes appropriate choices.

Of the three major components of the sector, namely water supply, sanitation and hygiene, water supply is the one that the country has a long history in working since1972. The focus of the water intervention was to reduce the high rate of under five child mortality due to diarrhea, as well as provide "safe" drinking water to control diseases like diarrhoea, dysentery, cholera, typhoid, and hepatitis. The control of microbial quality of water received priority in drinking water supply. Ground water supply was the obvious option providing access to about 97% of the population until the success was overshadowed by the presence of arsenic in excess of acceptable levels in the shallow aquifers. The success of the drinking water supply strategy was based upon the creation of an enabling conducive environment. However tackling the water supply alone did not remarkably reduce the disease burden.

In the 1980s, campaigns focusing on sanitation started with the emphasis on the promotion of latrines. This focus gained impetus in late 2003 when Government of Bangladesh (GOB) organized the South Asian Conference on Sanitation (SACOSAN) and declared the goal of 100% sanitation by 2010. Sanitation was again given a further boost in 2005 when the GOB developed a National Sanitation Strategy as a means of achieving two of the Millennium Development Goals (MDG) 4 reduce child mortality and 7 ensure environmental sustainability. This commitment is reflected in the Poverty Reduction Strategic Planning (PRSP) that envisages reducing infant mortality rate from the 2000 benchmark value of 66 to 37 by 2010 and 22 by 2015. Similarly, child mortality is to be reduced from 94 to 52 by 2010 and 31 by 2015.

Even though hygiene promotion is supposed to be an integral part of the strategy, the strategy is skewed more to the advantage of latrinization rather than hygiene in terms of the elements in the strategy. For example the policy guidelines, institutional arrangement and budgetary allocations are all in favor of latrinization. In spite of this, NGOs and some development partners, recognizing the synergistic effect of simultaneously addressing all three components have incorporated all of them in their interventions. Their efforts so far have been scattered, sporadic, and inadequate and unable to mobilize the full potential of human and organizational resource that abound plentifully both in the private and public sector. For example all most all the Sanitation, Hygiene Education and Water Supply projects are

working with the ministry of Local Government, Rural Development and Cooperatives (LGRD&C) but have not been able to tap into the rich potential of the Ministry of Health and Family Welfare so far as their human resource is concerned.

The impact of water, sanitation, and hygiene (WASH) programmes on hygiene behaviour still remains low in spite of the improvements in water supply and sanitation. As the second leading cause of child and infant mortality and morbidity, pneumonia and diarrhoea still remain a matter of concern for the country. There is evidence that hygiene practice particularly hand washing with soap and clean water at critical times reduce both the diseases. As a result monthly medical costs for common illness in Bangladesh decrease by 55% in rural and 26% in urban areas. Working days lost due to illness fell from 77 to 35 days per year, and school days lost due to illness fell from 16 to 7 days per year in rural Bangladesh. On the other hand the savings were used in buying food and clothing. Expenditure on food and clothing increased by 6% and 2% respectively.[1]

The weak link, so far as the WASH sector is concerned is the absence of a concerted effort by all on hygiene promotion. In the absence of that, the health impacts that can be derived from the sector will remain elusive. It is for this reason that there is an urgent call for a National Hygiene Promotion Strategy that will provide the platform for harnessing all towards the achievement of MDG targets, directly related to goals 4 and 7.

2. *Present status*

2.1. Global

The MDG goals call for a reduction of child mortality by two thirds between 1990 and 2015. As the deadline approaches, the reality is that although progress is being made, much more remains to be done.

Infectious diseases affect the world unequally. Sixty two percent of all deaths in Africa and 31% of all deaths in Southeast Asia are caused by infections (Global Health Council, 2005). At the same time, only 5% of all deaths in Europe are from infectious causes. Nearly nine million children under five of age die each year. A half of all child deaths each year are due to diarrhea and acute respiratory infections, both of which are transmitted from person to person during everyday interaction, through droplet and airborne spread, through skin contact and through contamination of the environment[2]. One of the most important ways of preventing these infections is hand washing with soap (HWWS).

Comparative research has already shown that investing in the promotion of hygiene can be at least as cost-effective, by increasing productivity, as investing in vaccination or oral rehydration therapy. An investment of US$ 3 per household per year is enough to avert diarrhoea in children under five when good water and sanitation are available, and US$ 6 per year when this is not the case

[1] National Sanitation strategy 2005.

[2] WHO. World Health Report 2002. Geneva: World Health Organization, 2002.

Diarrhea is more prevalent in the developing countries, in large part, due to the lack of safe drinking water, sanitation and hygiene, as well as overall poorer health and nutritional status. A review of more than 30 studies found that hand washing with soap cuts the incidence of diarrhea by nearly half.[3] Diarrheal diseases are often described as water-related, but more accurately should be known as excreta-related, as the pathogens come from fecal matter. These pathogens make people ill when they enter the mouth via hands that have been in contact with feces, contaminated drinking water, unwashed raw food, unwashed utensils or smears on clothes. Hand washing with soap breaks that cycle. According to the latest available figures, an estimated 2.5 billion people lack improved sanitation facilities, and nearly one billion people do not have access to safe drinking water [4]

The qualitative research in Kerala found that cleanliness was very important to mothers. Hands tended to be washed with soap when there was a prompting such as smell from cutting fish, touching animal dung or diarrheal feces, something visible such as dirt, or a feeling such as having been in contact with a poison or an impurity like non vegetable food, or before prayer or a sense of stickiness. One's own and one's children's feces do not smell bad and therefore may not prompt soap use.

In Ghana a national survey on mothers found that as few as 4% engaged in hand washing with soap (HWWS) after defecation, and only 2% after cleaning a child's bottom. It revealed that the strongest motivators for hand washing with soap were related to nurturing children, social acceptance and disgust of feces and latrines, especially their smell. Protection from disease is mentioned as a driving force, but was not a key motivator of hand washing behaviour. Researchers propose that much can be learnt from the world of consumer marketing.[5]

Availability of soap and water in or near the latrine also motivate users to wash hands. Previous studies indicated that life change events, and particularly the time of the arrival of a new baby are particularly good opportunities to introduce new habits.[6]

Demonstrating the impact of hygiene promotion on public health is both time-consuming and costly. Fortunately, in the 1990s, much progress has been made in developing methods for measuring the more intermediate impacts on hygiene behaviour. A 'critical mass' (over 75%) of good hygiene and sanitation behaviours can ensure that in due course public health impacts show up in the district, national and international statistics.

2.2. National

The impact of water, sanitation, and hygiene (WASH) programmes on hygiene behaviour still remains low in spite of the improvements in water supply and sanitation. The mid line report of a Health Impact Study (HIS) supported by Sanitation, Hygiene Education and Water Supply in Bangladesh (SHEWA-B, GOB-UNICEF) project and conducted by ICDDR'B in

[3] Diarrhea: Why children are still dying and what can be done; UNICEF, WHO; 2009
[4] Same as above.
[5] Beth Scottl et al. Health Policy and Planning, 2007
[6] Health in your hands-WB-WSP, 2002.

2009 shows that hygiene practices, related to hand washing and food handling is very poor in Bangladesh. For example, it was observed that only 1% of people wash both hands with soap (HWWS) before preparing food and before eating. Only 3% of caregivers wash hands properly before feeding children. The practice of excreta related hand washing, is however better than food related HWWS, it was observed that 30% of people wash hands with soap or ash and water after defecating whilst 36% of caregivers wash their hands after cleaning the anus of children. It was also observed that hand washing practice of female is higher than male (32% female, 21% male). Forty five percent of households (HH) have soap or ash and water at convenient places which is important for hand washing. The HIS midline report also shows that 90% of HHs use and maintain latrines properly, 16% of them dispose child feces in a hygienic way and 7% of the target population practice open defecation. Fifty percent of HHs store water in covered containers.

In June 2010 a formative research (FR) is conducted by London School of Hygiene and Tropical Medicine (LSHTP) with the support of GOB-UNICEF project. It was observed that mothers are always careful to rinse plates, sometimes hand rinse but not with soap. Hands touched many things such as child nappies, sweepings but no concern. Mothers take bath before lunch, change of clothes, so feel ***pavitra*** and don't feel to wash hands with soap. Before meals family members sit down on bed or floor. Get served a plate with food, plus hand rinse bowl filled with water. All splash right hand in bowl, have bowl sitting beside plate throughout meal for repeated use during and after meal. During behaviour trial everyone goes outside to tube well or bucket in yard, everyone washes both hands using soap and water; go inside to eat as normal. It means everyone knows that hands washing with soap before eating are a good practice. FR identified ***nurture, attraction, affiliation (Norms), status/respect, disgust and purity*** as motivating factors for hand washing. Out of six motives disgust got highest ranking but all motives could be used as arguments for hygiene promotion.

The FR also found that though many projects supported by the development partners are promoting hygiene, result remains low because the arguments are weak. People do not like to listen germ related health messages but the hygiene promotion activities in Bangladesh are germ based and adult oriented. Communities have poor understanding of disease and there is lack of use of visual aids during discussions. The front line workers often forget to mention SOAP! Analysing the motives, front line workers may use following arguments;

- Dirty hands are disgusting! *Khit Khit*
- Being attractive: *Akorshanio*
- Being like everyone else *Annoder anusharan kora*
- Being modern: *Adhunik*
- Good manners: *Adab Kaida.*

The FR team found that each household including poor's had 2-4 soaps for different purposes. This includes beauty soap, laundry soap (bar and ball) and detergent powder.

3. Objectives of the Hygiene Promotion Strategy

The general objective of this hygiene promotion strategy is to make a significant contribution in reducing water sanitation related under-five child morbidity and mortality through individual behavioural and collective social change. Specific objectives are to,

- Set a minimum national standard of hygiene practices
- Increase awareness on five domains of hygiene behaviour (i) disposal of human faeces, (ii) use and protection of safe water source, (iii) personal hygiene, (iv) food hygiene and (v) domestic and environmental hygiene and
- .Improve standards of hygiene behaviour on a sustainable basis

4. Scope of the National Hygiene Promotion Strategy

The scope of this strategy is to address primarily the issues related to five domains of hygiene practices, such as sanitation hygiene, water hygiene, personal hygiene, food hygiene and environmental hygiene.

5. Process of developing the strategy

Policy Support Unit, a unit of Local Government Division (LGD) working under Ministry of Local Government, Rural Development and Co-operatives (MOLGRD&C) identified 13 thematic issues of Sector Development Programme, National Hygiene Promotion Strategy is one, out of those 13 issues. UNICEF is given the responsibility to lead the process of developing the strategy. A participatory process was followed in developing the strategy. A working group was formed with the representations from different ministries, government departments, NGOs, development partners and private sectors. Firstly a concept paper was prepared by UNICEF. UNICEF prepared the National Hygiene Promotion Strategy, shared with the working group and updated with the inputs received from working group. Consultative meetings were organized with sector partners. However, the strategy is designed as a living document and may be revised from time to time based on needs and requirements.

6. *Terms and Definitions*

Terms and definitions of hygiene, hygiene education and hygiene promotion are defined here for common understanding of all concerned personnel.

6.1. What is Hygiene?

Hygiene is commonly understood as preventing infection through cleanliness. In broader call, scientific terms hygiene is the maintenance of health and healthy living. Hygiene ranges from personal hygiene, through domestic up to occupational hygiene and public health; and involves healthy diet, cleanliness, and mental health. Hygiene translates literally as 'Healthful'. The term hygiene means **"The practice to keeping oneself and one's surrounding clean to prevent illness or the spread of diseases."**

Hygiene means-
Keeping oneself and one's surrounding clean to prevent illness or the spread of diseases."

6.1. Hygiene education

Hygiene education is about helping people to understand, firstly, what causes some of their health problems and, secondly, what preventative measures might be possible. It needs to be approached in a very sensitive way, with a great deal of respect being shown to local beliefs and practices.

Hygiene Education: Exchange information among people to increase knowledge.
Hygiene Promotion: Process to change or develop the behaviour positively.

On the other hand hygiene education means the provision of information to bring about behaviour change. Traditional hygiene education does not attempt to empower people to make decisions not take account of the context or culture of the target population. The "knowledge, attitude and practice" (KAP) model underpins this approach and was founded on the belief that if people were only told about the causes of ill health, then they would automatically change their attitudes towards damaging practices and change their behaviour. It assumes that when people understand how sanitation related diseases are transmitted, unhygienic practices will be dropped and improved ones adopted. Whilst changes in behaviour often require access to knowledge and frequently a change in attitudes, this is not always the case. Individuals are not solely responsible for their own health and many factors such as poverty, housing, cultural values and norms may compromise their capacity to accept and act upon hygiene messages.

6.2. Hygiene promotion

Hygiene Promotion is the **planned, systematic attempt to enable people to take action** to prevent or mitigate water, sanitation, and hygiene related diseases and provides a practical way to facilitate community participation and accountability.

This would encompass personal, domestic, and environmental hygiene practices and any action or initiative taken to erect barriers to disease. The goal of hygiene Promotion is to assist people to understand and adopt practices designed to reduce their exposure to disease. In the current situation, hygiene promotion can:

- Encourage people to use and maintain toilets and bathing facilities properly.
- Discourage open defecation
- Reinforce practices such as washing hands with soap in six critical times (in particular, after defecation and before eating)
- Improve drinking water quality by promoting safe water collection and storage.
- Reduce health risks faced by women relating to poor menstrual hygiene

Again hygiene promotion means to covers a range of facilitative and enabling approaches to prevent water and sanitation related diseases and optimise the effects of water and sanitation interventions. Hygiene promotion is part of a broader health promotion framework which attempts to address the structural determinants of health (like ensuring access to water supplies) while supporting people's capacity and confidence to control the factors that determine their own health and the health of others. Effective health promotion is a process that strengthens individuals and groups to make changes in their own lives and also leads to changes outside their direct control such as social, economical and environmental conditions

7. Guiding principles

7.1. Hygiene is primarily about survival and health: The primary objective of the National hygiene promotion strategy is to make a significant contribution in reducing water sanitation related under-five child morbidity and mortality through individual behavioural and collective social change. It is focussed on the promotion of sustainable hygiene practices.

7.2. Hygiene should be the integral part of any water, sanitation project: Hygiene must be a component of any water-sanitation programme. Without this component no water sanitation project will be approved by the government.

7.3. Hygiene is dignity and status: though the primary objective is survival and health, other social factors such as dignity, status, respect, social norms, affiliation, attraction are also important.

7.4. Demand creation for sustainable change: Hygiene promotion and behavioural change leads to creating and sustaining demand for water, sanitation and hand washing facilities.

7.5. Financing for scaling up and sustainability: National, local government and community financing are crucial for promotion and awareness raising, capacity building, local resource mobilization and the creation of funding mechanism for sustainable national hygiene programme.

7.6. Communities are central to the planning process: Communities are the centre of planning and implementation of WASH programmes. Special emphasis should be given on effective involvement of hard core poor, poor and marginalized households (HH).

7.7. Gender sensitive approach: Hygiene promotion strategy/approach must address the special needs of women, adolescent girls and children. Gender issues would get total consideration in hygiene programme.

7.8. Social, cultural and technical appropriateness: Local social norms, values and cultural practices would be given due consideration in hygiene/behavioral change programmes. Indigenous knowledge, local wisdom must be respected and promoted.

7.9. Decentralization: Decision making for planning and implementation of hygiene projects/programmes must be operated and coordinated at the local level by local government institutions (LGI), such as Upazila Parishad (UZP), rural Union Parishad (UP),and urban pourashavas for sustained water, sanitation and hygiene (WASH) services. The LGIs would mobilize local resources for implementation of such project/programme. The national government will be responsible for funding, guiding, and monitoring WASH programmes through a consultative process.

7.10. Partnership building: Strategic partnership at national and local levels involving GO-NGO, LGI, development partners, private sector and community based organization (CBO) are essential for achieving progress with better and effective utilization of resources.

7.11. Emergency preparedness: Hygiene practices need to be planned with consideration of the impact of emergency situations, such as floods and cyclone.[7]

[7] National hygiene promotion strategy 2005 ??

8. Programme review

There have been many lessons learned over the previous 20 years in the water supply and sanitation sector in Bangladesh. Key experiences are detailed in this section.[8]

8.1. *The Social Mobilization (SOCMOB) experiences*

A pilot project in 20 Upazilas carried out by the NGO Forum for Drinking Water and Sanitation with support from UNICEF from 1994-1996 demonstrates that it is possible to raise the use of latrines above 90% through communication and social mobilization programme, making latrines available to the community and training on production and maintenance. Based on the lessons learned from this pilot project, NGO Forum implemented a .Social Mobilization for Sanitation, Hygiene and Safe Water Use Project. in 32 districts during 1998-99, with UNICEF financial support and in collaboration of District and Upazila administration, Union WatSan Committees, School Management Committees, Health and Family Planning field workers, Imams and partner NGOs (BRAC, PROSHIKA, RDRS, VERC). Almost 300,000 family latrines were constructed over a period of one year with zero subsidies. It was the first time that a social mobilization campaign of such a scope and size involving the Union WatSan Committees was implemented. A total of 2,253 Union WatSan Committees received orientation and training and were actively involved in mobilizing community in their constituencies.

Many lessons were learned from this programme but three most salient are summarized as follows:

• The involvement of big NGOs which have grass-root level administrative set-ups and which work with local partner NGOs proved to be very effective.

• The empowerment and capacity building of the local government structures and Union WatSan Committees was particularly successful to create public awareness

• Government Departments and NGO can work together in an optimum fashion and build a strong partnership if proper co-ordination is ensured and maintained.

8.2. *The Patgram Experiment*

In 1999, a one-Upazila sanitation programme based on the model of the Social Mobilization programme was initiated in Patgram Upazila in the North Western district of Lalmonirhat by the then- Upazila Nirbahi Officer (UNO), following an outbreak of diarrhea that killed fourteen children in the area simultaneously. Trained in ZOPP, the UNO gathered colleagues around him and conducted a problem analysis. The group decided that their objective was to achieve 100% sanitation coverage in the area.

The programme revived some of the successful features of previous Social Mobilization efforts and relied on support of other local government agencies, the Union Parishads and

[8] Inception report of Environmental Sanitation, hygiene and water supply in rural areas project; DPHE-UNICEF; 2000

local institutions such as the schools in disseminating information, local resource mobilization and monitoring. It also received some organizational and financial support from UNICEF. Because of its success in having a large percentage of latrines installed, the programme has attracted attention and praises from higher level government and is now known as the .Patgram experiment

The Patgram experiment. was studied during the inception phase by two separate teams commissioned by WELL (Hanchett, 2000, Leowinata, 2001). The experience and lessons learned were summed up. Strengths were identified as: increase of coverage, planning, monitoring and evaluation. Unlike the Social Mobilization programme, a baseline study was part of the Patgram process. A monitoring committee was also set up with four government officers. Regular grass-root monitoring was found to be a powerful tool to keep track of progress and to motivate people. Weaknesses were identified as: single focus emphasis on latrine installation, lack of emphasis on hand-washing and other hygiene-related behaviours, degree of dependence on one charismatic personality, absence of process documentation and compulsory payment for one type of high-cost water-sealed latrine.

8.3 The PRISM Experience

Social mobilization has made its mark on latrine coverage. It has yet to make as decisive a mark on hygienic behaviour. Campaigns are well suited for instant behavioural action. But only long-term intensive hygiene education and promotion, relevant to the needs of individual households will contribute to permanent behavior change. NGO experiences suggest the need for intensive, long-term approaches to hygiene education, especially regarding faecal risk. Between 1992-93, an NGO called PRISM ran a UNICEF assisted .social mobilization for sanitation. project in Ramgoti Upazila in Laxmipur district. The project strategy was to conduct a process of interpersonal communication with the entire population of 56,500 households. This was undertaken by 133, mostly female, Village Sanitation Motivators. Each visited around 425 households at least four times and held numerous community meetings, including meetings with the village men. Results were impressive and from this experience, many useful lessons were learned.

8.4. The SAFE and SAFER Projects

The need for thorough educational process is also clearly illustrated by the results of a Sanitation and Family Education (SAFE) project run by CARE Bangladesh in close collaboration with ICDDR-B among 9,141 households in Chittagong district in 1993-94. Hygiene promotion activities were designed to reinforce existing beneficial behaviours and specific, appropriate alternatives to harmful ones were developed. This was intended as a different strategy to that of promoting a set of pre-determined perfect hygiene behaviours. This approach succeeded in reducing diarrhoea by two thirds in the intervention areas. SAFE tested two models of community hygiene education for behaviour change- .single channel. and .multi-channel. The final evaluation demonstrated statistically that Model 2 was more effective than Model 1. The rigorous evaluation study showed that both of the SAFE intervention methods actually resulted in highly significant reduction of diarrhoea incidence among children.

The Sanitation and Family Education Resource. project, better known as SAFER, has evolved over the years from the multi-channel approach of SAFE project. There are three sections in the standard SAFER communication model: (1) sanitation and hygiene, (2) safe water, and (3) diarrhoea prevention and management. Each section includes a few clear and simple messages, presented visually in flash cards, in games, in pop-style songs, stories, or participatory action learning exercises. SAFER communication technique minimizes lecturing by the expert. The approach focuses on a few high priority behaviours for intervention, to raise awareness of diarrhea transmission and prevention.

SAFER hygiene behaviour change techniques were used in the WatSan Partnership Project in Rajshahi (CARE-DASCOH-IDE) and in the UNICEF funded Environmental Sanitation, Hygiene and Water Supply in Urban Slums and Fringes project. A dramatic reduction in child diarrhoea prevalence occurred across the total SAFER working area. The prevalence rate dropped by 70% on average: from 29.3% in 1996 to 8.7% in 2000.
Important lessons learned from SAFER include:
• There can never be one permanent perfect set of hygiene behaviour change communication materials. Their value is in the way they are used and adapted to new situations.
• Of the various participatory extension methods, courtyard sessions, in-school sessions and child-to-child activities were found to be the most effective.
• Specific verbal and non-verbal communication techniques are able to encourage high levels of audience involvement by minimising psychological distance between the field workers and session participants.
• Traditional Birth Attendants and Union Parishad Members were found to be among the most enthusiastic and diligent local supporters of hygiene behavior change.
• Community based monitoring seems to inspire people to improve their hygiene practices, including latrine use.
• A dramatic reduction in child diarrhoea prevalence occurred across the total SAFER working area. This corresponded to substantial increases in the use of latrines and hand washing both hands with soap or ash.

8.5. DASCOH Experience

The Participatory Action Learning (PAL) tools of self-learning through participants' action has been successful as demonstrated by the SAFER evaluation, further improvements have been made by helping people identify and address the obstacles they face in applying what they have learned. To overcome the gap between knowledge of good hygiene and changes in hygiene behaviour, DASCOH has developed a new tool by adding to PAL the element of identifying and overcoming hindrances and the cycle of planning, monitoring and evaluation. This tool is called .Participatory Action Learning and Planning or PALP, with planning standing for the problem solving part.

There are three elements that characterize this refined approach and that seem to be crucial for its effectiveness: (1) Self-learning, (2) Identifying hindrances and problem solving (3) Planning and monitoring.

8.6. The Integrated Participatory and Empowering (IPE) approach

The programme approach of Water Aid Bangladesh is known as IPEA-SWESHP, which stands for Integrated, Participatory and Empowering Approaches to Safe Water, Environmental Sanitation and Hygiene Promotion. This combined learning and practices from the SAFER method described in the previous section and those from SARAR and PHAST**.** Water Aid Bangladesh (WAB) feels that IPEA-SWESHP offers a more flexible and effective approach than its predecessors such as SAFER, because it (1) integrates 'hygiene behaviour change' activities into a broader social development context, which engages the whole community to consider water, sanitation and hygiene as a common public health issue and (2) promotes the use of hardware facilities (water and sanitation) by all of the people at household and community level (bazaar, bus stop, school, etc).

The IPE approach is based on *three* principles:

- ***Integration***: safe water supply, environmental sanitation and hygiene promotion are addressed simultaneously;
- ***Participation*****:** The whole community, including the hardcore poor, are actively involved in project planning, implementation, monitoring and evaluation. Individuals in the community are trained to become trainers; the community determines the best water supply and sanitation infrastructure option and hygiene promotion education inputs are facilitated;
- ***Empowerment***: People's capacities, skills and indigenous knowledge are recognised and valued.

The approach forms the basis of Community-Led Total Sanitation (CLTS). Village Education Resource Centre (VERC), a rural partner of Water Aid, piloted the CLTS/ full sanitation approach in 1999-2000, following the key principles of the IPE Approach, in response to the poor impact of previous attempts to improve sanitation[9] (Ahmed, 2006).

8.7. Sanitation, Hygiene Education and Water Supply in Bangladesh (SHEWAB-GOB-UNICEF) experience

UNICEF has been supporting water, sanitation programmes in Bangladesh since independence. From the mid-1980s onwards, it has included hygiene education as an integral part of its water and sanitation programme with the government of Bangladesh. In January 2002 UNICEF and the DPHE, on behalf of the Government of the People's Republic of Bangladesh, launched the hygiene focussed Environmental Sanitation, Hygiene and Water Supply in Rural Areas (ESHWRA) project in 10 plain and Chittagong Hill Tract (CHT) districts with financial support from DFID. The project had four components, (i) social mobilization for awareness building, (ii) Institutional capacity building, (iii) school sanitation and hygiene education and (iv) safe water supply. ESHWRA was the development phase of Sanitation, Hygiene Education and Water Supply in Bangladesh (SHEWA-B) project. After successful completion of ESHWRA, GOB-UNICEF started implementation of SHEWA-B

[9] Sector programme review-a workshop paper by Rokeya Ahmed; 2006

in 2007 in 68 new upazilas in 19 districts. SHEWA-B is one of the largest community-based projects for improving hygiene practices, sanitation, and water quality in a developing country with a focus on reaching the poor. SHEWA-B covers nearly 20 million people in rural and urban communities in both the plain lands and the CHT. SHEWA-B follows bottom up local level planning process at community and schools. The community and schools bear the responsibility of preparing their own water, sanitation, hygiene (WASH) plan, implement it and monitor for improvement of water, sanitation and hygiene situation. Local government institutions are very closely involved with all the processes. 97,000 WATSAN Committee members, all teachers and chairperson and a female member of SMC of 8402 primary schools were trained in sanitation, hygiene and safe water use. Around 1600 water sanitation facilities were constructed in primary schools and more than 12,000 community based water points were installed.[10] All the interventions including hygiene practices are regularly monitored through qualitative and quantitave methods by independent research and monitoring agencies. CHPs the NGO front line workers are accountable to the Union Parishad for their performances. Good progress is made on sanitation coverage, reduction of open defecation, use, maintenance and cleanliness of latrines, and on excreta related hand washing with soap during 2007-2009 in SHEWA-B districts.

School is an integral part of SHEWA-B. Hygiene education is incorporated in all 8,402 primary schools. There is a weekly hygiene sessions, students brigades are formed with all students irrespective of girls and boys of classes IV and V. What students brigades learn in schools disseminate those to their own houses as well as to the neighbouring houses. They monitor hygiene practices in their own houses and communities.

SHEWA-B has been using a mix of mass media and participatory interpersonal FACE TO FACE communications to inform and support choices of individuals (including children, adolescents, influential people, poor people) for changing behaviors based on (i) sound understanding of perceptions and culture of each different specific target audience, (ii) rights, responsibilities and obligations of individuals based on the principles of CRC, CEDAW, (iii) linking with other departments/sectors to ensure consistency and collaboration and (iv) qualitative and quantitative monitoring information.

3.8 DPHE-DANIDA Water Supply and Sanitation Project

An intensive hygiene promotion programme was undertaken under the DPHE-DANIDA Water Supply and Sanitation Project. Hygiene promotion activities were conducted through household visits, courtyard meetings, community meetings, school and teastall sessions, video shows, popular theatre shows, children's rallies, miking (rally with messages and slogans spread through a (hand) loudspeaker, International Health Day campaigns, etc. by the staff of partner NGOs. Different kinds of Information, Education, Communication (IEC) materials are distributed for mass dissemination of standard messages, on, for example, *ludu, pussles*, stickers, pocket notebook, calendars, poster and display boards[11].

[10] Annual Report of SHEWA-B project; 2009
[11] Sector programme review-a workshop paper by Rokeya Ahmed; 2006

8.9. DISHARI experience

As Dhaka Ahsania Mission (DAM) is the partner of Water Aid Bangladesh, it sometimes uses also the tools and techniques from the WAB hygiene promotion guidebook.

Para Action Committee members work voluntarily without remuneration. They are trained under DISHARI to facilitate hygiene promotion activities and sessions with groups of fellow villagers. In the preliminary stage, DISHARI workers help them by facilitating through demonstrations. The local government representatives are also aware of good and bad hygiene and sanitation, and support the participatory activities and local action plans through community visits and speeches in different community meetings.

8.10. The School Sanitation Project

More attention is today being focussed on children via the schools. Not only must they be encouraged to use latrines and wash their hands, but promote this behaviour at home. The expectation is that, if they absorb new habits and an appreciation of the health consequences, they will maintain them for the rest of their lives. Teachers and children are therefore becoming the country's sanitation pioneers and reformers.

A special School Sanitation Project was launched in 1992 jointly by the DPHE and the Directorate of Primary Education with support from UNICEF. During the first phase of the project, over 1,000 sanitation facilities were constructed. However, lack of community involvement and ownership seemed to be the problem. UNICEF Chittagong Divisional Office undertook an experiment with five schools in Moulvibazaar District. The responsibility of construction was vested in the School management Committees. Sub-Assistant Engineers and Upazila Education Officers provided technical support. Necessary funds, materials and design of the facilities were given directly to the Committees, who employed masons to do the work accordingly to the specifications.

Experience showed that school latrines frequently became noxious and were soon abandoned by their users. Great care was taken to improve the design of the facilities. New facilities were designed to include a tube well whose hand-pumped water enters a 500 litre tank equipped with a drinking water tap. The tank is raised so that water can be supplied from there directly to other taps in the latrine compartments. Two compartments, back to back, provide a girls and a boys lavatory. The taps allow the pans to be flushed clean on every occasion. The school is expected to provide soap or ash is provided in each compartment for hand washing.

The experience gave good result in terms of timely and quality construction and better maintenance. As a result, the construction of school WatSan facilities was devolved to SMCs in more than 1500 schools in seven districts, under the supervision of the Upazila Authorities. Co-ordination Committees with membership from DPHE, Directorate of Primary Education

(DPE), Directorate General of Health Services (DGHS) and NGOs have been established at both Upazila and District level.

Through separate School Sanitation Project water and sanitation facilities were constructed in about 4,400 primary schools where there was a need covering 44 Districts. Hygiene education was included in the class routine of all 4,400 schools. There are clear indications that the project has increased enrolment and school attendance, particularly of girl students. Moreover, the project has fostered behavioural change in relation to hygiene and sanitation in and it had a demonstration effect contributing to increased demand for private sanitary latrines.

Some of Bangladesh's non-formal education programs have incorporated hygiene learning into the curriculum. Students take up cleanliness as a class project, conducting community surveys, discussing the topic with people in their neighbourhood, and reporting back to school. At the end of the project, the children write a play demonstrating their new knowledge and perform it for the rest of the school and in the community.

9. Hygiene promotion strategy

Since 80s GOB, national, international NGOs, development partners have been implementing different strategies for hygiene promotion and behavioural changes. Review of the strategies showed that some of the initiatives worked well some did not. The national hygiene promotion strategy is developed through review and lessons that learnt from global and Bangladesh experiences. The analysis of participants and mass media is also done.

9.1. Participant analysis

Out of eight MDGs, Goals 4 and 7 are directly linked with sanitation, hygiene and safe water issues. Community is formed of several diverse groups, but for maximum efficiency and impact, participant audiences need to be carefully targeted. Participant audiences are divided in to three categories;

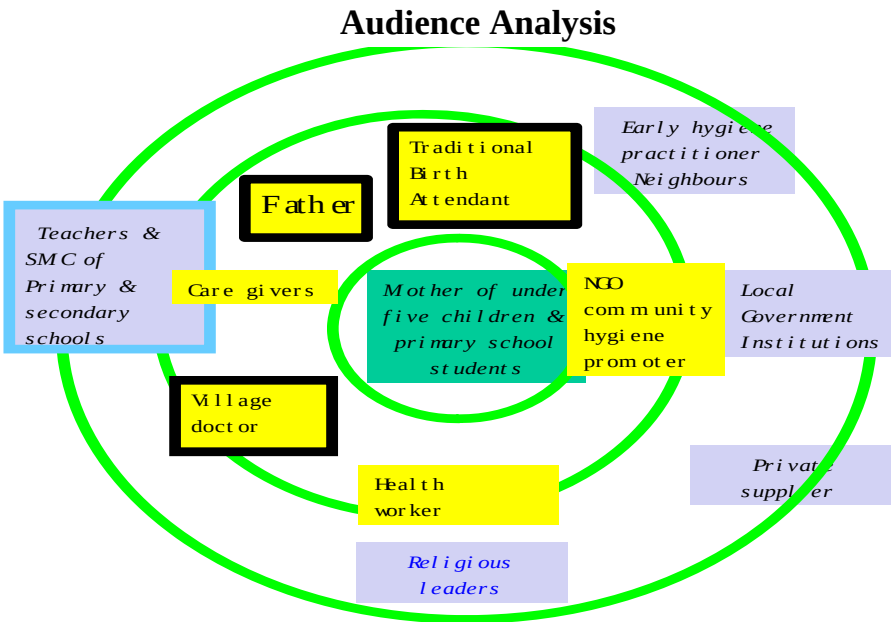
- **Primary participant/target audience:** Primary participant audiences are those people who are carrying out the risky practices e.g. mothers handling baby's feces and feeding baby without washing hands with soap. So, though the main beneficiaries from improving hygiene behaviours are young children, the primary participant group for the hygiene promotion is mothers of these children.

  School children form the other key participant group in two respects: their habits can be moulded at a young age, and they can be used as agents of change by reinforcing the selected hygiene practices within the home environment.
- **Secondary participant/target audience:** Secondary target audiences are those who influence the primary audience and who are in their immediate society, e.g. fathers-in-law, mothers–in-law, husband. It is the male head of household who controls

expenditure and makes decisions that affect all household members. It is therefore important that men, especially head of households, are included wherever possible.

- **Tertiary participant/third target audience:** Tertiary participant/third target audiences are very important. They are the people who lead and shape opinion, e.g. school teachers, religious leaders, and members of local government institutions, political leaders, traditional leaders and elders. These people have a major influence on the credibility and hence on the success or failure of the programme.

An analysis of participants is given below



To reduce child mortality of under five aged children mothers are the primary participant audience to address. The hygiene promotion strategy should emphasize the fact that hygienic practices, like other social behaviours, cannot be achieved by individual change in behaviour but requires concerted action from the entire community. Sustained change in the behaviour is more likely to occur in a supportive environment. A supportive environment consists of family and community, social, religious and cultural norms, access to information, access to facilities/technologies and existence of a functional national policy and strategy. So, a concerted effort is needed to create a supportive environment through raising awareness of all primary, secondary and tertiary participants on hygiene issues.

9.2. Media analysis

People of Bangladesh are fast moving toward visible electronic media. Television (TV) and radio spill over beyond the project areas. These electronic media cover the larger population. Mass media provides the backdrop for the other inter-personal communication packages for easy acceptance and assimilation. The low and irregular exposure to mass media among the

core target audience need to be taken cognizance of, by utilizing each available media to its full potential.

Television is the most popular medium of entertainment and a credible source of information in rural and urban areas of Bangladesh. Television programmes are broadcast throughout the country by Bangladesh Television (BTV) and some other private channels. According to the National Media Survey, 2009, television is viewed by 87% of urban dwellers and 62% rural dwellers. Seventy percent of populations between 15 and above watch TV at least once in seven to ten days. The reach of TV to the female viewers (63%) is still behind that to the male viewers (76%). The viewership is higher in Chittagong division (75%) and lowest in Barisal division (60%). The number of viewership of the state run Bangladesh Television (BTV) has declined in the five years, e.g., from 98% to 83%. Across the country, most of the people watch TV in their own homes (62%), followed by the neighbours' houses (rual 30% and urban 11%).

On all the days of the weeks, 8:00 pm to 10:00 pm is the peak time for watching TV. During weekly holidays people prefer to watch TV at 3:00 pm to 5:30 pm and also 8:00 pm to 11:00 pm. Currently 40% of the TV owners have cable connection. However, 17% in the rural areas and 63% in the urban areas have cable connection. BTV telecasts Bangla movies on Fridays at around 3:00 pm, which is found to be the most watched TV programme by TV viewers (80%) followed by Bangla news (73%).[12] Consumption pattern should be the basis of planning the television spots.

Radio: Though radio is the second most powerful media after TV in Bangladesh, its reach is declining every year. Interestingly, the access to radio is increasing in the metro-politan areas due to private FM channels. In 2009, the reach of radio in metro politan areas declined from 20% to 18%. However, overall listening to radio has declined from 36% in 1995 to 19% at present. Radio listening habit is higher in the rural areas (21%) in comparison to urban areas (14%). Comparing among males and females, the scenario is quite in favours of males (23%) than females (15%). The preferred listening time is 7:00 to 8:00 in the morning, 2:00 to 4:00 in the afternoon and also 7:00 to 11:00 in the evening. During Fridays, a large number of radio listeners listen to weekly drama at around 3:00 to 4:00 in the afternoon. Among the listeners of all regions, Bengali news is one of the most listened programmes (78%), broadcast during different times. Film songs are also popular among the 73% of the listeners. Other popular programmes are drama (45%), band music (27%), sports news (17%), educational programmes (15%) and health programmes (10%). [13]

Newspaper: The overall habit of reading newspaper has slightly increased during the last three years (2006 to 2009). Currently 24% of the population across the country read news

[12] Nielsen Media and demographic Survey Bangladesh 2009;
[13] Same as above.

paper at least once in a week. As expected, newspaper reading remains an urban, which is mainly limited in the metropolitan areas.[14]

Using this information and the diarrhoea incidence peaks, the annual radio schedule needs to be planned. Moreover Public Private Partnership (PPP) can be built to sponsor programmes on hygiene, sanitation and safe water use for television and radio.

9.3. Desired hygiene behaviours

A hygiene promotion strategy is primarily concerned with targeting specific behaviours and social practices that are important in preventing faecal-oral disease transmission with a complementary improvement in water supply and sanitation. The range of hygiene behaviours that may affect disease transmission can be broadly classified into five clusters called 'behavioural domains'. These are:

- Sanitation hygiene
- Water hygiene
- Personal hygiene particularly hand washing with soap in critical times
- Food hygiene
- Environmental hygiene

Each domain in the above list involves a series of hygiene practices, such as

Sanitation hygiene

• Regular use of sanitary latrines by all family members
• Safe disposal of children's faeces
• Cleanliness of sanitary latrines

Water hygiene

• Safe collection, storage and management of water
• Wash raw fruits and vegetable with safe water before eating
• Management of waste water

Personal hygiene:

• Wash both hands with soap before preparing and feeding children
• Wash both hands with soap before eating (breakfast, lunch and dinner)
• Wash both hands with soap or ash after cleaning baby's bottom
• Wash both hands with soap or ash after defecation
• Use sandal in latrine
• Use sanitary napkins or clean, dry rags during menstruation and wash used rags with soap, dry in sun light and store in clean and safe place for re use

Food hygiene

• Always cover food
• Eat worm food
• Do not eat rotten food

[14] Nielsen Media and demographic Survey Bangladesh 2009;.

Environmental hygiene

• No open defecation

• Solid and liquid waste management

Obviously no programme can effectively cover all practices in all domains and hence the need to prioritise, which practices are likely to be most effective in preventing disease transmission. It also depends on the hygiene status of particular areas. For example latrine coverage of Bangladesh improved significantly. Areas those achieved 100% latrine coverage now need to give importance on use by all family members and cleanliness of latrines. Hand washing appears to be one practice which cuts across all the domains. It is one of the examples of a predominantly private arena where we desire to use public sector policy to influence. This makes it even more challenging.

10. Hygiene Promotion strategy

Hygiene promotion is a long term process. Though it is a private domain it requires active participation and involvement of different actors from individual to whole community, national to local government institutions, and public-private sectors. The strategy is described below

10.1. Decentralization: Implementation of the hygiene promotion strategy would be decentralized. Union will be the focus and Union Parishad (UP), the lowest tier of local government institutions will be responsible for implementation. It was found in different projects implemented by GO and NGOs that role of UP is crucial in mobilization of community, planning and implementation of water, sanitation and hygiene (WASH) projects. In implementing hygiene promotion strategy UP also need human and financial resources. Currently 20% of ADP allocation is reserved for sanitation. This fund needs to be continued even if the UP achieved 100% sanitation coverage. This fund would be used to hire Community Hygiene Promoters(CHP). UP needs at least three CHPs, who would facilitate the process of hygiene promotion like pourashavas, where there is an urban development officer to facilitate development issues including WASH issues. If UP is financialy solvent, would hire CHPs from their own fund too. front line workers of any WASH project will be accountable to the UP. UP will prepare union based WASH plan based on community level action plan with technical support from department of Public Health Engineering (DPHE)/NGOs. Development partners will support to implement union WASH plan. All members of UP including the secretary and members of union and ward WATSAN committees would be trained for their capacity building in implementing the hygiene promotion strategy.

10.2. Community participation: Community participation process must be the essential part of hygiene promotion strategy. To achieve sustainable improvements in hygiene practice then it is important that communities are actively involved in assessment and analysis of their own situation, and translate it into a social map. This visualization helps communities in preparing their Community Action Plan (CAP) selecting the right behaviours for change. Community level front line workers/community hygiene promoters may facilitate the planning process but it requires training to build capacity of front line workers. Front line

workers ensure the participation of **poor and marginalized** HHs in hygiene promotion activities.

10.3. Limit number of target behaviours

Too many messages confuse participant groups and then they also prioritise behaviours according to their choice. Therefore focus should be on changing just one or two behaviours to improve the chances of success. This also favours a process approach as once there are clear indications that the required behaviours have improved then other specific behaviours may be targeted at a later date. It is also important that the messages for changing behaviours are kept short and simple, and put in terms that can be understood and make sense to the population.

10.4. Use mix and multi media communication channels: People are more likely to take note and act when they receive messages from a number of mix and multi media channels. Again, the hygiene promotion is not an educational campaign, but a motivational one, so a combination of channels will be used.

The Mass-media will be used to help disseminate the information rapidly, create interest in the minds of the audience and provide a credible identity to the campaign. Mass media also provides the environment that helps the assimilation of grassroots level activities. Radio, Television including the private channels, news papers, and district information offices will be used for hygiene promotion. Outdoor media such as poster, leaflet, stickers, wall paintings, school latrine door painting, bill boards and glow boxes will be placed at strategic location as a reminder. Social Marketing Agencies may be hired as in charge of placing the outdoor materials

However, mass media alone lacks the personal touch required to move most people to change their habits. Actual change in behaviour is more likely to occur when people receive message through interpersonal communication (IPC) channels especially when this is a locally respected and trusted source including family, neighbours and relatives. The interpersonal communication (IPC) is the most effective communication. It follows two ways communication, community has the opportunity to ask questions for clarification. It involves different village level influence networks already well entrenched in the daily lives of the community. These village level influencer groups are people whom people look to for improving their quality of life. More importantly, they are people who also relate to the community culturally, socially and personally. The IPC activities will use the existing network of health and family welfare functionaries under MOH&FW, Tube Well Mechanics

Of DPHE, community level workers of local NGOs, traditional birth attendants, village doctors and the private latrine producers. Hygiene and sanitation promotion will also be performed by the caretakers and members of the Water User Groups.

An important channel of communication is to build alliance with local influential leaders. The potential partners are local political leaders (members of the Union Parishads), religious leaders, school teachers, Ansar/VDP and youth clubs. Support to these groups in the form of

supply of information and communication materials, briefing and training organized by the Union WatSan Committee and DPHE upazila based staff and facilitated by the local NGOs.. They will then motivate their communities through their own respective forums. The idea is to bring the hygiene, sanitation and water issues upfront in the official agenda of the Union Parishad and use its collective influence for speedy and effective hygiene promotion. Similarly, Imams and Vante the religious leader of budhist community also form an important influencing segment for the community. Besides their religious role, Imam and Vante play an important part in modifying and reinforcing related behaviours in the community

It is found in the formative research conducted by LSHTM in 2010 that people do not like preaching and lecturing but like entertainment. Interactive popular theatre (IPT), folk media WASH fair will be organized in media dark areas where mostly the poor and marginalized live. Modern Information technology such as SMS, email will be used to deliver messages where applicable.

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10.5. Use schools as resource centre and student as child to child and child to community change agent: Habits are often learned by doing at an early age, there are opportunities for change, especially at life changing events. Schools are a good focus of hand washing programs. Schools are key environment, not just for learning about hand washing but for introducing the habit into practice, so it lasts. Hygiene is integrated with **Better Health Better Education** programme of DPE. Students will learn sanitation and hygiene through demonstration and practical sessions. Assembly can be used as a forum for learning. Students will disseminate the messages they learnt in the school to their own families and monitor as well.

But reality is that some studies shows that almost 50% primary schools do not have soap in latrines in primary schools so majority of students wash hands only with water in critical times. It is important that students have access to water, sanitation and hand washing facilities in school. They should learn how to use and maintain the facilities practically in school and carry the messages and practices in to their houses.

DPE may organize art competition, poster competition, debate, quiz on WASH issues during sanitation month, Global Hand Washing day. All schools may observe **school cleanliness** at least once in a year.

10.6. Public Private Partnership

While the public and private sector have always worked together in one way or another, the idea of a direct partnership is relatively new. Governments have contracted out services to the private sector or handed over responsibility entirely via privatization, but only recently has the idea of joint programming with joint responsibility become a reality. Over the last few years Public Private Partnership (PPP) in the health sector have been used to develop and facilitate access to vaccines and treatments, promote behaviours and products that reduce disease occurrence and improve health services.

A partnership can flourish only if both partners gain from it. In the case of hand washing, there are obvious benefits to both sides; industry may sell more soap and on the other hand government benefits from the private sector's expertise in designing effective communications to improve public health.

Government of Bangladesh takes the PPP as an important policy for development of different sectors. The vibrant private sector in Bangladesh has made significant contribution to provision of water and sanitation services. Small businesses, masons and mechanics have helped advance the water and sanitation coverage and keep the millions of hand-pumps in operation. Soap companies in Bangladesh are involved in this sector too. Partnership would be built with plastic companies in developing user friendly hand washing device. PPP may contribute in developing area based environment friendly sanitation equipment as well.

10.7. Research and development: Research and development activities will be undertaken to create an enabling environment for sustainable behaviour change.

10.8. Strategy for emergency response: Bangladesh is pre-dominantly is a disaster prone country. Flood, cyclone is regular phenomena. The following strategies need to be considered to respond to emergency.

11. Emergency prepaqredness programme must include hygiene component.
12. Flood shelters and other public private institutions should have adequate water, sanitation facilities and hygiene kits.
13. Hygiene promotion activities with key messages must be undertaken during emergencies
14. Flood and cyclones are seasonal. So hygiene materials must be pre-positioned in flood prone areas before disaster.

11. Institutional framework

The responsibility for operationalisation of the National Hygiene Promotion Strategy requires a close coordination at the central as well as the local levels. Local Government Division of Ministry of Local Government Rural development and Cooperatives is the prime ministry to make the strategy operational but convergence with other ministries like the Ministries of Health and Family Welfare (MOH&FW), Information (MOI), Environment (MOE), and Primary and mass Education MOPME) is also important. LGD will create an enabling environment at local level by allocating resources, ensuring implementation of the strategy through monitoring. Hygiene is a part of health. Currently MOHFW is involved in curative measure only, but by doing preventive activity such as implementing the hygiene promotion strategy by health and family planning workers could be achieved more with less cost. There are examples that through hygiene practices, particularly washing hands with soap at critical times could prevent diarrhoeal death of under age of five year child. MOPME would ensure hygiene education in primary schools and ensure hygiene practices in schools by ensuring facilities through directorate of primary education (DPE). Primary school students could promote the practices in to their houses as well. MOI will spread the messages countrywide through all it's channel.

Union parishad (UP) is the lowest tier of local government institutions and mandated to ensure water sanitation facilities at union level. But the fact is that the UPs lack both the resources, human and financial. It is proved that if UPs are given the responsibility with authority it could perform well. In 2003 the sanitation census was done by the UPs with a very short time with minimum resources. With the leadership 0f UPs, 100% sanitation coverage was achieved in many UPs. Hygiene is an integral part of water and sanitation, so UPs would be the central of hygiene promotion strategy.

The component management will be responsible for i) overall planning, ii) identification of partners to implement the activities, iii) co-ordination of the activities in close co-operation with the implementing and local level partners; iv) co-ordination of activities with other components and agencies; and v) monitoring and quality assurance.

In addition to the Components there are the government agency, the DPHE and others with reach down to the union level. The local government and the private sector are important stakeholders at the local level. Last but not the least are the communities. The organisational arrangement for planning, implementation and monitoring of the activities must therefore flow from and fit the management structure for the SPS. The structure must also account for the roles of different stakeholders at different levels.

The government's organisational structure for Chittagong Hill Districts is different from the structure for the rest of the country. The Ministry for Chittagong Hill Tracts Affairs (MOCHTA) is the line ministry for development of the Hill Districts. Other government development agencies such as the DPHE, Directorate of Health and Family Welfare and the Department of Education must all work under the overall direction of the MCHTA. The difference in structure, however, is not too drastic to warrant separate consideration. With little modification, the overall organisation structure for hygiene promotion will hold good for the Chittagong Hill Districts as well.

Hygiene promotion must, by necessity, adopt a participatory approach with stakeholders (upazila and union parishads, government agencies at local levels, private sector, CBOs and the community) in partnership at different levels. NGOs with a history of experience and success in participatory planning and development have a natural advantage over government agencies. NGO strength lies in working with the people especially in planning and managing social/cultural aspects of development. These resources and strength will be tapped.

12. Monitoring

Monitoring of hygiene promotion activities will include qualitative and quantitative aspects with particular attention to gender specific information. Simple, time bound indicators based on the specific objectives need to be developed and the means of verification will be identified to measure progress and effects over time. A mix of methods will be used for monitoring; observation is one of those, as is it proved that reported data always shows better result than observed data.

Monitoring will be done by the community through review and updating the CAP. This will ensure that the community obtains feedback of their own efforts and consequently will be able to make decisions regarding future actions. Where needed, the existing component monitoring system will be adapted to accommodate the requirements of participatory monitoring of hygiene promotion activities.

The components on regular intervals and over a longer period will undertake monitoring studies. These studies shall serve as evidence for impact monitoring, thus supplementing the baseline survey. At the same time, the experience gained from these studies shall allow for better and more detailed adjustments of activities and campaign approaches.

Progress and impact will be monitored through periodic surveys, the result of which will be compared to the baseline surveys. These surveys will be conducted by the independent research agency/researchers. In addition, consolidation of experience and performance assessments of the different components, enabling comparative analysis will be undertaken.

13. Capacity Building

In view of the roles and responsibility of different stakeholders at different levels capacity building including training at any level will be an important component to build/raise skills and competence to discharge the responsibility. Therefore, assessment of needs is a pre-requisite to designing interventions for capacity building.

The hygiene promotion strategy relies on locally available human resources and therefore specialised training will form a major part of this strategy. However, an educated background is not necessary for this sort of training particularly for the front line workers such as CHPs. Thus facilitators can be drawn from a variety of sources (i.e. NGOs, CBOs', TW mechanics, health assistants, CHPs, TBAs, VDs and community). Training is best provided through specially designed participatory methods with intense follow-up on-the-job training and visits.

Participatory training workshops will be organized. These may be actually enhanced by bringing together people from different backgrounds, agencies and locations as they draw on sharing experiences. They also help addressing the problem of co-ordinating local partners in the field.

Capacity building for hygiene promotion should not be a discrete function in isolation. It must be an integral part of the strategy of improving sector capacity to effectively address problems on water supply, sanitation and hygiene promotion.

In the spirit of participatory process, need assessment, design and implementation of interventions for capacity building must involve relevant target groups. Appropriate levels of management must implement the interventions within a standard framework.

It is difficult to change habits deeply entrenched in the culture and psyche of people. Building on past experience and lessons, prevailing culture and context can make significant contribution towards bringing about changes. The national agencies such as National Institute for Local Government (NILG), The ITN Centre, will be used for capacity building in WASH sector. NGOs, some government agencies/programmes and even private sector offer a variety of training modules, courses and materials. These resources will be used where appropriate, in building capacity for hygiene promotion. Co-operation may include use of resource persons, materials, modules, courses and logistic in a spirit of reciprocity.

The GoB has the Essential Services Package (ESP) under the Health and Population Sector Programme (HPSP). Child Health Care is an important component of ESP. The HPSP assigns priority to Behavioural Change Communication (BCC). In addition there are many WSS projects under DPHE, LGED with assistance from GoB, UNICEF, The World Bank, DFID, DANIDA, Government of Netherlands etc. Co-operation with such projects would be beneficial for both capacity building and hygiene promotion under for WASH Sector.

The components have to consider capacity building at both the individual and institutional levels. While individuals with skill, competence and commitment are critical for promotion of hygiene practices, sustainability require capacity within permanent entities. Experience shows that single purpose “committees” relying on voluntary inputs and limited interests do not sustain beyond the project period. Organisation rooted in the community such as educational/religious institutions, private sector, social clubs are likely to survive. Union parishads and local office of central government agencies also have a high degree of permanence but are slow in adapting to changes and are seldom proactive. Cross-sectoral organisations with multiple linkages to a number of projects/programmes and to UPs will have a better possibility of long-term success. Water and sanitation interventions may just be the entry point for such organisations.

Programmes involving active stakeholder participation must maintain a high degree of flexibility to accommodate variety of community needs and situation. Capacity building for hygiene promotion will follow an adaptive design with every phase benefiting from the lessons of the preceding phase. This presumes a continuing process of monitoring to learn lessons and apply them to improve subsequent implementation.