Best Practice in Hygiene Promotion Programmes: an evaluation template to determine cost-effectiveness.

Dr. Juliet Waterkeyn
Africa AHEAD
www.africaahead.com

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Method</td>
<td>Which Methods are used to reach audience?</td>
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<tr>
<td>2. Scope</td>
<td>Which diseases / conditions are addressed?</td>
<td></td>
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<tr>
<td>3. Length</td>
<td>Period of contact with beneficiaries.</td>
<td></td>
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<tr>
<td>4. Integration</td>
<td>Type of development activities undertaken.</td>
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<tr>
<td>5. Coverage</td>
<td>How many people targeted at the same time?</td>
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<td>6. Cost</td>
<td>‘Cost per beneficiary’</td>
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<tr>
<td>7. Effectiveness</td>
<td>Number of observable hygiene indicators.</td>
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<tr>
<td>8. Sustainability</td>
<td>How long new practices have been maintained?</td>
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<td>9. Scalability</td>
<td>Has the Model been used effectively at scale?</td>
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<tr>
<td>10. Ethics</td>
<td>Which human values does the Model encourage?</td>
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DEVELOPMENT MODEL
Which of these models of health promotion are you using?

1. Social Planning
2. Health Belief
3. PHAST
4. Community Health Club
5. Community Led Total Sanitation
6. CLTS adapted (plus)
7. Social Marketing
8. Sanitation Marketing
9. Total Sanitation–San Marketing
10. Demonstration Model
11. Other
COMMUNICATION:
Which CHANNELS are employed to reach the target audience?

1. Village meeting
2. Loose Group gathering
3. Club membership
4. Clinic / anti natal
5. Schools
6. Individual home visits
7. Media (TV or radio)
8. Posters & pamphlet
9. Billboards
10. Other
Why is a ‘Club’ so effective?

- Group consensus is developed: group decision takes pressure off individual.

- Not constantly going back to the basics, build on knowledge.

- ‘Supermarket approach’: one stop shop where all issues covered as everyone is there.

- Saves time, effort and money, rather than door-to-door by village health worker.
11 million children die each year. 88% deaths could be prevented by good hygiene.

HOLISTIC HEALTH: Which DISEASES / conditions are addressed by health promotion in your model?
HOLISTIC HEALTH: COMMUNITY HEALTH CLUBS ADDRESS ALL PREVENTABLE DISEASES

1. Diarrhoea dysentery cholera
2. Skin disease
3. Eye disease
4. Worms
5. Acute Respiratory Infection
6. Malaria
7. Bilharzia
8. HIV
9. TB
10. Reproductive Health
11. Malnutrition
COMMUNITY CONTACT:
How many FACE TO FACE sessions with beneficiaries during training?

1. **zero**
2. 1–2
3. 3–4
4. 5–8
5. 9–12
6. 13–16
7. 17–20
8. 21–24
9. 25–30
10. >31–50
11. >51
12. other specify

<table>
<thead>
<tr>
<th>Theory Session</th>
<th>Zuva</th>
<th>Facilitator’s Signature</th>
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<tbody>
<tr>
<td>1 Zvakatikomberedza</td>
<td></td>
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</tr>
<tr>
<td>2 Kuona rudzi rwezvirwere</td>
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<td></td>
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<tr>
<td>3 Utsanana/Kugeza maoko</td>
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<tr>
<td>4 Kuchengeredza Misha zvoneutsanana</td>
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<tr>
<td>5 Panobva mvura ye kunwa</td>
<td></td>
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<tr>
<td>6 Kuchengeredza mvura mumba</td>
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<td>7 Kushandisa mvura mumba</td>
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<td>8 Mvura ye kunwa</td>
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<td>9 Kufamba Kunoita uruchiona</td>
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<td>10 Manyoka</td>
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<td></td>
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<tr>
<td>11 Mvura yemunu neshuga</td>
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<td>12 Zvimbudi</td>
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<td>13 Chipfunga</td>
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<td>14 Chimhungwe</td>
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<tr>
<td>15 Kudya kunodiwa nemuvi</td>
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<td>16 Makonye</td>
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<tr>
<td>17 Zvirwere zveganda nemaziso</td>
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<tr>
<td>18 Rurindu zvezvirwere zvechipfuwa</td>
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<tr>
<td>19 Mukondombera</td>
<td></td>
<td></td>
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<tr>
<td>20 Kuranga zvekuita</td>
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WHY THE NUMBER OF SESSIONS IS IMPORTANT

The more face to face interactions the stronger the response.

This research shows that change is most significant between 5–12 sessions (up to 3 months of weekly meetings).
INTEGRATION:
Highlight how many TYPES of benefit during your programme?

1. Health education
2. Improved hygiene
3. Water supply
4. Safe Sanitation
5. Saving groups
6. Income generating projects
7. Nutrition and agriculture
8. Environment / reforestation
9. HIV/AIDS coping mechanisms
10. Women’s empowerment
11. Child care / play schools
12. Human Rights / abuse
Why Integration is important

- Good for the community: ‘Real development’
- More cost-effective to build on existing efforts
- Development is a process: reinforced at each stage, takes time.
- Health Promotion is a non divisive
- Builds trust so more complicated projects can be managed effectively by the community
5. COVERAGE: How many people ATTEND the activity at one time?

1. <10
2. 11–20
3. 21–50
4. 51–75
5. 76–99
6. up to 500
7. up to 1000
8. general public
9. unknown
Why is number of people important?

1. A critical mass of people can tip the balance of opinion

2. Public health needs everyone to be involved

3. No impact on disease reduction if there is not a high % of CHC members in a clinic catchment area.
6. COST PER BENEFICIARY:  US$
Calculate this by cost of programme divided by number of beneficiaries

1. <US$100
2. <US$500
3. <US$200
4. <US$100
5. <US$75
6. <US$50
7. <US$25
8. <US$10
9. <US$5
10. <US$1
Cost Effectiveness of CHC Programme

Cost per beneficiary = \frac{\text{Cost of the project}}{\# \text{ members} \times \# \text{household}}

HA TINH PROVINCE, VIETNAM

- Average number per household: 4.58
- Number of CHC members: 828
- Number of beneficiaries estimated at 10,808
- Cost per beneficiary (one year, 2010): US$0.87

District Head of Environmental Health said: 

*CHC project is low-cost – high result*. 
7. EFFECTIVENESS: % improvement of observable hygiene indicators p>0.001

1. ODF / ZOD
2. Hygienic latrine
3. Hand wash facility / method
4. Use of soap
5. Disposal of child faeces
6. Clean drinking water / treatment
7. Clean water storage
8. Clean kitchen / eating habits
9. Personal hygiene / wash facility
10. Pot rack / clean plate storage
11. Solid waste management
12. Swept floor / yard
13. Grey water recycling

p>0.05
Bang for your Buck: Comparing amount of change

<table>
<thead>
<tr>
<th>Type</th>
<th>Disease</th>
<th># Messages</th>
<th>% Change</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PHAST</td>
<td>Diarrhoea</td>
<td>17</td>
<td>5.6 %</td>
<td>Uganda</td>
</tr>
<tr>
<td>2. Social Marketing</td>
<td>Diarrhoea</td>
<td>4</td>
<td>13 %</td>
<td>Burkina Faso</td>
</tr>
<tr>
<td>3. CLTS</td>
<td>Diarrhoea</td>
<td>1</td>
<td>33%</td>
<td>Nigeria</td>
</tr>
<tr>
<td>4. CHC A</td>
<td>Diarrhoea</td>
<td>17</td>
<td>47%</td>
<td>Zimbabwe</td>
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<tr>
<td></td>
<td>Skin disease</td>
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<td>Eye Disease</td>
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<td></td>
<td>Worms</td>
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<td>ARIs</td>
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<td></td>
<td>HIV/AIDS</td>
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<tr>
<td></td>
<td>Malaria / Bilharzia</td>
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4. Waterkeyn & Cairncross, 2005
SUSTAINABILITY: How many months after the end of the programme was Hygiene Behaviour measured?

1. during
2. 1–2
3. 3–5
4. 6
5. 7–12
6. 13+
7. 24
8. 36
9. 60
10. more
9. SCALABILITY: At what level can the Model be expanded and used effectively to scale?

1. Village
2. Town / urban
3. IDP / refugee emergency
4. District
5. Provincial
6. < 5 Districts
7. 50% of districts
8. 75% of districts
9. National
10. All levels
ALL 15,000 VILLAGES IN RWANDA WILL HAVE A COMMUNITY HYGIENE CLUB BY 2012: 11 million
10. ETHICAL BEHAVIOUR CHANGE
Which of these human values does the Model actively encourage during promotion?

1. Self-respect
2. Self-discipline
3. Self-reliance
4. Shared responsibility
5. Individual rights
6. Respect & tolerance of others
7. Increase common unity (Ubuntu)
8. Spread of knowledge
9. Empowerment of women
10. Increase of social capital (trust & reciprocity)
Values in Charter of the United Nations

- Freedom
- Equality
- Respect for nature
- Tolerance
- Solidarity
- Shared responsibility

*Fundamental values essential to international relations in the 21st century*

* UN Millennium summit 2000
TIME FOR REFLECTION ON THE ETHICS OF OUR TRADE:

Medical Practitioners have to conform to the Hippocratic Oath when dealing with the public.

Public health professionals have no such standard of behaviour.

As development practitioners we should have standards (like Sphere) that provide ethical guidelines so we do not undermine local communities dignity or inadvertently cause division within villages by our project.
The Community Health Club Model is an ethical behaviour change Model which uses positive peer pressure to achieve sustainable change, by reinforcing positive cultural norms.

‘In Africa we sit under a tree, ‘til we agree.’
Julius Nyerere, the first President of Tanzania
How did your programme score?

Lets do good development!
Thank you for your attention
See: www.africaahead.com