Best Practice in Hygiene Promotion Programmes:

an evaluation template to determine cost-effectiveness.

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10 Indicators of Good Development Practice

1.Method	Which Methods are used to reach audience?
2.Scope	Which diseases / conditions are addressed?
3. Length	Period of contact with beneficiaries.
4. Integration	Type of development activities undertaken.
5.Coverage	How many people targeted at the same time?
6. Cost	'Cost per beneficiary'
7.Effectiveness	Number of observable hygiene indicators.
8.Sustainability	How long new practices have been maintained?
9. Scalability	Has the Model been used effectively at scale?
10. Ethics	Which human values does the Model encourage?

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

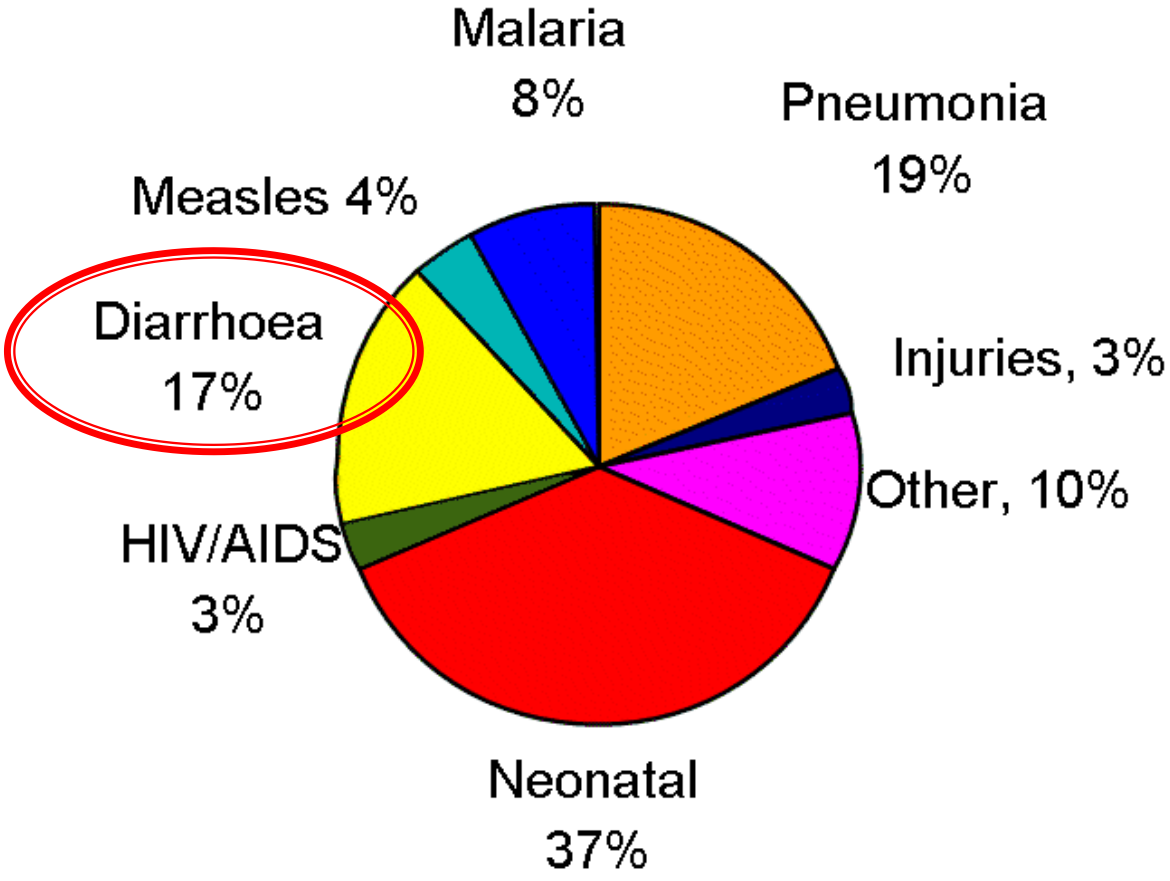
COMMUNICATION:
Which CHANNELS are employed to reach the target audience?

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?

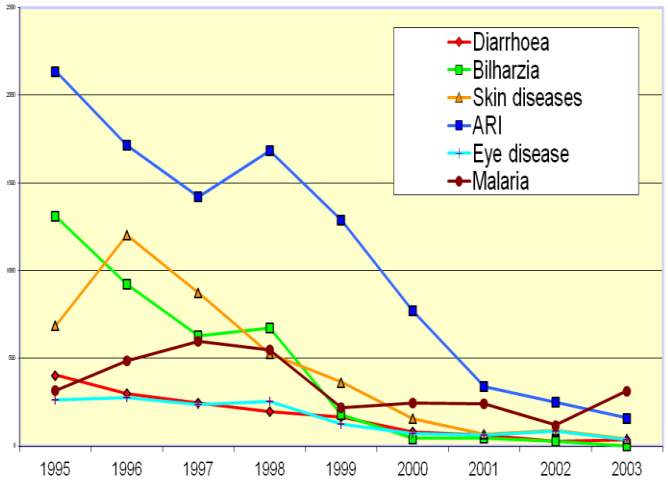
- Group consensus is developed : group decision takes pressure off individual
- Not constantly going back to the basics, build on knowledge.
- 'Supermarket approach': one stop shop where all issues covered as everyone is there.
- Saves time, effort and money, rather than door-to-door by village health worker.

HOLISTIC HEALTH:
Which DISEASES / conditions are addressed by health promotion in your model?



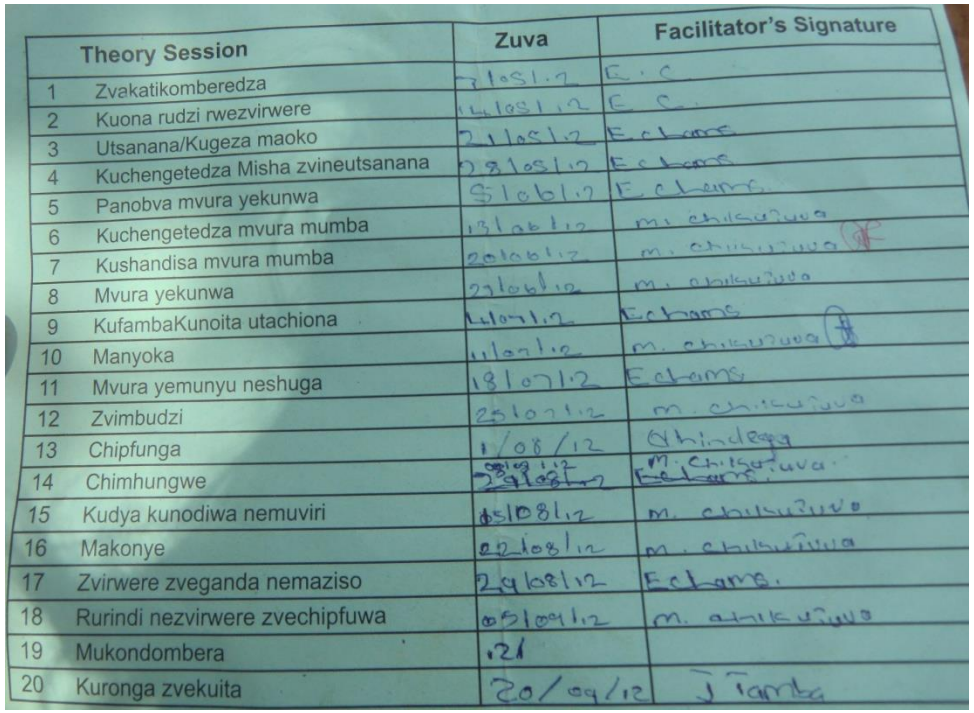
11 million children die each year
88% deaths could be prevented by good hygiene

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

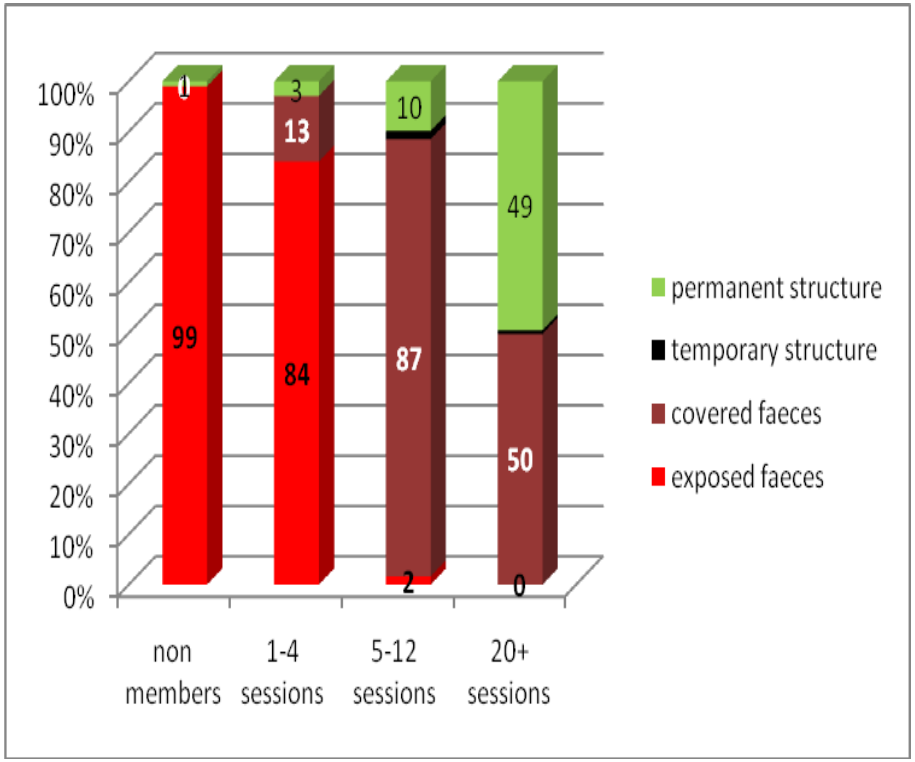
COMMUNITY CONTACT:
How many FACE TO FACE sessions with beneficiaries during training?



	Theory Session	Zuva	Facilitator's Signature
1	Zvakatikomberedza	7/05/12	E. C
2	Kuona rudzi rwezvirwere	14/05/12	E. C.
3	Utsanana/Kugeza maoko	21/05/12	E. Chams
4	Kuchengetedza Misha zvineutsanana	28/05/12	E. Chams
5	Panobva mvura yekunwa	04/06/12	E. Chams.
6	Kuchengetedza mvura mumba	11/06/12	M. Chikuvuwo
7	Kushandisa mvura mumba	18/06/12	M. Chikuvuwo
8	Mvura yekunwa	25/06/12	M. Chikuvuwo
9	KufambaKunoita utachiona	02/07/12	E. Chams
10	Manyoka	09/07/12	M. Chikuvuwo
11	Mvura yemunyu neshuga	18/07/12	E. Chams
12	Zvimbudzi	25/07/12	M. Chikuvuwo
13	Chipfunga	1/08/12	Chindega
14	Chimhungwe	08/08/12	M. Chikuvuwo. E. Chams.
15	Kudya kunodiwa nemuviri	15/08/12	M. Chikuvuwo
16	Makonye	22/08/12	M. Chikuvuwo
17	Zvirwere zveganda nemaziso	29/08/12	E. Chams.
18	Rurindi nezvirwere zvechipfuwa	05/09/12	M. Chikuvuwo
19	Mukondombera	12/	
20	Kuronga zvekuita	20/09/12	J Tamba

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

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

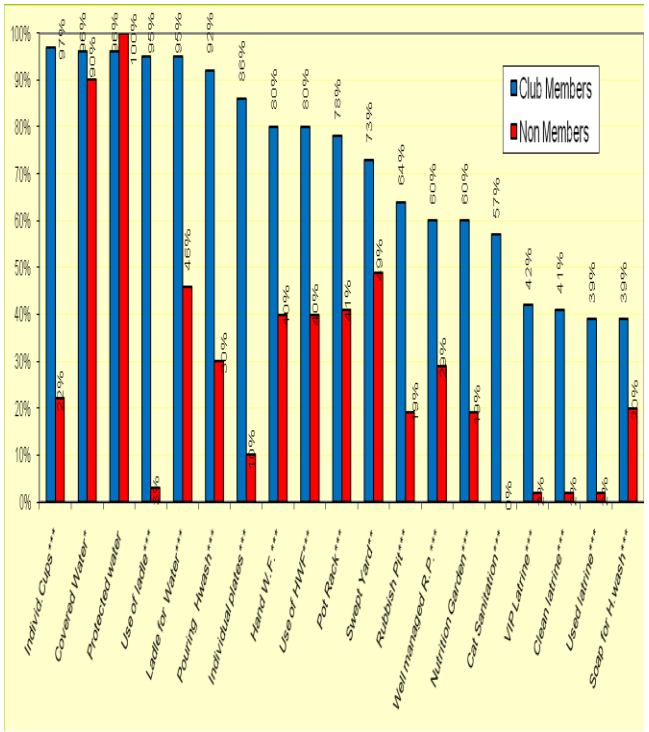
Cost per beneficiary = $\frac{\text{Cost of the project}}{\text{\# members x \#household}}$

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



p>0.05

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

Bang for your Buck: Comparing amount of change

Type	Disease	# Messages	% Change	Country
1.PHAST	Diarrhoea	17	5.6 %	Uganda
2. Social Marketing	Diarrhoea	4	13 %	Burkina Faso
3. CLTS	Diarrhoea	1	33%	Nigeria
4.CHC A	Diarrhoea	17	47%	Zimbabwe
	Skin disease			
	Eye Disease			
	Worms			
	ARIs			
	HIV/AIDS			
	Malaria / Bilharzia			

1. Palmer (WSP-World Bank) (2005)
2. 2.Cave & Curtis, 2002.
3. WaterAid , 2010.
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?

TIME TO SCALE UP

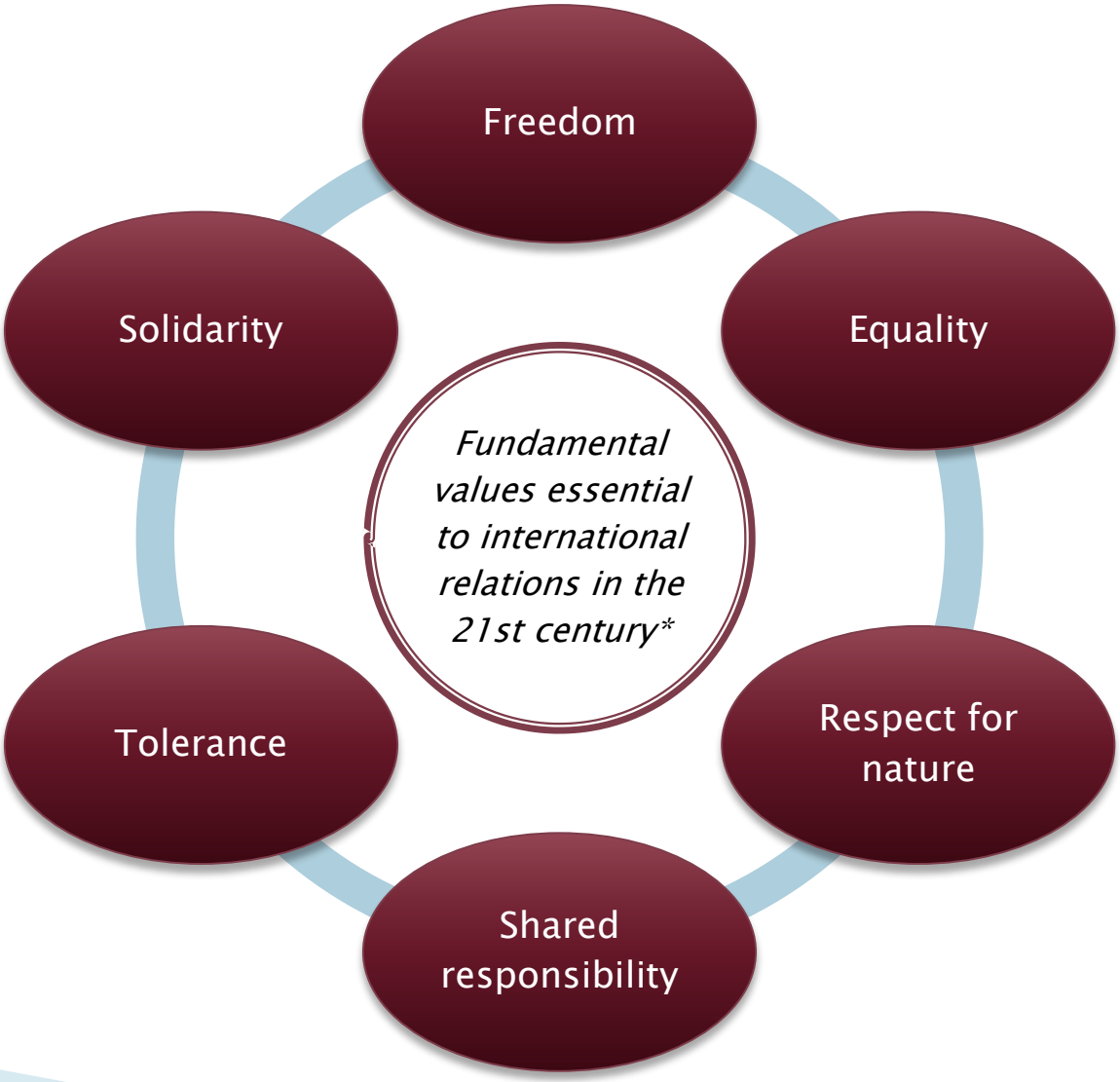
1. Village
2. Town /urban
3. IDP / refugee emergency
4. District
5. Provincial
6. < 5 Districts
7. 50% of districts
8. 75% of districts
9. National
10. All levels

ALL 15,000 VILLAGES IN RWANDA WILL HAVE A COMMUNITY HYGINE 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



* 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

Lets do good development!

Thank you for your attention

See: www.africaahead.com