



Activity Report 138

Strengthening Hygiene Promotion
in the West Africa Water Initiative
(WAWI) Partnership
in Ghana, Mali and Niger

Assessing the Capacity of WAWI Partners
to Promote Hygiene

by

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About the Author

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The WAWI Partnership has the human resources and the commitment to have positive impact on hygiene. Best wishes in ensuring healthier countries, cities, communities, villages, and lives in West Africa.

This report is a follow-on to EHP Activity Report 124, *West Africa Water Initiative (WAWI) Monitoring and Evaluation Plan, Program Framework and Indicators*, which was prepared by EHP Activity Manager, Lisa Nichols, in January 2004.

Acronyms

BCS	Behavior Change Strategy
BCCS	Communication Strategy for Behavior Change
CCG2	Carter Center Global 2000
CIIFAD	Cornell International Institute for Food, Agriculture and Development
DRI	Desert Research Institute
EHP	Environmental Health Project
FGD	focus group discussions
HKW	Helen Keller Worldwide
HP	Hygiene Promotion
ITI	International Trachoma Institute
MOU	Memo of Understanding
SAFE	Surgery, Antibiotics, Face Washing, and Environmental Change
SAPHTA	Hygiene (is not actually an acronym, translated means “hygiene”)
TA	Technical Assistance
UNICEF	United Nations International Children’s Education Fund
USAID	United States Agency for International Development
WAWI	West Africa Water Initiative
WCC	World Chlorine Council

Executive Summary

Effective disease reduction requires that the basic elements are accessible and available to audiences to practice desired hygiene behaviors; clarity and consistency are provided to audiences; audience understanding, knowledge, and ability are in place; and outside influencing factors are supporting desired hygiene behaviors. To fulfill these requirements, disease reduction programs must ensure that appropriate and crucial staff capacities are in place. This WAWI hygiene promotion (HP) capacity assessment appraised the necessary skills and capacities of each WAWI partner carrying out hygiene promotion activities.

The three necessary elements to behavior change include: (1) access to hardware — water, sanitation and household technologies such as soap safe water containers, water, sanitation and household technologies, (2) hygiene promotion activities — communication and training, and (3) enabling environment — policy and others. Where these three elements overlap, maximum behavior change is possible. When the provision of all three elements begins to happen more often in the same villages, communities, and districts, the overlap increases and so does the potential for increased and sustained behavior change.

Three main components and seven sub-components were examined during this assessment utilizing self-assessment tools, in-depth interviews, focus group discussions, observations, and materials review. The components and sub-components comprised:

Component 1: Behavior Change

- a. Key Behaviors — Identify key behaviors that are clear, simple, and precise and determine these behaviors with the intended audience.
- b. Messages — Clearly link messages to key behaviors and pretest with the intended audience.

Component 2: Strategy

- a. Design and Development — Use research and experience to develop a complete behavior change strategy (BCS) determining feasible behaviors and the six main areas.
- b. Implementation — Develop a plan of action based on the strategy, and carry out activities specified in this plan in a timely fashion.
- c. Monitoring and Evaluation — Monitor activities at least every three months and develop and implement an evaluation that includes clear, precise, and simple indicators — process, outcome, and impact.

Component 3: Resources

- a. Personnel — Hire sufficient staff and train them well.

- b. Finances — Develop an adequate budget to carry out strategy activities and identify financial sources to support this budget.

Based on assessment findings, the following four capacities appear to need to be strengthened:

1. Delineation of complete BCS as a “partnership,” includes:
 - Clear behavior analysis
 - Detailing of all intervention areas
2. Development of evaluation linked to BCS
3. Development of linkages between HP and water infrastructures
4. Training of partner staff in HP

WAWI should consider (1) developing a WAWI-wide hygiene promotion strategy to complement the work that each partner is presently engaged in and enhance the HP work that the partnership will be able to complete; (2) training WAWI partner staff in behavior change techniques — to focus on new and complementary techniques and build the capacity of the partnership to use these techniques; and (3) maximizing use of existing partner HP capacity — to rely more on what each HP capacity or set of HP capacities an individual partner brings to the strategy, only to pull in outside expertise when the partnership feels it is necessary.

To implement these recommendations, the following would need to be in place: (1) BCS model for WAWI countries to use; (2) WAWI Hygiene Promotion Behavior Change Specialist to provide training, assistance and technical support as needed; and (3) adequate funds and resources per country to carry out country-specific HP BCS.

These possible next steps could operationalize the recommendations and put the requirements in place:

1. Hold a three-day, WAWI-wide working seminar to develop/agree upon BCS model to adopt.
2. Prepare a BCS working model document for each country to use in developing their country-specific BCS.
3. Detail a partner HP capacity matrix (could be completed at the BCS working seminar).
4. Develop, by country, a three-year WAWI hygiene promotion behavior change strategy. (This could allow WAWI to achieve its Strategic Framework Objective 2 — Outcomes and Outputs, while also meeting country- and partner-specific needs and mandates.)
5. Develop, by-country, budgets to carry out country-wide HP BCS.

1. Introduction

1.1. Background

The World Summit on Sustainable Development has formally endorsed “partnerships” as a model for action. Organizations around the world are strengthening existing alliances, and fostering new collaborations to make progress on achieving the United Nations’ Millennium Development Goal of “halving, by 2015, the proportion of people without sustainable access to safe drinking water.” As part of this global movement towards partnership, the West Africa Water Initiative (WAWI) was launched in late 2001 to help improve the lives of poor and vulnerable rural and urban populations in the developing world. The impact of this initiative is expected to be significant and will result in increased access to services, improved health and welfare, and more sustainable management of water resources for hundreds of thousands of people. The following are the goals of WAWI:

- Increase the level of access to sustainable, safe water and environmental sanitation services among the poor and vulnerable populations
- Reduce the prevalence of water-borne diseases including trachoma, guinea worm, and diarrheal diseases
- Ensure ecologically and financially sustainable management of water quantity and quality
- Foster a new model of partnership and institutional synergy

Leadership and major funding for WAWI has been provided by the Conrad N. Hilton Foundation. WAWI is a natural outgrowth of the Hilton Foundation’s years of experience with World Vision and other international nongovernmental partners to provide rural water and sanitation as part of integrated community development. In 2002, the Hilton Foundation expanded their long-standing efforts in not only Ghana, but also in Mali and Niger, and added a peri-urban as well as rural focus to their work. While the core emphasis remains the link between water and health — in particular diseases such as trachoma, guinea worm and diarrhea — the need for attention to a broader water management context has been recognized and embraced. WAWI works in rural and peri-urban communities in Ghana, Mali, and Niger.

To accomplish the goals of WAWI, a partnership of 14 distinguished international institutions has been assembled:

1. The *Conrad N. Hilton Foundation*, a private charitable foundation devoted to the alleviation of human suffering and provision of humanitarian assistance in the United States and abroad, focusing on areas including blindness, early childhood development, domestic violence, and homelessness. The Hilton Foundation is the primary external donor and serves an important coordination and oversight role for its grantees.

2. *World Vision International*, a Christian relief and development organization, takes the lead in well drilling, pump installation, and alternative water source development, along with community mobilization to facilitate local ownership and sustainable management of systems. World Vision will also establish a broad-based regional training program to support “hardware” and “software” components of the overall initiative for WAWI partners and counterparts.
3. *The United States Agency for International Development (USAID)*, the bilateral assistance agency of the U.S. Government, provides funding to WAWI partners and will also help strengthen the integrated water resources management orientation of the initiative through support to areas including: livelihoods and income generation, policy and enabling environment, gender mainstreaming, and hydrologic information management in both rural and peri-urban settings.
4. *United Nations International Children’s Fund (UNICEF)*, an international organization within the United Nations system committed to helping children living in poverty in developing countries, works in several priority areas of action including water and environmental sanitation. UNICEF focuses its efforts on rural school-based sanitation and hygiene, well rehabilitation and alternative water source development, and advocacy and enabling environment activities.
5. *WaterAid*, a private charity dedicated to the provision of domestic water, sanitation, and hygiene promotion for the world’s poorest people, is the principal implementer of peri-urban water supply and sanitation efforts within WAWI, in addition to supporting rural sanitation and hygiene capacity building and outreach.
6. *The World Chlorine Council (WCC)*, a non-profit network of national and regional trade associations and their member companies representing the global chlorine chemistry industry, will join with the Global Vinyl Council to provide a product donation of PVC pipe for tube wells in the target communities.
7. *Winrock International*, a non-profit environment and development organization, collaborates with the Desert Research Institute to develop sustainable, smallholder irrigation and micro-irrigation activities.
8. *Lions Club International (Lions)*, the grant-making arm of a worldwide private voluntary service club organization, provides funding and in-country volunteers to carry out a targeted trachoma prevention campaign in Mali and Niger as part of their blindness program.
9. *The Cornell International Institute for Food, Agriculture and Development (CIIFAD)*, a research and academic institution, supports community mobilization and water development in the context of sound natural resources management, pursuing action research and pilot activities in sustainable agriculture, environmental protection, and rural development.
10. *The Desert Research Institute (DRI)*, a research and academic institution, undertakes hydro-geologic analysis and modeling and will provide capacity building to strengthen government information management systems.

11. *The International Trachoma Initiative (ITI)*, an organization dedicated to eliminating the world's leading cause of preventable blindness, supports and works through international agencies, governmental and nongovernmental organizations to implement the SAFE strategy through antibiotic distribution, applied research and communication, and advocacy.
12. *The United Nations Foundation*, provides grants and develops innovative public-private partnerships in the areas of children's health; the environment; peace, security and human rights; and women and population. UNF supports other WAWI partners in the areas of strategic planning, public affairs, and resource mobilization.
13. *The Helen Keller Worldwide (HKW)*, a worldwide organization that focuses on "bringing the world into view," carries out information, education and communication work on nutrition, trachoma, primary health care, etc., areas which impact on preventing blindness.
14. *The Carter Center Global 2000 (CCG2)*, an organization, in partnership with Emory University, guided by a functional commitment to human rights and the alleviation of human suffering, collaborating with other local organizations, government, public- and private-sector, seeks, among one of its programs, to improve the quality of life through projects to eradicate and control infectious diseases such Guinea worm disease.

In its first five-year phase, this new partnership of ten international institutions will invest more than US\$40 million in small scale, potable water supply, sanitation, hygiene, and integrated water resources management activities in Ghana, Mali, and Niger. Additionally, as part of its contribution to WAWI, USAID has awarded a Task Order under the Water Indefinite Quantity Contract to ARD, Inc., to serve in a management, coordination, and facilitation role in respect to USAID's financial contribution to the Initiative.

1.2. Purpose

During discussions held in Bamako and Seattle with key WAWI staff, in particular with World Vision and Water Aid representatives, EHP proposed to provide technical assistance in areas identified by the partners. Several options were considered and it was decided, by all of the WAWI partners, that EHP should focus on hygiene promotion. An EHP consultant was asked to visit Ghana, Mali, and Niger from Jan. 18 to Feb. 12, 2004 to conduct a three-country assessment of WAWI partners' capacity to promote hygiene, and based on this assessment, provide guidance on possible hygiene promotion next steps, partner capacities to strengthen, and capacities to share among partners.

1.3. Assessment Objectives

More specific assessment objectives included, on the topic of water-borne diseases — diarrheal diseases, trachoma, and guinea worm:

- Identify existing hygiene promotion activities among WAWI partners.
- Determine importance and value of hygiene promotion activities for WAWI partners.

- Identify how hygiene promotion is/could be related to water infrastructure improvement activities of WAWI partners.
- Identify mechanisms to sustain hygiene promotion and practices at the community level either by building on existing mechanisms to sustain water source improvements or by identifying alternative and feasible mechanisms.
- Describe hygiene promotion technical assistance provided by and to WAWI partners.
- Specify country similarities and differences in carrying out hygiene promotion activities.
- Ascertain the capacity of each WAWI partner interviewed to carry out hygiene promotion activities.
- Determine the needs for/gaps in hygiene promotion capacity among WAWI partners.

2. Methodology

2.1. Design

2.1.1. Hygiene Promotion Capacity Framework

This assessment focused on hygiene promotion (HP) or more specifically, the behavior change implicit in hygiene promotion and a strategy that can encourage and support that behavior change. To productively assess partner capacity to promote hygiene, it was necessary to detail a framework to use to examine, equally among WAWI partners, basic capacities necessary to the effective promotion of positive hygiene behaviors. The EHP team developed the following foundation. With technical assistance from the EHP consultant, each component and sub-component (see Chapter 3, Section 3.2.4) was further delineated for use in the field.

Component 1: Behavior Change

Sub-Component A: Key Behaviors — Identify key hygiene behaviors with a proven health impact to be promoted that are clear, simple, and precise and determine these behaviors with the intended audience.

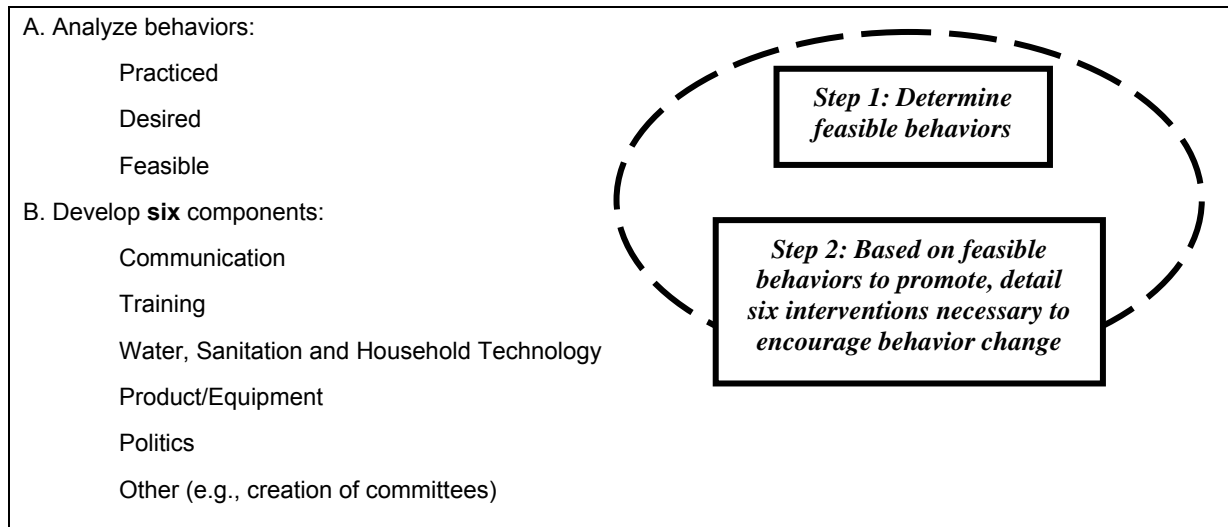
Sub-Component B: Messages — Clearly link messages to key behaviors and pretest with the intended audience.

Component 2: Strategy

Sub-Component C: Design and Development — Use research and experience to develop a complete behavior change strategy (BCS) determining feasible behaviors and the six main areas (see Chapter 4 for more specifics on a BCS).

The following figure provides additional detail on the BCS process.

Figure 1: Basic Process of Developing a Behavior Change Strategy



Sub-Component D: Implementation — Develop a plan of action based on the strategy and carry out activities specified in this plan in a timely fashion.

Sub-Component E: Monitoring and Evaluation — Monitor activities at least every three months and develop and implement an evaluation that includes clear, precise, and simple indicators — process, outcome, and impact.

Component 3: Resources

Sub-Component F: Personnel — Hire sufficient staff and train them well.

Sub-Component G: Finances — Develop an adequate budget to carry out strategy activities and identify financial sources to support this budget.

The following component, though not included on the self-assessment, was included in interview and focus group discussions and on observational site visits.

Component 4: Provision of Water, Sanitation and Household Technology

Sub-Component H: Water Sources — Ensure access to/provision of safe water sources.

Sub-Component I: Feces Disposal — Ensure access to/provision of school and home latrines.

Sub-Component J: Products — Guarantee that all necessary products are available.

2.1.2. Assessment Methods Used

The following methods were used to carry out the WAWI hygiene promotion capacity assessment based on the assessment framework delineated above:

- a. A simple capacity assessment tool was used with each in-country WAWI partner (see Annex A for a complete list of organizations contacted).
- b. Follow-up in-depth interviews were conducted with each in-country WAWI partner, upon completion of a capacity assessment tool. Furthermore, phone and in-person interviews were conducted with all other primary and secondary sources (see Annex A).
- c. Focus Group Discussions (FGDs) and Observations — After discussions with WAWI staff and country team leaders, partner project communities were visited and when possible, community FGDs were conducted and informal observational tours of the community were carried out.
- d. Document and Materials Review — Project and partner documents were reviewed prior to and during the course of the assessment as required and as deemed necessary. Hygiene promotion materials were reviewed in-country based on self-assessment findings and availability (see Annex B for a list of documents reviewed).

2.2. Sources, Sample Size, and Sites

The assessment was carried out in Accra and Tamale, Ghana; in Bamako, Bla, and San, Mali; and in Niamey and Zinder, Niger, from Jan. 18 to Feb. 12, 2004.

Table 1 below indicates a complete list of sources used, methods used with each source, and sample size for each source and method by country.

Table 1: Assessment Sources and Sample Size

Methods/Sources	Desired Sample Size*	Actual Sample			
		Ghana	Mali	Niger	TOTAL
Quantitative Self-Assessment with Partners	7 (21)	6	5	7	18
In-depth Interviews with Partners	7 (21)	6	5	7	18
Interviews with Partners	4 (12)	5	4	4	13
Interviews with Secondary Sources	4 (12)	1	6	7	14
Community Discussions	3 (9)	2	1	1	4
Community Observations	3 (9)	2	1	4	7
Partner Materials Sets Review	5 (15)	3	2	4	9**
Country Debriefing (formal & informal) with Partners ***	3	1	1	1	3

* Desired per country 70-75% of estimated total sample size (TOTAL Sample Desired)

** From five different organizations

*** Debriefs have been added here as they were used to gather additional information, to clarify and correct previously collected information, and to process information with partners.

3. Assessment Findings

3.1. Self-Assessment Results

Quantitative self-of partners’ capacity to promote hygiene assessments were administered via questionnaires in which various HP-related capacities were ranked (Annex C) as a first step in the assessment process. The self-assessment tool covered all three components with the seven sub-components being further broken down into specific phrases partners could use to self-report and rate their organizations’ capacity under each component (see Section 3.2.4 for the complete list).

A “perfect” capacity score is 112. The self-reported WAWI-wide average was 91 out of 112: 25 out of 28 for Behavior Change, 48 out of 60 for Strategy, and 18 out of 24 for Resources (see Annex C for more quantitative specifics). Table 2 below shows the self-reported average capacity of WAWI partners by country in each of the three main components of behavior change, strategy, and resources.

Table 2: Self-Reported WAWI Average HP Capacity by Country and by HP Component

HP COMPONENTS	COUNTRY					
	<i>Ghana</i>		<i>Mali</i>		<i>Niger</i>	
	<i>Score</i>	<i>Percentage</i>	<i>Score</i>	<i>Percentage</i>	<i>Score</i>	<i>Percentage</i>
Country Average (out of 112)	90	80	92	82	97	87
Behavior Change (out of 28)	25	89	25	89	28	100
Strategy (out of 60)	48	80	49	82	52	87
Resources (out of 24)	17	71	18	75	20	83

Self-assessments were administered to seven out of the twelve “implementing” partners—Carter Center, ITI, HKW, Lions, WaterAid, World Vision, and UNICEF. For purposes of the assessment finding reporting, each of the seven was given a partner number at random. Given the nature of their work in the field, CIIFAD, DRI, WCC, Winrock, and the United Nations did not complete self-assessments. They were, however, when possible, interviewed. Table 3 details the self-reported capacity by partner broken down by the three main components respectively.

Table 3: Self-reported HP Capacity by Partner and by HP Component

PARTNER NUMBER (randomly assigned)	HP COMPONENTS							
	Partner Overall (out of 112)		Behavior Change (out of 28)		Strategy (out of 60)		Resources (out of 24)	
	Score	Percentage	Score	Percentage	Score	Percentage	Score	Percentage
Partner 1	88	79	27	96	45	75	16	67
Partner 2	92	82	22	79	40	67	20	83
Partner 3	102	91	27	96	56	93	20	83
Partner 4	78	70	25	89	38	63	15	63
Partner 5	94	84	25	89	49	82	20	83
Partner 6	88	79	24	86	47	78	17	71
Partner 7	95	85	27	96	50	83	18	75

As can be seen by Table 3, WAWI partners, in general, feel fairly confident about their overall HP capacity. They appear to be fairly confident as well about their Behavior Change, but less confident over their Strategy and Resource capacities.

However, as one partner so aptly put it: *“Our scores (self-assessment results) are so high.... We think we are doing so well, but we are not having an impact like we want on behavior! Why? What are we missing...? We think be are doing things (behavior change) that we are not actually doing.... We need to reexamine what we do and how we do it....”* This sentiment was repeated and concurred upon in all three countries.

3.2. Qualitative Findings

The second step in the assessment process was qualitative — conduct of interviews, FGDs, and observations. The qualitative work was used to substantiate quantitative findings and to clarify issues and trends of apparent importance to partners.

3.2.1. Overview of Findings

For the most part, qualitative findings support the self-reported scores of partners, there were three important exceptions. A partner’s understanding of what each capacity entailed and encompassed had an impact on the way each partner self-assessed its capacity. With subsequent qualitative discussions and further probing, most partners acknowledged that they may have been overly “generous” in their self-assessments. Following in-depth interviews, discussions were held on key behaviors, behavior change strategies, and evaluation indicators. The majority of partners acknowledged that not only had they overrated what they do, but that the partnership might need to come together in common understanding and approach to these three exceptions — key behaviors, a BCS, and an evaluation plan and indicators.

Characterization of Key Behaviors

There appears to be confusion over how to detail and present a key behavior, though, over what constitutes a key behavior. For example, all are aware that “wash hands” is a key behavior, but it has mostly translated out into their work as something like “*Handwashing is important because it will reduce how often your children get sick.*” Instead of something clear and straightforward like “*Wash your hands after using the toilet with ashes and water.*”

The one notable exception is in the CCG2 Guinea worm program which uses “*Filter surface water to avoid Guinea worm*” — a clear key behavior and a key message. Statistics indicate a significant reduction in the number of Guinea worm cases in all three countries. And while this key behavior/key message combination cannot take full credit for this reduction, it has aided through its clarity, simplicity, and feasibility (see Chapter 4, Sections 4.2.1 and 4.2.2 for more on key behaviors).

Ingredients for an Effective, Comprehensive Behavior Change Strategy

Again there appears to be some confusion over what constitutes a complete BCS (see Chapter 4). For the most part, partners are implementing communication strategies; communication and training strategies (commonly referred to as behavior change communication strategy or communication strategy for behavior change—BCCS); or a combination of water, sanitation and household technology, product provision, and other interventions. No one partner appears to be implementing a complete BCS with all six intervention areas fully covered, nor does any one partner appear to have the capacity to do this. However, the collective HP capacities of the partnership are tremendous. And the potential that exists for the WAWI partnership to implement a comprehensive BCS with an appropriately linked evaluation is unlimited.

Delineation of Precise, Concise Evaluation Indicators

The apparent lack of clear evaluation indicators appears to have two main causes: (1) insufficient time and thought have been given to this by the partners and as a “partnership,” and (2) clear HP key behaviors have yet to be delineated thus making it very challenging to detail precise, corresponding indicators (see Chapter 4, Sections 4.2.3 and 4.3.3 for more on evaluation and indicators). World Vision’s Social Viability Study, used to begin its work in communities, could be used as a basis for thinking about some of these indicators. While this study is not exactly in the form needed, it could provide an excellent supporting document. As well, EHP has developed *Activity Report 124, West Africa Water Initiative (WAWI) Monitoring and Evaluation Plan, Program Framework and Indicators*. This document should begin to facilitate the process, if key behaviors are identified and a strategy can be put in place. Furthermore, another document that could be tapped and selectively adapted based on a designed BCS would be the WAWI Program Framework, which presently has one goal, four objectives, 21 outcomes, and 61 outputs. The outcomes represent “types of information needed” for an evaluation plan and the outputs, if reformulated, represent possible “indicators.”

3.2.2. Country-Specific Synthesis by Assessment Objective

Commonalities among countries are clearly evident in the following table, which provides a synthesis of findings by country. Section 3.2.3 details these WAWI-wide commonalities. Table 4 compares country findings by assessment objective. *“How can we (the partners) work together when we do not know each other... do not know what the other does or how they do it ...we need to get to know each other better to work as partners....”*

Table 4: Synthesis of Qualitative Findings — by Country by Assessment Objective

Assessment Objective	Ghana Findings Synthesis	Mali Findings Synthesis	Niger Findings Synthesis
Objective 1: Identify existing HP activities.	Form water and management committees Build school and home latrines Provide water sources Raise awareness, inform, and educate on three areas of trachoma, guinea worm, and diarrheal diseases* Provide training in selected areas-masons, community hygiene/health workers, etc. Develop educational HP materials	Organize water and management committees Build school and family latrines Construct water sources Raise awareness, educate and inform on the three areas* Transfer technical competences to the community Train community promotion agents in the field	Organize management committees Build school and family latrines Construct water sources Raise awareness, educate, and inform on the three areas* Train community field agents Develop educational materials for community agents
Objective 2: Determine the importance and value of HP.	Most partners feel HP is important and the majority considers it a priority.	The majority of partners appreciates the importance of hygiene and most give it priority.	All partners appreciate the importance of HP and give it priority.
Objective 3: Identify how partners link HP activities to water infrastructures.	For the most part, there is no concerted effort to link infrastructures with HP activities, but a few exceptions exist (1) education on cleanliness around water sources, and (2) water treatment education.	In general, partners do not link infrastructure activities with HP activities. They concentrate on building and maintaining structures.	In general partners do not link HP activities to infrastructures, but in the villages, there are several instances of linkages promoted by the community (1) committee hygienist has started to include hygiene education in her work and (2) female group has begun to organize regularly cleaning of village water source.
Objective 4: Identify possible support systems in the communities.	Several excellent potentials exist: Expanded use of management and water committees Use of district assemblies Inclusion/use of mothers' groups and listening groups — youth and adult	There are several opportunities to pursue: Expanded role of management and water committees Inclusion/use of previously trained community field agents	A couple of opportunities exist: Expanded role of water committees Use of women's groups Expanded role of SAPHTA women's units
Objective 5: Describe support and technical assistance (TA) provided, by WAWI.	Strongest TA includes numerous educational materials and link to communities. Weakest TA provided is construction of water sources and latrines both family and school.	Strongest TA provided is education and communication and the transfer of technical competence to the community. Weakest TA provided is construction of water sources.	Strongest TA provided is in education and communication. Weakest TA provided is in water source construction.

Assessment Objective	Ghana Findings Synthesis		Mali Findings Synthesis		Niger Findings Synthesis	
Objective 6: Specify country differences and similarities (see Section 3.2.3 Objective 6).						
Objective 7: Ascertain the capacity of partners to provide HP.	Strengths: Participation of community Priority importance of HP Implementation of activities Monitoring Sufficient staff Budgeted resources	Weaknesses: Clear key behaviors Links between key behaviors and messages Complete BCS Sufficient and appropriate training for staff Supplemental resources	Strengths: Inclusion of community Use of experience and research Implementation of activities Sufficient staff Budgeted resources	Weaknesses: Key behaviors Link of messages to key behaviors Complete BCS Complete evaluation plan with clear indicators Trained staff Supplemental HP resources	Strengths: Involvement of community Implementation of activities Sufficient staff Importance and value of HP Budgeted resources	Weaknesses: Key behaviors identified Messages clearly linked to behaviors Complete BCS Monitoring Evaluation Appropriate sufficient training for staff
Objective 8: Determine capacities to strengthen.	Clearly analyze behaviors to detail key behaviors Delineate ALL six components of a BCS Develop evaluation plan with precise indicators, linked to BCS Develop formal linkage between HP activities and infrastructures Solicit resources necessary to implement complete BCS		Identify and clarify key behaviors Clearly link messages to these key behaviors Develop a complete BCS — ensuring that all six components are covered Consistently monitor HP activities Develop an evaluation plan with clear indicators Train staff in HP — with competences and information appropriate to each level		Clarify key behaviors Link messages to identified key behaviors Develop a complete BCS Develop an evaluation plan with clear indicators Train staff in HP with information and competences appropriate to each level	

Furthermore, significant differences emerge from this table synthesis. These differences will need to be taken into careful consideration if a WAWI-wide HP behavior change strategy is to be executable and ultimately effective. These differences include:

- Development of education HP materials
- Transfer of technical competence to the community
- Priority importance of HP
- Regular monitoring
- Need for the construction of latrines

3.2.3. Objectives 1-6 WAWI-wide Synthesis

The following WAWI-wide commonalities were culled from the country findings. These commonalities give clear direction to how WAWI could go about formulating a strategy that would allow each partner to meet its own organizational imperatives, while also allowing the WAWI partnership to develop and pursue complementary HP activities and mandates, each reinforcing the other (see Chapter 4, Section 4.3 for a strategy model).

Objective 1: Existing HP Activities

WAWI partners in Ghana, Mali, and Niger:

- Form water and management committees
- Provide water sources
- Build school and home latrines
- Raise awareness, inform, and educate on three areas of trachoma, guinea worm, and diarrheal diseases
- Provide training in selected areas-masons, community hygiene/health workers, community field agents, etc.
- Develop educational HP materials
- Transfer technical competences to the community

“We all have the same basic activities, but we do them a little differently.... And are we having the impact we want with all these same things... everywhere... . Do we need to start to think about doing some new, different activities...?”

Objective 2: Importance and Value of HP

Most partners feel HP is important, and the majority consider it a priority.

Objective 3: Links between HP Activities and Infrastructures

For the most part, there is no concerted effort to link infrastructures with HP activities. Work concentrates on building and maintaining structures. A few exceptions exist: (1) education on cleanliness around water sources; and (2) water treatment education. As well, there are several instances of linkages promoted by the community itself:

- Committee hygienist, who has started to include hygiene education in her work.
- Female group, which has begun to organize regularly cleaning the village water source and wants to start additional promotion activities.

“We focus on being sure the equipment works... and people can repair it, not yet on education or strong hygiene promotion....”

Objective 4: Potential Links and Support Systems

There appears to be several opportunities to build on existing community support mechanisms. Some thoughts for consideration include:

- Expanded role and use of management and water committees
- Use of district assemblies
- Inclusion/use of mothers' groups and listening groups — youth and adult
- Inclusion/use of previously trained community field agents
- Expanded role and use of women's groups

“We have over 6,000 trained women and mothers..., we could easily add hygiene activities to their role in the communities...”

Objective 5: Support and TA Provided

The weakest technical assistance provided by WAWI organizations to participating communities appears to be in the construction of water sources and latrines in households as well as schools. The strongest TA seems to be in numerous educational materials developed, the link to communities, the ongoing education and communication, and the transfer of technical competence to the community.

“We have a lot of expertise and experience, but we do not share it as we might... we don't really know what the other partners have that can be shared and learned....”

Objective 6: Country Differences and Similarities

Numerous similarities and differences between countries among partners emerged during the assessment.

Similarities:	Differences:
<ul style="list-style-type: none"> • Need for organization and structure to HP within WAWI • Lack of complete BCS — all components insufficiently covered in partner areas • Need for a comprehensive evaluation plan with specific HP indicators clearly linked to a BCS • Need for supplemental resources to carry out a BCS and an evaluation • Interest in using HP as a common umbrella under which to bring partners together in work • Types of HP activities carried out 	<ul style="list-style-type: none"> • Need to establish clear lines of communication around HP • Coordination of HP activities among partners in the field • Implication of government in HP • Awareness of external HP partner possibilities • Understanding of partner HP roles • Clarification and agreement on geographic areas of intervention • Interest in balanced, two-way HP collaboration • Some unique activities: <ul style="list-style-type: none"> - Ghana — WaterAid/New Energy, “trials in improved practices” type work - Mali — ITI, developing BCCS - Niger — SAPTHA women’s group work and collaboration

Objective 7: HP Capacity of Partners

Based on self-reported scores, interviews, FGDs, observation, and materials review, each sub-component was examined in detail and an assessment of organizational HP capacity for each partner was completed.

As can be seen in Table 5 (shaded average scores), in general, where one partner has weaker capacity, one or more partners have stronger capacities. If information on these capacities can be shared among partners and the capacity enhanced as needed (see Annex E for more detail), the potential for support and technical assistance between partners would be optimal.

What becomes immediately visible are the following strengths and weaknesses:

Strengths:	Weaknesses:
<ul style="list-style-type: none"> • All capacities exist to some degree • Community includes and participates • Experience and research used • HP is of priority importance • Activities are regularly implemented • Activities are monitored • Sufficient staff is in place • Resources are budgeted well for HP <p><i>The following strength became clear during interviews and observations:</i></p> <ul style="list-style-type: none"> • Numerous products required, soap making, wagons, etc. are provided 	<ul style="list-style-type: none"> • Key behaviors are insufficient • Links between key behaviors and messages are unclear • Complete BCS is not in place • Complete evaluation plan with clear indicators hasn't been sufficiently developed • Appropriate training for staff is insufficient • Supplemental HP resources have not been identified <p><i>The following weakness became clear during interviews and observations:</i></p> <ul style="list-style-type: none"> • There is limited access to needed water, sanitation and household technology/infrastructures — water sources and school and home latrines

Objective 8: Capacities to Strengthen

This in-depth analysis prompts the emergence of seven areas that need to be reinforced (see Annex E for a Possible Capacity Strengthening Program):

1. Delineation of a complete BCS
2. Development of evaluation plan with precise indicators, linked to the BCS
3. Development of formal linkages between HP activities and infrastructures
4. Solicitation of resources necessary to implement complete BCS
5. Identification and clarification of key behaviors
6. Clearly link messages to these key behaviors
7. Training of staff in HP with competences and information appropriate to each level.

Table 5: WAWI-Wide Capacity Assessment

CAPACITY OF WAWI PARTNERS TO PROMOTE HYGIENE (based on compilation of self-assessment scores and qualitative analysis)										
Capacity Characteristic ▼ Partner ►			Average	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5	Partner 6	Partner 7
Behavior Change	Key Beh	Use key behaviors.	2	3	2	3	1	2	2	4
		Reflect these key behaviors in HP activities.	2	2	2	2	2	2	2	3
		Identify the key behaviors with the intended audience.	2	2	2	2	2	3	2	2
	Messages	Link the messages with key behaviors.	2	3	2	2	2	2	2	3
		Reflect these messages in the HP activities.	2	2	2	2	2	2	2	3
		Ensure that messages are understood, acceptable, and appropriate for the intended audience.	2	2	3	2	2	2	2	2
		Pretest the messages with the intended audience.	2	3	2	3	2	2	2	2
Strategy	Design & Develop	Develop a behavior change strategy.	1	2	1	2	1	1	2	1
		Use research to develop this strategy.	3	3	4	3	3	3	4	2
		Use experience to develop this strategy.	4	4	4	4	4	4	4	2
		Use program and/or organizational examples to develop the strategy.	4	4	4	4	3	3	4	3
		Have tool and materials to develop the activities in this strategy.	3	3	3	3	3	3	3	3
	Implementation	Develop an implementation plan.	4	4	4	4	3	4	4	4
		Complete programmed activities.	3	3	3	3	3	3	3	3
		Modify the plan using results from monitoring and evaluation.	2	3	2	3	2	2	2	2
		Link HP to water infrastructures and activities.	2	2	3	2	2	2	2	2
		Direct the HP toward the same intended audience that uses the water infrastructures and activities.	2	2	3	2	1	3	3	2
		Look for effective mechanisms to support the HP activities in the community.	2	2	2	2	3	2	2	3
M&E	Develop a monitoring and evaluation plan.	2	2	3	2	2	3	3	2	

		Monitor activities every three months at least.	3	3	3	3	3	3	3	3
		Establish specific indicators.	2	3	2	2	2	2	3	2
		Conduct an evaluation of HP activities at least once a year.	2	2	2	3	1	2	3	1
Resources	Human	Give priority to HP activities.	4	4	4	4	4	4	4	4
		Have a person responsible for HP.	4	4	4	4	4	4	4	4
		Have other staff that helps with HP activities.	3	3	3	3	3	3	3	3
		Train the staff who work on HP activities.	2	3	3	3	2	2	2	2
	\$\$	Develop an appropriate budget for these HP activities.	3	3	3	3	3	3	3	3
		Have access to other resources for HP as needed.	2	2	3	3	2	2	3	2
<i>Totals</i>			71	78	78	78	67	73	78	72

4 - Excellent Capacity, should be sharing and helping other partners.

3 - Improved Capacity Needed, look to other partners for capacity enhancement.

2 - Limited Capacity, requires assistance from other partners to effectively ensure this capacity.

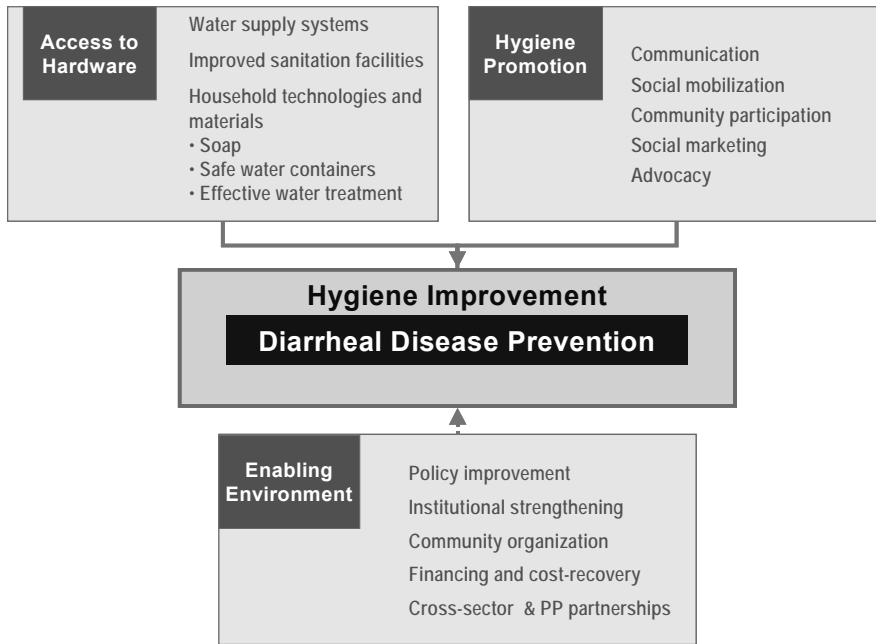
1 - No Capacity, should decide how to get this hygiene capacity piece covered in their projects — support, technical assistance, training, etc.

4. Strengthening Hygiene Promotion in the WAWI Partnership

An overarching conclusion that has come out of this assessment is that in order to effectively have an impact on hygiene behaviors in trachoma, guinea worm, and diarrheal diseases, the partnership needs to come together to address key behaviors and to utilize its collective HP expertise. Chapter 4 provides the possible basis for this umbrella of hygiene promotion. It includes a model of hygiene promotion and behavior change that could be adopted by the WAWI partnership. This model would allow the partnership to address HP issues collectively while still allowing them the flexibility to meet their organizational objectives and mandates. While the model was discussed theoretically with most partners, it was not formally presented as it is being done here. Hopefully, this formal presentation can serve as a guide to the development of an eventual WAWI behavior change strategy for hygiene promotion and/or country-specific BC strategies for HP.

The three necessary elements to behavior change include: (1) access to hardware — water, sanitation and household technologies such as soap, safe water containers; (2) hygiene promotion activities — communication and training; and (3) enabling environment — policy and others. Where these three elements overlap, maximum behavior change is possible. When provision of all three elements begins to happen more often in the same villages, communities, and districts, the overlap increases and so does the potential for increased and sustained behavior change.

Figure 2. The Hygiene Improvement Framework

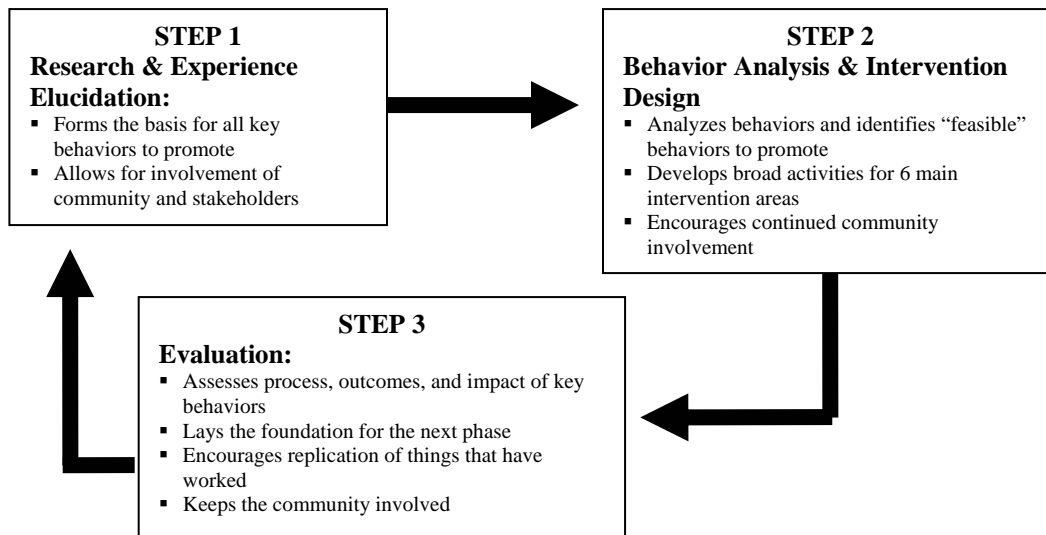


4.1. Behavior Change Strategy

As previously cited, this assessment focused on the hygiene promotion or more specifically, the behavior change implicit in hygiene promotion and a behavior change strategy that can encourage and support that behavior change. There are three primary steps to developing this behavior change strategy: (1) research and experience elucidation; (2) behavior analysis and intervention design; and (3) monitoring¹ and evaluation. Each of these steps is detailed briefly below in Figure 2.

¹ Monitoring has been intentionally excluded from this presentation to allow for the delineation of a simplified model behavior change strategy. For more on monitoring, see *Joint Publication 7. Improving Health through Behavior Change — A Process Guide on Hygiene Promotion*.

Figure 3: Steps in Behavior Change Strategy Development



4.2. Steps in Behavior Change Strategy Development

4.2.1. Step 1: Elucidation of Experience and Research

Experience and research forms the basis of all key behaviors to promote. It is from our experiences that we narrow down and focus our analysis efforts determining what we know and what we still need to know. Furthermore, we can effectively pull information from organizational/program/project models and lessons learned. Based on this initial culling of behavioral knowns and unknowns, we can determine if additional research is necessary, and if so, how much, with whom, and on what particular behavioral aspects, e.g., actual practices, motivators, barriers, etc. This is our first opportunity to involve our communities in programs that will impact on their lives — to hear what they have to say and what they want to do. Once experience examination and research conduct have been concluded and synthesized and an initial analysis of trends and patterns has been completed, it is time to develop the behavior change strategy.

4.2.2. Step 2: Behavior Analysis and Interventions Design

What is Behavior Analysis?

Behavior impacts on actions in the home and the community to promote healthy living, prevent health problems, and cure or limit their impact. In diagnosing feasible behaviors, it is necessary to recognize that context influences behaviors and subsequent health problems. There are both internal and external barriers that may exist, as well as internal and external motivators for change. Barriers may be internal resistances or external obstacles. Internal resistance might be

internalized values about negative beliefs, perceived influence of others, etc. External obstacles include money, physical mobility, access to health services or products, etc. Motivators include internal and external factors that enable people to make changes or reinforce positive changes.

To effectively analyze behavior, it is necessary to examine ideal behavior and actual behavior and the obstacles and motivators to these behaviors, and based on this analysis determine possible feasible behaviors. Furthermore, it is useful to examine these three factors: (1) behaviors that it is felt will have a greater impact on the health problem, (2) the magnitude of the change (for those adopting the behaviors and as a result of adopting the behavior), and (3) the status of other “cluster” behaviors, e.g., a series of behaviors that are required to have the desired impact on health, such as handwashing and proper disposal of feces have more impact than just handwashing, that can work together to encourage the behavior adoption, facilitate its adoption, and/or help to sustain its practice.

What is Intervention Design?

Based on the feasible behaviors identified in the first part of a Behavior Change Strategy, interventions need to be delineated — what can be done, what should be done, and how can it be done? A solid combination of six main intervention areas can more effectively encourage and sustain a change in health behaviors: (1) communication activities and tools; (2) training; (3) water, sanitation and household technologies; (4) policies; (5) products; and (6) other — peer and community support.

- **Intervention Area 1: Communication Activities and Tools** details specific materials that can be developed to encourage the behavior change and activities during which these materials can be used, e.g., brochure on handwashing instructions, poster on face washing, etc.
- **Intervention Area 2: Training** delineates possible training audiences, training needs, and training content, e.g., workshop on how to train community workers on proper hygiene practices, etc. Training interventions are usually used in conjunction with communication activities and tools.
- **Intervention Area 3: Water, Sanitation and Household Technology** recommends possible changes to present services that will facilitate the adoption and sustained practice of health behaviors, e.g., build safe water points, construct school and home latrines, etc.
- **Intervention Area 4: Policies** suggests ways that the government can create a more favorable environment in which to practice the desired health behaviors, e.g., develop hygiene supervision guidelines, etc.
- **Intervention Area 5: Products** lists other materials, items or hardware necessary to effectively practice the health behavior, e.g., soap, water storage containers, spigot handwashing containers, etc.
- **Intervention Area 6: Other, Peer and Community Support** proposes additional activities that can take place within the community to encourage the health behavior change and help to sustain its practice, e.g., Hygiene Day, social marketing of drying materials, etc.

While any one of these intervention areas can encourage behavior change, all used together effectively increases the likelihood that the behavior will be changed and that that change will be sustained.

4.2.3. Step 3: Evaluation

Evaluation allows us to see if we are on track and to make adjustments as the process continues, if we are not. But what do we evaluate? An evaluation plan should be clearly and consciously linked to the BCS. This allows for a concerted tie between key behaviors and the success indicators established. Historically, projects attempt to evaluate too much in too many ways, instead of focusing on the essential — the feasible key behaviors being promoted. While many other items are useful and interesting to evaluate, the essential is “whether people have changed their behavior and whether that behavior can be/is being sustained.” If this is the starting point for a BCS evaluation, all other issues will flow naturally and logically. Comprehensive evaluation should not only be linked to the BCS, but it should contain outcome, process, and impact indicators as well for a well-rounded examination of how successfully the BCS is. It is another excellent opportunity to keep the community involved in its own HP behavior decisions and the direction that their HP program takes.

4.3. Model for a WAWI Behavior Change Strategy

The following is only a “model.” Though it uses information gathered during the course of this assessment, it is not complete, and it is not intended to be used “as is,” but only to give the WAWI partnership an idea of how they might formulate a strategy for the partnership as a whole (not for/as individual organizations) with each partner playing roles necessary to ensure changed behavior in the first instance and a sustained behavioral practice in the second instance.

4.3.1. Behavior Analysis

Table 6 details possible feasible key behaviors to promote as a *partnership*, to the extent possible based on information available to the author. As can be seen and as discussed in Section 4.2.1, it will most likely be necessary for the WAWI partnership to collect research already completed, analyze it in light of HP capacities, and if necessary, conduct additional spot research to fill in the information gaps identified on HP behavior.

Table 6: Sample Behavior Analysis for WAWI BCS

Ideal Behavior*	Actual Behavior*	Feasible Behavior*	Obstacles/Barriers	Motivators
Trachoma: Wash face at least twice daily with soap and water.	Trachoma: Wash face one every 2-3 days with water only.	Trachoma: Wash our face before going to sleep every day with soap/soap substitute and water.	Limited access to water sources To be determined based on research (old and new), experience, program/project models	Easy access to water sources Availability of soap To be determined based on research (old and new), experience, program/project models
Guinea Worm: Drink only potable water.	Guinea Worm: Drink water that is available.	Guinea Worm: Filter surface water before drinking it. <i>(Actual key behavior used now by CCG2 program)</i>	Limited access to water sources To be determined based on research (old and new), experience, program/project models	Easy access to water sources To be determined based on research (old and new), experience, program/project models
Diarrheal Diseases: Wash hands with soap and water and towel dry at 5 critical times.	Diarrheal Diseases: Wash hands occasionally without soap or ashes, with used, dirty water and dry on dirty clothing.	Diarrheal Diseases: Wash your hands with soap/soap substitute and clean water and air dry before eating.	Limited access to water sources To be determined based on research (old and new), experience, program/project models	Easy access to water sources Availability of soap To be determined based on research (old and new), experience, program/project models
* Other behaviors exist, used only one possible hygiene area under each theme to show process.				

4.3.2. Interventions Design

Based on the feasible key behaviors identified in Section 4.3.1, Table 6 “Behavior Analysis,” the following model interventions design could be detailed. The next table also indicates partners who are presently working in the area of a particular intervention and indicates the extent to which they are implementing these interventions.

Table 7: Sample Interventions Design for WAWI BCS

Intervention 1	Intervention 2	Intervention 3	Intervention 4	Intervention 5	Intervention 6
Communication Activities	Training	Water, Sanitation and Household Technology	Policies	Product	Other
FOR ALL FEASIBLE BEHAVIORS IN TRACHOMA, GUINEA WORM, AND DIARRHEAL DISEASES					
Demonstrations Brochures Flipcharts Group discussions Theatre, songs Experiences of "healthy" families Case studies on "positive" experiences Manuals Complete educational kit Educational games	Train communication agents, health staff, etc.: Proper face and Handwashing steps Basic water issues How to conduct a community group meeting Train community members in: Masonry Pump repair Soap making Water filtration	Water sources	Advocacy at the national level Community, local participation in hygiene development, & decision making, discussion Inclusion of government agencies in HP work	Soap Handwashing basins Cleaning kits Soap making kits Wagons Wheelbarrows	Contest for "clean household" Support/encourage associations, hygiene groups, etc. Clean Village, Clean Household promotion Creation of water/management committees Trials in improved practices
WHETHER EACH PARTNER IS PRESENTLY DOING:					
HKW** ITI** Lions* World Vision** UNICEF**	CCG2* HKW** ITI** Lions** WaterAid** World Vision**	WaterAid** World Vision** UNICEF**	CCG2* ITI* WaterAid* UNICEF*	World Vision* UNICEF**	CCG2* Lions* WaterAid** World Vision**
**Work being done - * Minimal efforts being done					

4.3.3. Evaluation

Taking the BCS one step further allows WAWI to clearly link the strategy with an intended evaluation plan and clear success indicators. The following table illustrates a possible, simplified evaluation plan based on the Model Behavior Analysis presented in Table 6 and the Model Interventions Design presented in Table 7.

It should be reiterated that Tables 6, 7, and 8 are not intended to be used “as is” since information on which the model is based is incomplete and the strategy and plan are not comprehensive covering only selected possible key behaviors per hygiene area. It is only intended to show a possible model for WAWI, the linkages between the three steps, and the way in which WAWI partners could better collaborate and maximize their HP capacity expertise and strengths.

For information on indicators and data collection instruments to evaluate water, sanitation and hygiene interventions, please refer to *EHP Strategic Report 8, Assessing Hygiene Improvement: Guidelines for Household and Community Levels*. The purpose of the Guidelines is to help program planners and managers design, implement and evaluate water, sanitation and hygiene interventions.

Table 8: Sample Evaluation Plan and Indicators based on WAWI BCS Model

Key Feasible Behaviors to Promote and to Evaluate		
<p>Trachoma: Wash our face before going to sleep every day with soap/soap substitute and water.</p> <p>Guinea Worm: Filter surface water before drinking it.</p> <p>Diarrheal Diseases: Wash your hands with soap/soap substitute and clean water and air dry before eating.</p>		
Evaluation Questions	Information Needed	
What do you want to know about your key behaviors?	Type of Information What type of information do you need to answer your questions?	Indicators* What indicate success?
OUTCOME - How well is the intended audience practicing the promoted behaviors?	Observed behaviors Reported behaviors	% of pop properly washing faces daily % of pop properly washing hands before eating % of pop filtering drinking water % of pop who reported reduced barriers % of pop who report heighten motivators
PROCESS — To what extent are the six intervention areas being carried out?	Access to needed Services Access to needed materials, equipment, and products Completion of communication, training and other activities	% of pop with access to safe water source % of pop with access to soap/soap substitute % of trained pop with soap-making kits ## of trained groups selling soap % of trained pop w/ed kits ## of community ed sessions occurred ## of trained community agents ## of trained community members ## of new government agencies involved % of hshd designated as “Clean Households”
IMPACT — How have the practiced behaviors affected each disease addressed?	Prevalence rates of diseases	% reduced cases of trachoma % reduced cases of Guinea worm % reduced cases of diarrhea in children under 5s

**All of these indicators do not need to be used; again just giving an idea of what indicators might be used with the three identified key behaviors.*

5. Next Steps and Recommendations

The following country-specific next steps are a direct reiteration of discussions by the EHP consultant with WAWI partners in each country. An attempt has been made to accurately reflect partner issues and requests in the following section.

5.1. Ghana Possible Next Steps

Based on specific feedback and discussions with WAWI partners in Ghana, the following next steps have been detailed.

Strategy:

1. Define HP for WAWI and its partners — an operational definition.
2. Consider developing a countrywide WAWI policy for HP.
3. Develop a BCS for WAWI with clearly defined roles and activities for each partner.

The following would depend on the actual strategy developed, just ideas shared among partners:

4. Focus more on actual key behaviors in each of the areas covered.
5. Pick one, new needed HP intervention (activity, material, product) and develop a WAWI piece.
6. Conduct an HP materials audit to determine what exists with each partner on hygiene in each of the three areas.
7. Based on HP materials audit, develop a list of potential materials — new and old.
8. Develop an HP materials kit for all partners to use.
9. Develop an evaluation plan based on the BCS with clear process, outcome and impact indicators.

Access to Hardware (though outside the purview of this study, could have a positive impact on hygiene promotion):

10. Concentrate on the provision of water.

11. Concentrate on the provision of latrines — family and school.

Organizationally (though outside the purview of this study, could have a positive impact on hygiene promotion):

12. Convene a conference in which partners can learn more about each other and about partner HP activities, strengths, and weaknesses — “get to know each other.”

13. Develop a capacity matrix (see Section 3.2.4).

14. Create strong coordinating structure and develop guidelines for implementing HP activities.

15. Establish a forum to regularly share HP lessons learned.

16. Document WAWI HP process.

17. Create an HP technical database for sharing information.

18. Explore new HP partner possibilities.

19. Conduct an HP sensitivity workshop for partners.

5.2. Mali Possible Next Steps

Based on discussions and feedback from WAWI partners in Mali, the following next steps have been proposed.

Strategy:

1. Develop a BCS for WAWI Mali.
2. Detail key behaviors in the three areas in which to concentrate efforts.
3. Develop a specific evaluation plan for the strategy.

The following would depend on the actual strategy developed, just ideas shared among partners:

4. Conduct an HP materials audit.
5. Develop a list of materials available and potential materials needed to better promote hygiene.
6. Explore how to better involve the government and the private-sector.

Access to Hardware (though outside the purview of this study, could have a positive impact on hygiene promotion):

7. Concentrate on the provision of water.

Organizationally (though outside the purview of this study, could have a positive impact on hygiene promotion):

8. Develop a capacity matrix and a coverage and activities matrix.
9. Develop an operational definition of hygiene promotion for WAWI.
10. Determine the role of each partner and consider Memorandums of Understanding (MOUs) for each partner.
11. Hold regular partner consultations.
12. Organize regular field visits to partner sites.
13. Develop a WAWI communication system.
14. Reexamine the objectives of WAWI and WAWI Mali and discuss changes needed and/or reconfirmation.
15. Clarify the geographic intervention zones and determine whether and how to add additional zones.

5.3. Niger Possible Next Steps

Discussions and feedback from WAWI partners in Niger have resulted in the following proposed next steps.

Strategy:

1. Develop a complete HP BCS for WAWI that covers all elements necessary to effectively promote hygiene and ultimately change behavior.
2. Detail key behaviors for each area — trachoma, guinea worm, and diarrheal diseases.

The following would depend on the actual strategy developed, just ideas shared among partners:

3. Determine a minimum packet for hygiene promotion (PMPH) to cover in each zone where partners work including a minimum kit.
4. Consider minimum standards for the PMPH.
5. Ensure that each partner has access to resources necessary to implement PMPH.
6. Carry out audit of educational materials available on hygiene in the three areas.
7. Based on the audit, develop a list of materials available and others potentially needed.

8. Develop simple tools to use in the field — monitoring, animation, etc.

Access to Hardware (though outside the purview of this study, could have a positive impact on hygiene promotion):

9. Focus on providing water sources.
10. Explore new partner possibilities to support provision of water sources.

Organizationally (though outside the purview of this study, could have a positive impact on hygiene promotion):

11. Develop an HP capacity matrix and a coverage and activities matrix.
12. Develop an operational definition of hygiene promotion for WAWI.
13. Define common HP terms used (harmonize, complement, etc.) to make sure all partners speak the same language.
14. Determine the HP role of each partner.
15. Conduct a communication audit among partners to ensure information is shared in a timely and complete manner.
16. Identify other potential HP partners and explore the possibilities.
17. Reexamine the objectives of WAWI and WAWI Niger and discuss changes needed and/or reconfirmation.

5.4. Recommendations

The following recommendations reflect a reformulation of partner concerns and issues combined with an analysis of findings and the author's experience and background in hygiene promotion and hygiene behavior change.

5.4.1. WAWI Short-Term

WAWI should consider developing a WAWI-wide hygiene promotion strategy — to complement the work that each partner is presently engaged in and enhance the HP work that the partnership will be able to complete; training WAWI partner staff in behavior change techniques — to focus on new and complementary techniques and build the capacity of the partnership to use these techniques; and maximizing use of existing partner HP capacity — to rely more on what each HP capacity or set of HP capacities an individual partner brings to the strategy, only to pull in outside expertise when it is felt necessary by the partnership.

To implement these recommendations, the following would need to be in place: (1) BCS model for WAWI countries to use; (2) WAWI Hygiene Promotion Behavior Change Specialist to

provide training, assistance and technical support as needed; and (3) minimum of US\$100,000 per country to carry out country-specific HP BCS.

These possible next steps could operationalize the recommendations and put the requirements in place:

1. Hold a three-day, WAWI-wide working seminar to develop/agree upon BCS model to adopt.
2. Prepare a BCS working model document for each country to use in developing their country-specific BCS.
3. Detail a partner HP capacity matrix (could be completed at the BCS working seminar).
4. Develop, by country, a three-year WAWI hygiene promotion behavior change strategy. (This could allow WAWI to achieve its Strategic Framework Objective 2 — Outcomes and Outputs, while also meeting country- and partner-specific needs and mandates.)
5. Develop, by-country, budgets to carry out country-wide HP BCS.

5.4.2. WAWI Long-Term

The WAWI partnership should carefully consider the following recommendations:

1. Determine ways to assure water sources to all partner project areas, even where World Vision does not work.
2. Better clarify what World Vision’s role means as “lead agency” and clearly define its responsibilities for partners.
3. Identify common hygiene promotion needs and assure that these needs are met in partner project areas.
4. Expand the role of water and management committees to include hygiene promotion — supply committees with a hygiene promotion kit. Overlap and use existing community groups.
5. Develop/adopt a BCS framework to use as a model for each country that they can fill out to meet their specific needs. If it is possible to develop a WAWI-wide BCS, but allow for country tweaking to meet unique needs, that would be superb, otherwise a model to use would serve the same purpose.
6. Use framework and country BCS strategies to cultivate partnerships by coming together around commonalities.
7. Collect all hygiene promotion materials — print and non-print — from all three countries and put together a complete packet of hygiene promotion materials available. If possible, make sure that a translation of each piece is available in French and English.

8. Share “best practices” and lessons learned on a regular basis through an established forum.
9. Consider using Niger as the testing ground for a BCS model: (1) closer partner collaboration exists; (2) materials in French would cover two countries and translation back to English faster and easier; (3) solid basis for all HP capacities is in place; (4) partner willingness and availability is great; and (5) stronger ties and coordination with government and private-sector exist.
10. Delineate a clear set of possible key behaviors to promote in trachoma, in Guinea worm (though the area is well-covered already and could be incorporated “as is” at present), and in diarrheal diseases.
11. Based on a clearly detailed BCS, consider a minimum essential HP package to ensure, i.e., 1–2 must do/have items in each of the six intervention design areas, e.g., *sample only* — (1) communication, one flipchart with a page per key behavior; (2) training, train community agents in use of flipchart ; (3) water, sanitation and household technology, water provision; (4) policy, advocacy paper on integration of hygiene promotion; (5) products, local soap making kits; (6) other, inclusion of local mother volunteers into water/management committees.
12. Clearly delineate the HP role of each partner in each country (since roles do vary by country and by partner) and generate individually discussed and agreed upon MOUs.
13. Review all possible next steps recommended by country partners and adopt those that would be feasible and appropriate to the WAWI-wide partnership as well.
14. Review original WAWI HP objectives and HP intervention zones, assess, change as needed and set up some provision for exceptions and develop criteria for determining these exceptions.
15. In particular, revisit geographic HP intervention zones and reach agreement among all WAWI partners.
16. Once geographic intervention zones have been agreed upon, complete coverage and HP activities matrices for each country (see sample in Annex D).
17. Develop/complete/agree upon HP capacity matrix (see Chapter 3, Section 3.2.4) and share with all partners.
18. Based on finalized HP capacity matrix, develop a specific HP capacity strengthening program (see Annex E for a tentative program). This program could include training of partner staff, technical assistance from partner-to-partner, informational seminars, technical development workshops, etc. Methodologies should vary according to need, time, and resources available. Partner expertise and specialties should be utilized in every instance possible.

5.4.3. EHP

EHP should consider providing funding to the WAWI partnership to:

1. Convene an HP get-to-know-you conference in each country. These conferences could be used to learn more about each partner, discuss and detail HP definition, agree on HP capacities, agree upon zones of interventions, detail roles and responsibilities and develop MOUs, in other words, complete all basic foundation activities necessary to an effective partnership. *“Take nothing for granted, make no assumptions, detail abilities, expectations, and roles in writing for the health of a partnership and the future of its potential impact.”*
2. Carry out, if possible, 1-2 additional activities on the HP Capacity Enhancement Program (see Annex E) and/or 1-2 possible next steps. Country WAWI partnerships would be required to put together a separate budget for each activity or step they chose to complete.

Key EHP Documents for Further Reading

Activity Report 124. *West Africa Water Initiative (WAWI) Monitoring and Evaluation Plan, Program Framework and Indicators*

Joint Publication 7. *Improving Health through Behavior Change — A Process Guide on Hygiene Promotion*

Strategic Report 8. *Assessing Hygiene Improvement — Guidelines for Household and Community Levels.*

Annex A. Organizations Contacted

Names have been withheld to ensure the confidentiality promised. Only organizations contacted have been provided here. WAWI “official” partners are shaded.

Organization	Contacted in Ghana	Contacted in Mali	Contacted in Niger
Agricultural Research & Development (ARD)		X	
AquaDev			X
ASDAP		X	
Carter Center/Global 2000	X	X	X
Central Water & Sanitation Association (CWSA)	X		
Cornell International Institute for Food, Agriculture, & Development	X		
Desert Research Institute		X	
Helen Keller Worldwide		X	X
International Trachoma Institute	X	X	X
Lions Club International		X	X
Ministry of Health-Dept of Hygiene & Sanitation		X	X
Ministry of the Environment — Dept of Sanitation		X	
Ministry of Water & Energy-Dept of Sanitation		X	X
National Blindness Prevention/Control Program		X	X
National Water Utility Company			X
New Energy (WaterAid representative)	X		
Peace Corps			X
PLAN International			X
SAPHTA			X
UNICEF	X	X	X
US Embassy			X
USAID		X	
WaterAid	X	X	
Winrock	X		X
World Chlorine Council			
World Vision	X	X	X
TOTAL Organizations Contacted in Each Country	9	15	16

Annex B. List of Documents Reviewed

1. ARD Ghana Rural Water Program (GRWP) Phase III, End of Project Evaluation Hardware Team Summary
2. ARD Management and Marketing Sub-team Report
3. ARD/USAID Lessons Learned and Implications for WAWI, Ghana (GRWP) Evaluation.
4. ARD/USAID Preliminary Software Findings, Recommendations, and Lessons Learned.
5. Complete notes from “Second WAWI Partners Headquarters Meeting” hosted by World Vision, in Washington DC from September 3-5, 2003.
6. Complete notes from WAWI workshop held in Bamako, Mali, July 2003.
7. Donor Survey within the Water Sector of WAWI countries, WAWI/ARD/USAID.
8. <http://www.waterforthepeople.org/initiative/wawi/wawi.htm>
9. Hygiene Promotion education materials from Carter Center, HKW, ITI, World Vision, and UNICEF.
10. Integrated Water and Coastal Resource Management (Water IQC) Task Order Scope of Work, WAWI Technical Support and Grants Management Activity (ARD IQC).
11. Organizational information on Winrock International, WaterAid, DRI, LCIF, WCC, CIIFAD, HKW, Carter Center, ITI, World Vision, and UNICEF.
12. Proposals submitted to Hilton Foundation:
 - a. World Vision — GRWP Phase IV, April 6, 2002
 - b. World Vision — Mali and Niger Rural Water and Health Project, April 6, 2002
 - c. DRI — Ghana Rural Water Project Phase IV and Pre-Phase IV Activities, April 2002
 - d. CIIFAD — Support for World Vision Ghana Rural Water Project, March 28, 2002
 - e. UNICEF — Water and Sanitation in West Africa, April 2002.

- f. WaterAid — Water Supply, Sanitation, and Hygiene Promotion for the Poor in Ghana and Mali, April 8, 2002
 - g. LCIF — WAWI Concept Paper
13. Summary of Agreements and Follow-Up Actions, WAWI Partner meeting, Washington, DC, December 30, 2002.
 14. Summary Report of WAWI Implementation Workshop, Bamako, Mali, June-July 2003.
 15. WaterAid Implementation Plan, WAWI, submitted to ARD/USAID, February 2003.
 16. WaterAid Strategic Contribution Indicators (SCI).
 17. WAWI Internal and External Communications Summary of Findings and Options for Consideration, WAWI/ARD, August 2003.
 18. WAWI Communications Strategy and Decisions Support Poll Results, ARD, October 2003.
 19. WAWI Workshop June 30-July 3, 2003 ARD Workplan Technical Assistance Section Summary.
 20. Winrock Annual Report, WAWI/Ghana, February 2003.
 21. World Vision GRWP Phase II, Extension End of Project Evaluation June 2003, Lessons Learned and Implications for World Vision, Ghana.
 22. World Vision Transformational Development Indicators, Field Guide Volume One, Getting Started, World Vision Development Resource Team, December 2002.

Annex C. Tally of Self-Assessment Scores

	Behavior Change	Strategy	Resources	Totals
WAWI-wide	25.3	47.5	17.8	90.6
By Country by Component:				
Ghana	25	48	17	90
Mali	25	49	18	92
Niger	25	52	20	97
By Partner by Component:				
Partner 1	27	45	15.5	87.5
Partner 2	22.8	48.7	19.7	91.2
Partner 3	26.7	55.3	19.7	101.7
Partner 4	25	38	15	78
Partner 5	25	49	19.5	93.5
Partner 6	24	47	17	88
Partner 7	26.7	49.3	18.3	94.3
By Partner by Country by Component:				
Partner 1				
Mali	26	48	14	88
Niger	28	52	19	99
Partner 2				
Ghana	17	46	16	79
Mali	19	52	25	96
Niger	26	54	24	104
Partner 3				
Ghana	28	52	20	100
Mali	28	56	18	102

Niger	24	58	21	103
Partner 4				
Niger	25	38	15	78
Partner 5				
Ghana	25	48	20	93
Mali	21	47	19	87
Partner 6				
Ghana	28	43	14	85
Niger	20	51	20	91
	Behavior Change	Strategy	Resources	Totals
Partner 7				
Ghana	25	49	15	89
Mali	27	44	20	91
Niger	28	55	20	103
By Country by Partner by Component:				
Ghana				
Partner 2	17	46	16	79
Partner 3	28	52	20	100
Partner 5	25	48	20	93
Partner 6	28	43	14	85
Partner 7	25	49	15	89
Mali				
Partner 1	26	48	14	88
Partner 2	19	52	25	96
Partner 3	28	56	18	102
Partner 5	21	47	19	87
Partner 7	27	44	20	91
Niger				
Partner 1	28	52	19	99

Partner 2	26	54	24	104
Partner 3	24	58	21	103
Partner 4	25	38	15	78
Partner 6	20	51	20	91
Partner 7	28	55	20	103
(if a partner is not included on the country list, it means they either do not work there or they did not submit a self-assessment)				

WAWI Partner Capacity Assessment - TALLY by Partner							
Randomly Assigned Partner Number	#1	#2	#3	#4	#5	#6	#7
I. Hygiene Promotion "Behaviour Change"							
A. Behaviours							
1. We promote specific key behaviours in each of the areas in which we work.	4	3.7	4	4	3.5	4	3.7
2. Our hygiene promotion activities reflect the key behaviours promoted.	4	3.3	4	4	4	3.5	4
3. The behaviours promoted were identified thru contact with the intended audiences.	3.5	3.5	4	4	4	3	4
Behaviors sub-total	11.5	10.5	12	12	11.5	10.5	11.7
B. Messages							
4. We have specific messages that correspond to each key behaviour promoted.	4	3.3	4	4	3.5	3.5	4
5. Our hygiene promotion activities reflect the messages developed.	4	3.7	3.3	4	3.5	3	3.7
6. Our messages are understood, accepted by and appropriate to the audience.	4	2.8	3.3	4	3	3.5	3.7
7. The messages developed were pretested with the intended audiences.	3.5	2.5	4	1	3.5	3.5	3.7
Messages sub-total	15.5	12.3	14.6	13	13.5	13.5	15.1
Behavior Change Sub-Totals	27	22.8	26.6	25	25	24	26.8
II. Hygiene Promotion "Strategy"							
A. Design & Development							
8. We have developed a strategy for our hygiene promotion activities.	4	3.5	4	1	3.5	4	3.7
9. Our strategy and activities are based on research.	3.5	3.5	4	4	3	3	2.7
10. Our strategy and activities are based on experience.	2	3.3	4	4	3.5	3.5	3
11. Our strategy and activities are based on another program-country or organizational.	2.5	2.7	3.7	4	1.5	3	3.3
12. We have specific tools and materials that we use to develop our activities.	4	2.8	4	3	3.5	3.5	3.7
Design & Development sub-total	16	15.8	19.7	16	15	17	16.4
B. Implementation							

13. We have an implementation/roll out plan for our hygiene promotion activities.	3.5	3.7	4	4	4	4	3.7
14. We complete scheduled hygiene promotion activities.	3.5	3	3.7	1	3.5	2.5	3.7
15. We revise our plan based on monitoring and evaluation results.	4	2.8	4	4	4	3	3.7
16. Our hygiene promotion is closely linked with water infrastructure improvements.	3.5	3.8	3.3	1	3	3	3
17. Hygiene promotion reaches the same households as improved water infrastructure.	2	3.5	3.3	1	3.5	3	3
18. There are effective community-based mechanisms to sustain water improvements.	2	3.2	2.3	1	3.5	3	3
Implementation sub-total	18.5	20	20.6	12	21.5	18.5	20.1
Randomly Assigned Partner Number	#1	#2	#3	#4	#5	#6	#7
C. Monitoring & Evaluation							
19. We have a monitoring and evaluation plan.	2	3.7	4	1	3.5	3	3.3
20. We monitor our hygiene promotion activities on at least a quarterly basis.	3.5	3.5	4	4	3.5	3	3.3
21. We have established indicators for the results of our hygiene promotion activities.	2	3.5	4	4	3	3	3.3
22. We have conducted at least one evaluation of our hygiene promotion activities.	3	2.2	3	1	2.5	2.5	3
Monitoring & Evaluation sub-total	10.5	12.9	15	10	12.5	11.5	12.9
Strategy Sub-Totals	45	48.7	55.3	38	49	47	49.4
III. Hygiene Promotion "Resources"							
A. Human							
23. Hygiene promotion is a clear priority for our organization.	4	3.8	4	4	4	3.5	3.7
24. We have a "point person" for hygiene promotion.	2	3.7	4	4	3.5	4	3
25. We have staff who focus on hygiene promotion.	3	3.2	4	1	3	2.5	3.7
26. Staff who work on our activities have been trained in hygiene promotion.	3.5	3.3	3.7	4	3	3	3.7
Human sub-total	12.5	14	15.7	13	13.5	13	14.1
B. Financial							
27. We have sufficient financial resources to carry out hygiene promotion activities.	1.5	3	2	1	3	2	2.3
28. We have access to additional financial resources if needed.	1.5	2.7	2	1	3	2	2

Financial sub-total	3	5.7	4	2	6	4	4.3
Resources Sub-Totals	15.5	19.7	19.7	15	19.5	17	18.4
GRAND TOTALS	87.5	91.2	101.6	78	93.5	88	94.6
Organization/Partner	#1	#2	#3	#4	#5	#6	#7

WAWI Partner Capacity Assessment - TALLY by Partner and by Country								
Randomly Assigned Partner Number	Partner 1		Partner 2			Partner 3		
Country	Niger	Mali	Ghana	Niger	Mali	Ghana	Niger	Mali
I. Hygiene Promotion "Behavior Change"								
A. Behaviors								
1. We promote specific key behaviors in each of the areas in which we work.	4	4	3	4	4	4	4	4
2. Our hygiene promotion activities reflect the key behaviors promoted.	4	4	2	4	4	4	4	4
3. The behaviors promoted were identified thru contact with the intended audiences.	4	3	3	4	3.5	4	4	4
Behaviors sub-total	12	11	8	12	11.5	12	12	12
B. Messages								
4. We have specific messages that correspond to each key behaviour promoted.	4	4	2	4	4	4	4	4
5. Our hygiene promotion activities reflect the messages developed.	4	4	3	4	4	4	2	4
6. Our messages are understood, accepted by and appropriate to the audience.	4	4	2	3	3.5	4	2	4
7. The messages developed were pretested with the intended audiences.	4	3	2	3	2.5	4	4	4
Messages sub-total	16	15	9	14	14	16	12	16
Behavior Change Sub-Totals	28	26	17	26	25.5	28	24	28
II. Hygiene Promotion "Strategy"								
A. Design & Development								
8. We have developed a strategy for our hygiene promotion activities.	4	4	3	4	3.5	4	4	4
9. Our strategy and activities are based on research.	4	3	4	4	2.5	4	4	4
10. Our strategy and activities are based on experience.	4	2	4	4	2	4	4	4
11. Our strategy and activities are based on another program-country or organizational.	3	2	2	4	2	3	4	4
12. We have specific tools and materials that we use to develop our activities.	4	4	3	3	2.5	4	4	4
Design & Development sub-total	19	15	16	19	12.5	19	20	20
B. Implementation								

13. We have an implementation/roll out plan for our hygiene promotion activities.	4	3	3	4	4	4	4	4
14. We complete scheduled hygiene promotion activities.	4	3	2	3	4	3	4	4
15. We revise our plan based on monitoring and evaluation results.	4	4	3	3	2.5	4	4	4
16. Our hygiene promotion is closely linked with water infrastructure improvements.	3	4	4	4	3.5	2	4	4
17. Hygiene promotion reaches the same households as improved water infrastructure.	2	4	3	4	3.5	2	4	4
18. There are effective mechanisms to sustain water improvements.	2	4	3	3	3.5	2	2	3
Implementation sub-total	19	22	18	21	21	17	22	23

Randomly Assigned Partner Number	Partner 1		Partner 2			Partner 3		
C. Monitoring & Evaluation								
19. We have a monitoring and evaluation plan.	4	2	3	4	4	4	4	4
20. We monitor our hygiene promotion activities on at least a quarterly basis.	3	4	3	4	3.5	4	4	4
21. We have established indicators for the results of our hygiene promotion activities.	4	2	3	4	3.5	4	4	4
22. We have conducted at least one evaluation of our hygiene promotion activities.	3	3	3	2	1.5	4	4	1
Monitoring & Evaluation sub-total	14	11	12	14	12.5	16	16	13
Strategy Sub-Totals	52	48	46	54	46	52	58	56
III. Hygiene Promotion "Resources"								
A. Human								
23. Hygiene promotion is a clear priority for our organization.	4	4	4	4	3.5	4	4	4
24. We have a "point person" for hygiene promotion.	4	2	3	4	4	4	4	4
25. We have staff who focus on hygiene promotion.	3	3	3	4	2.5	4	4	4
26. Staff who work on our activities have been trained in hygiene promotion.	4	3	2	4	4	4	3	4
Human sub-total	15	12	12	16	14	16	15	16
B. Financial								
27. We have sufficient financial resources to carry out hygiene promotion activities.	2	1	2	4	3	2	3	1
28. We have access to additional financial resources if needed.	2	1	2	4	2	2	3	1
Financial sub-total	4	2	4	8	5	4	6	2
Resources Sub-Totals	19	14	16	24	19	20	21	18
GRAND TOTALS	99	88	79	104	90.5	100	103	102
Country	Niger	Mali	Ghana	Niger	Mali	Ghana	Niger	Mali
Organization/Partner	Partner 1		Partner 2			Partner 3		

WAWI Partner Capacity Assessment - TALLY by Partner and by Country								
Randomly Assigned Partner Number	Part 4	Partner 5		Partner 6		Partner 7		
Country	Niger	Ghana	Mali	Ghana	Niger	Ghana	Niger	Mali
I. Hygiene Promotion "Behavior Change"								
A. Behaviors								
1. We promote specific key behaviors in each of the areas in which we work.	4	4	3	4	4	4	4	3
2. Our hygiene promotion activities reflect the key behaviors promoted.	4	4	4	4	3	4	4	4
3. The behaviors promoted were identified thru contact with intended audiences.	4	4	4	4	2	4	4	4
Behaviors sub-total	12	12	11	12	9	12	12	11
B. Messages								
4. We have specific messages that correspond to each key behaviour promoted.	4	3	4	4	3	4	4	4
5. Our hygiene promotion activities reflect the messages developed.	4	3	4	4	2	3	4	4
6. Our messages are understood, accepted by and appropriate to the audience.	4	3	3	4	3	3	4	4
7. The messages developed were pretested with the intended audiences.	1	4	3	4	3	3	4	4
Messages sub-total	13	13	14	16	11	13	16	16
Behavior Change Sub-Totals	25	25	25	28	20	25	28	27
II. Hygiene Promotion "Strategy"								
A. Design & Development								
8. We have developed a strategy for our hygiene promotion activities.	1	4	3	4	4	3	4	4
9. Our strategy and activities are based on research.	4	2	4	3	3	4	2	2
10. Our strategy and activities are based on experience.	4	4	3	3	4	3	4	2
11. Our strategy and activities are based on another program-country or organizational.	4	1	2	3	3	3	4	3
12. We have specific tools and materials that we use to develop our activities.	3	3	4	4	3	3	4	4
Design & Development sub-total	16	14	16	17	17	16	18	15
B. Implementation								
13. We have an implementation/roll out plan for our hygiene promotion activities.	4	4	4	4	4	4	4	3

14. We complete scheduled hygiene promotion activities.	1	4	3	2	3	4	4	3
15. We revise our plan based on monitoring and evaluation results.	4	4	4	3	3	4	4	3
16. Our hygiene promotion is closely linked with water infrastructure improvements.	1	4	2	3	3	3	3	3
17. HP reaches the same households as improved water infrastructure.	1	4	3	2	4	3	3	3
18. There are effective mechanisms to sustain water improvements.	1	4	3	3	3	3	3	3
Implementation sub-total	12	24	19	17	20	21	21	18

Randomly Assigned Partner Number	Part 4	Partner 5		Partner 6		Partner 7		
Country	Niger	Ghana	Mali	Ghana	Niger	Ghana	Niger	Mali
C. Monitoring & Evaluation								
19. We have a monitoring and evaluation plan.	1	3	4	2	4	3	4	3
20. We monitor our hygiene promotion activities on at least a quarterly basis.	4	3	4	3	3	2	4	4
21. We have established indicators for the results of our hygiene promotion activities.	4	2	4	3	3	4	4	2
22. We have conducted at least one evaluation of our hygiene promotion activities.	1	2	3	1	4	3	4	2
Monitoring & Evaluation sub-total	10	10	15	9	14	12	16	11
Strategy Sub-Totals	38	48	50	43	51	49	55	44
III. Hygiene Promotion "Resources"								
A. Human								
23. Hygiene promotion is a clear priority for our organization.	4	4	4	4	3	3	4	4
24. We have a "point person" for hygiene promotion.	4	4	3	4	4	1	4	4
25. We have staff who focus on hygiene promotion.	1	4	2	2	3	3	4	4
26. Staff who work on our activities have been trained in hygiene promotion.	4	4	2	2	4	3	4	4
Human sub-total	13	16	11	12	14	10	16	16
B. Financial								
27. We have sufficient financial resources to carry out hygiene promotion activities.	1	2	4	1	3	3	2	2
28. We have access to additional financial resources if needed.	1	2	4	1	3	2	2	2
Financial sub-total	2	4	8	2	6	5	4	4
Resources Sub-Totals	15	20	19	14	20	15	20	20
GRAND TOTALS								
Country	Niger	Ghana	Mali	Ghana	Niger	Ghana	Niger	Mali
Organization/Partner	Part 4	Partner 5		Partner 6		Partner 7		

Annex D. Sample Coverage and Activities Matrix

MATRIX OF COVERAGE AND HYGIENE PROMOTION ACTIVITIES IN "COUNTRY-NAME"									
Activity ▼ Zone/Village ►	Area 1 (cite name e.g. Tamale)	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	(continue on in this way, listing all of the intervention zones, villages, etc in which partners work)
Construct family latrines	5, 6, 10, 11								
Construct schools latrines	4, 11								
Organize water committees	1, 10								
Train hygiene promotion agents	1, 4, 5, 6, 7								
Train community members									
Construct water sources									
Provide selected HP products									
Develop educational materials									
Raise awareness									
Inform and education community									
Train masons									
Train in soap-making									
Train in pump repair & maintenance									
Continue to list out ALL activities carried out by partners; be as specific as the partnership decides it needs to be.									

Carter Center/Global 2000 - 1 CIIFAD - 2	WaterAid - 7 Winrock - 8	Use the numbers at the left to indicate in the matrix above where each partner carries out
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DRI - 3 HKW - 4 ITI - 5 Lions — 6	WCC - 9 World Vision - 10 UNICEF - 11	that activity, if they do.
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Annex E. Possible Capacity Strengthening Program

The first five build on each other and would need to be carried out in order. #6 - #9 could be done at anytime.

Capacity Strengthening Topic	Purpose	Length	Format	Outcomes/Outputs
1. Identifying Hygiene Promotion (HP) Behaviors	Provide a clear understanding on how to analyze behaviors and determine “key” behaviors to promote.	3 day	Workshop	List of clear common key behaviors to promote Staff capable of analyzing HP behaviors Additional research needs identified
2. Developing an Hygiene Promotion Behavior Change Strategy (BCS)	Create a model that will allow all partners to work together effectively to change behavior in their intervention zones.	2 day	Conference	Framework & common basis established
	Produce country-specific strategies that take into account partner and country uniqueness.	5 days	Workshop	Country behavior change strategies Staff trained in process & framework
3. Designing Intervention Creative Briefs	Elaborate outlines/tools for individual interventions to be conducted, providing guidelines and structure to development.	1-2 weeks	Workshop	Detailed creative briefs Staff trained in brief development & use
4. Evaluating Hygiene Promotion	Design an evaluation plan that is clearly linked to and reflects the BCS and the key behaviors to promote. Review types of indicators and how to design measurable qualitative ones.	Series of 4, 3-hour sessions (12 hours total)	Seminar	Evaluation plan (linked to BCS) Clear success indicators Staff trained in indicator design based on key behaviors Set of simple community-based evaluation tools
5. Monitoring Hygiene Promotion Programs	Prepare a monitoring plan. Establish monitoring protocol.	1 hour monthly meetings	Working Groups	Monitoring plan Staff trained Set of simple community-based monitoring tools
6. Fundraising for Water, Sanitation and Household Technology Provision	Examine new ways to solicit funds for needed HP activities. Develop plans to move forward.	Series of 5, 2-hour sessions (10 hours total)	Seminar	Fundraising plans (FR) Concept papers Staff capable of using innovated FR techniques

Capacity Strengthening Topic	Purpose	Length	Format	Outcomes/Outputs
7. Developing a Staff Training Program	Consider HP staff needs and develop a tentative training calendar.	3-5 days	Workshop	WAWI partner staff training program calendar Simple staff training needs assessment tool Partners identified to conduct training pieces
8. Expanding the WAWI Hygiene Promotion Partnership	Ensure a clear understanding of what a “partnership means.” Develop criteria for seeking new partners. Build a stronger, more cohesive partnership.	Series of 3, 2-hour sessions (6 hours total)	Seminar	Criteria for new partner determination List of potential new partners Guiding principles “What it means to be a partner” Strengthened WAWI partnership
9. Linking Hygiene Promotion Activities and Hygiene Promotion Infrastructures	Investigate ways to link activities and infrastructures and build country plans and individual partner plans. Delineate challenges and opportunities.	Series of 3, 2-hour sessions (6 hours total)	Seminar	List of existing opportunities List of creative linking techniques Plan of Action for linking in 3 communities per partner