TOOLS & METHODS

Designing and implementing a hygiene awareness-raising and sanitation promotion strategy

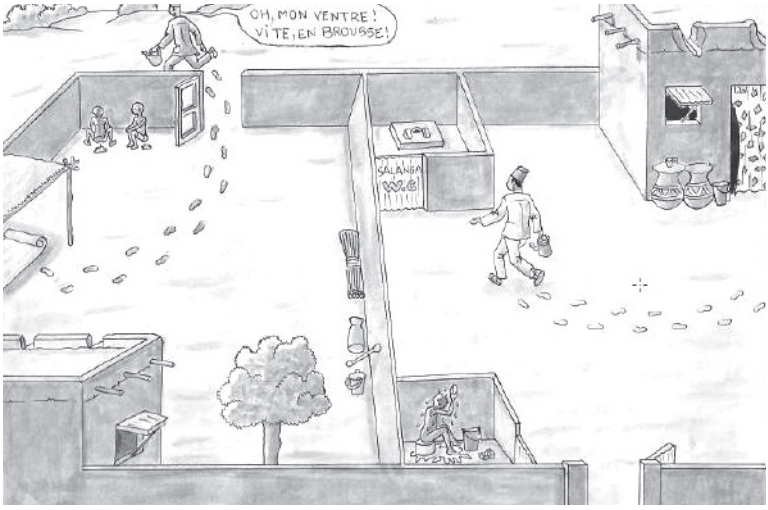
Guidelines for action

pS-Eau

programme
Solidarité-Eau

Designing and implementing

a hygiene awareness-raising and sanitation promotion strategy



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Introduction

Why be concerned about sanitation and hygiene?

Over one million people around the world die each year from diseases caused by a lack of safe water and sanitation, with most of these deaths recorded in developing countries.

Using good sanitation and hygiene practices is one of the most effective means of reducing the spread of diarrheal diseases, which are the leading cause of death among children under five.

There are three key practices that can significantly reduce these risks:

- **Handwashing with soap** alone can prevent between 500,000 and 1.4 million deaths per year (Curtis, Cairncross, 2003).

- **Access to proper sanitation facilities at home** can reduce diarrheal diseases by 32% (Scott, 2006).

- **The hygienic treatment, handling and storage of drinking water** can also significantly help improve families' health.

In addition to improving public health, the positive impacts of proper hygiene and sanitation also include: reduced spending on healthcare, increased productivity and a higher school enrolment rate, etc.

Encouraging individuals and communities to adopt good sanitation and hygiene practices is one of the key factors for development.

What is the scope of this document?

This document focuses on two distinct activities that have been considerably developed over the last few years and which today form **an integral part of water and sanitation projects.**

The aim of **hygiene awareness-raising** is to improve the hygiene behaviors not only of water and sanitation service users, but also of inhabitants of a given town or area. Hygiene awareness-raising takes place through various types of information and communication activities, etc.

Sanitation promotion aims to provide households with sanitation facilities, particularly toilets, showers and sinks. Sanitation promotion also usually involves information and communication activities.

It is difficult to separate hygiene awareness-raising and sanitation promotion: if a household has a toilet installed but fails to follow the appropriate hygiene practices, there will be less of a positive impact on the family's health. And vice versa: hygiene awareness-raising will have little impact if it is carried out in an unsanitary environment where families have no interest in using sanitation facilities.

Box 1: What type of sanitation and hygiene is covered in this document?

Hygiene refers to all measures, practices and behaviors that aim to reduce infection and the outbreak of infectious diseases. Within this document, hygiene specifically refers to the practices and behaviors used within the private sphere: handwashing and personal hygiene; the handling, storage and treatment of water at home; food hygiene, etc.

Sanitation as covered in this document refers to the management of household wastewater and excreta. It therefore does not include solid waste or waste produced by polluting, industrial activities.

What are the objectives of this guide?

A wealth of literature has been produced on hygiene awareness-raising and sanitation promotion methods. However, there is little to no guidance available to help sector stakeholders determine which method would be best-suited to their particular situation. In light of this, the objectives of this document are twofold.

1. Address hygiene awareness-raising and sanitation promotion using a rational and methodical approach that is based on the key stages of the project cycle (diagnostic, objective setting, design, implementation and evaluation).

2. Explain how the sanitation and hygiene promotion and awareness-raising methods and tools work in order to provide stakeholders with guidelines and methods for selecting a specific approach.

STAGE 1

Carry Out a Social and Health Assessment

Hygiene and sanitation projects often overlook the importance of the diagnostic/assessment stage. However, the information collected helps provide an understanding of local public health issues and thus enables tailored activities to be defined. In other words, when carried out correctly, a diagnostic helps you design a relevant program that targets those population groups most vulnerable to health risks. The social and health assessment plays a central role, namely that of describing the target area and defining the various hygiene and sanitation issues encountered therein. More specifically, the assessment should provide the answer to two key questions:

1. What is the profile of the target environment?

2. What are the unsafe practices employed and who uses these unsafe practices?

Define the strategic settings in which to carry out the assessment

The main aim of the social and health assessment is to identify the unsafe hygiene behaviors practiced by inhabitants, which means determining which hygiene practices are being used in everyday life settings. Within each given area, whether urban or rural, there are numerous places in which hygiene practices are employed on a daily basis. Nevertheless, it is possible to reduce the number of 'strategic' everyday life settings to four, either because they are places in which daily hygiene activities are performed or because the people living in these places are particularly vulnerable to health risks:

- **The plots and houses in which families live.** It is essential that good hygiene practices are followed within the domestic sphere.

- **Schools.** Children are one of the groups most at risk from poor hygiene. In addition, schools are places of learning; therefore, they are the ideal places in which to conduct hygiene awareness-raising activities.

- **Healthcare centers** are places in which there is a high risk of contamination. Furthermore, they are also visited by people particularly vulnerable to infection.

- **Public places,** which here include public toilets and water points located in markets, stations and unplanned settlements. Large numbers of people pass through and/or live in these areas, which can consequently pose a risk to public health.

Therefore, a social and health assessment should ideally be carried out in each of the above-listed settings found within the target area. However, it is possible to reduce the number of settings to match the project's aim and scope. For a regional project focusing on schools or healthcare centers, for example, there would be no need to carry out the assessment with households or in public places.

Profile the target environment

This step involves collecting information on the current situation to build a picture of the target environment. Regardless of whether the assessment is being conducted in an urban or rural area, as a minimum, the following data should be collected:

- The social and health situation and demographic context.

- The situation with regard to sanitation facilities.

- The human resources available to carry out hygiene awareness-raising and sanitation promotion activities.

There are usually three sources of information that can be used to collect these three types of data (which are defined in more detail below):

1 **A literature review** of the various documents available can often provide a considerable amount of first-level data, depending on the type of literature that has been prepared. Priority should be given to analyzing the most recent census and household surveys conducted in the area, as well as any documents pertaining to past water, sanitation and hygiene projects (reports, evaluations). Under no circumstances should this literature review be neglected as it is an extremely important step: it helps avoid unnecessary duplication of effort and enables you to determine the type and amount of any missing data that will need to be collected. The relevant documents can notably be obtained from the local authority, the state's devolved technical departments, NGOs, consulting firms and development partners that have previously implemented projects, or are currently working, in the area. Data from regular nationwide studies and surveys can also be obtained from the national authorities.

2 **Field visits** to the four types of strategic everyday life settings should also be carried out. A sufficient number of sites need to be visited to ensure they are representative of the area as a whole. It is also worth talking to the people who live in the area. Local organizations (such as neighborhood committees, for instance) are often able to provide valuable information on the types of hygiene practices commonly used by local residents.

3 **Targeted interviews** with key contacts can provide useful information on the area's organizational set-up: heads of the neighborhood or village, religious or community leaders, heads of local organizations and associations, etc.

Obtain information on the social and health situation and demographic context

In order to obtain information on the demographic context and social and health situation, the following type of data should be collected:

- **Demographic:** to determine the number of people the awareness-raising and promotion activities need to target.

- **Socio-economic:** notably to provide an overview of the population's level of education and standard of living, as well as of current social cohesion dynamics.

- **Health:** to identify the prevalence of pathogenic diseases linked to lack of sanitation and hygiene (the number of cases of diarrhea often provides a suitably reliable indicator for this).

The table below provides an indicative list of the data to be collected from each strategic setting.

Table 1: List of the data to be collected to obtain information on the social and health situation and demographic context

SETTING	DATA TO BE COLLECTED
SCHOOLS	• number of pupils and teachers • breakdown of pupils by age and by gender • attendance rate by age and by gender • level of motivation of school stakeholders (teachers, parents' associations, etc.) • most commonly reported diseases (diarrhea, bilharzias, etc.)
HEALTHCARE CENTERS	• number of patients and nursing staff • the most commonly reported diseases • the groups most affected by these diseases (by age and by gender)
PUBLIC PLACES	• number of people using facilities, such as water points and public latrines, etc. (per day) • fees charged for using these facilities
HOUSEHOLDS	• population size and breakdown (by age and by gender, ethnic and religious minorities, etc.) • literacy rates • the most common diseases • inhabitants' main economic activities • income levels • local organizations' level of motivation and activities

Ascertain the current situation with regard to water, sanitation and hygiene

It is possible to obtain information on existing water and sanitation facilities using data on:

- Water supply and sanitation service **coverage** (the number of water and sanitation facilities found in homes and in schools, etc.).

- Current **service levels**. For water: standpipes, handpumps, household taps, wells, soakaways, water quality… For sanitation: basic latrines, ventilated latrines, showers and sinks, etc.

- The **operational status** of water and sanitation facilities. For water: continuous or intermittent supply, the most common types of breakdown … For sanitation: the level of degradation and state of toilets, showers and sinks, etc.

It is also important to gather information on current projects, particularly on how these have been implemented. This type of review will be useful during the subsequent hygiene awareness-raising and sanitation promotion strategy design stage, as it will enable you to develop messages that are aligned to ongoing programs. An example of inconsistency (to be avoided at all costs) would, for instance, involve promoting the installation of latrines using a partial subsidy in an area where other initiatives are offering full subsidies.

Identify the resources and skills available

This involves identifying the local public and private sector stakeholders with the skills and availability to work on the awareness-raising and promotion strategy design and implementation stages. It will be necessary to identify resources and their relevant skills from among:

- The **devolved technical departments** in charge of water, sanitation and health and education, including their local branches, and ascertain the availability of their staff.

- **International and local NGOs** working in the area that specialize in social support and awareness-raising.

- **Community-based associations and organizations** willing to convey messages and liaise with local residents (water point management committee, village WASH committee, parents' association, etc.).

- Communication firms or companies working in the **private sector** that specialize in marketing hygiene and sanitation-related goods and services.

At this point in the diagnostic stage, it is also important to determine the financial and human resources available at **local authority** level, along with the staff's skill level and commitment. If decentralization has taken place, it is this local authority staff that will ultimately be responsible for planning, coordinating and even carrying out hygiene awareness-raising and sanitation promotion activities over the long-term. Typical questions to ask include: is there a hygiene and sanitation technical officer within the local authority? If yes, has this person received hygiene awareness-raising training? Does the local authority have financial resources they can allocate to awareness-raising and promotion activities?

Identify the unsafe practices employed

Unsafe practices include all behaviors that can cause human infections. With specific regard to hygiene and sanitation, these unsafe practices fall into four main categories:

- Water handling and consumption practices (how water is transported and stored at home, where applicable, the quality of the water consumed and treatment methods used, water used for cooking, etc.).
- Practices related to the use of sanitation facilities (use – or not – of toilets, handwashing after going to the toilet, wastewater disposal, cleaning and maintenance of sanitation facilities, etc.).
- Personal hygiene practices.
- Food hygiene practices.

Who to interview

Hygiene and sanitation-related behaviors can vary widely depending on a person's gender, age and social role. To make it easier to identify unsafe practices and the people most at risk from these practices, it is therefore advisable to first segment the population. In practice, for each strategic setting, this means dividing people into groups using variable criteria, such as gender, age, social status, income levels and housing, etc. The table below provides examples of segmentation that can be used to help clearly define the target audience of a given activity.

Table 2: Strategic settings and examples of corresponding population segments to be used to help identify unsafe practices

SETTING	EXAMPLE OF SEGMENTATION
SCHOOLS	• Schoolchildren (boys) • Schoolchildren (girls) • Adult staff (headteacher, teachers, cleaning staff) • Parents' associations
HEALTHCARE CENTERS	• Patients • Nursing staff
PUBLIC TOILETS & SHOWERS	• Users • Managers / cleaning staff
HOUSEHOLDS	• Heads of household • Mothers • Young children • The elderly

What tools should be used?

In the majority of cases, both quantitative and qualitative approaches will be used to conduct a field study into unsafe practices.

Qualitative methods are used to obtain a description of the unsafe behaviors: exactly what are these behaviors, what motivates these behaviors, what are people's attitudes, etc. There are a number of different qualitative methods that can be used:

- **Focus group discussions** involve inviting small groups (of between 5 and 10 people) of the same age, gender and social status to openly talk about the target topics.

- **Direct observation** consists of collecting information on people's behaviors by observing their daily habits. This means shadowing the people being studied for a given period of time.

- **Individual interviews** (either in-depth or semi-structured) to discuss a topic introduced by the interviewer.

Quantitative methods provide figures to supplement the qualitative data, particularly to determine the proportion of the population that uses a specific unsafe behavior, for example. Again, there are a number of different methods that can be used:

- **Questionnaires** are used to collect information from a large number of people, who are asked to respond to a series of closed questions (with a limited number of possible responses).

- The **KAP survey** (Knowledge, Attitudes and Practices survey) is a questionnaire-based tool that is particularly well-suited to studying hygiene behaviors. It can be used to collect both quantitative data (on the number of people who use soap to wash their hands, for example) and qualitative information (reasons people do not use soap to wash their hands). However, this type of survey requires both time (between 4 and 12 weeks, depending on the scope of the survey) and resources, in particular people with specific expertise in using this type of tool.

It is highly recommended that you use a combination of both qualitative and quantitative approaches as this provides considerably greater scope for analyzing the information collected. The survey tools best suited to the various segments of the population are detailed in the table 3.

Table 3: Recommended survey tools to be used with the various population segments

SETTING	EXAMPLE OF SEGMENTATION	SURVEY TOOLS	COMMENTS
SCHOOLS	Schoolchildren	Questionnaires + Direct observation	Valuable information can be obtained by asking a sample of schoolchildren about their practices. However, it can be difficult to routinely organize this approach as not all children are receptive to completing formal questionnaires. Therefore, direct observation remains the best means of studying their behaviors and determining how often they wash their hands with soap after going to the toilet.
	Adult staff (headteacher, teachers, cleaning staff)	Questionnaires + Focus group discussions + Individual interviews	If the diagnostic stage involves only one or a handful of schools, individual interviews provide an excellent means of obtaining more detailed information on topics covered by the questionnaire. Where the survey covers several schools, focus group discussions are a good way of quickly and cost-effectively collecting a wide range of information, notably from teachers. As they are key resources, it is recommended that individual in-depth interviews are always held with headteachers.
HEALTHCARE CENTERS	Patients	Questionnaires	For patients, it is necessary to assess both their handwashing practices and their effective use of facilities. As direct observation is difficult (the patients are often all in different rooms), the most suitable survey method generally involves holding individual interviews with a representative sample of patients.
	Nursing/ cleaning staff	Questionnaires + Focus group discussions	As with schools, healthcare centers are particularly affected by any failure to meet hygiene standards. The nursing staff's compliance with hygiene practices, especially handwashing with soap and cleaning of sanitation facilities, needs to be both quantified (through questionnaires on how often they wash their hands, with and without soap) and qualified (in focus group discussions on their perceptions, attitudes and difficulties practicing hand hygiene).

SETTING	EXAMPLE OF SEGMENTATION	SURVEY TOOLS	COMMENTS
PUBLIC PLACES	Users	Questionnaires	The users of public sanitation facilities are notoriously fickle. Therefore, the questionnaire is the best survey tool for assessing their level of satisfaction with these facilities and identifying reasons for their dissatisfaction.
	Managers/ cleaning staff	Questionnaires + Individual interviews	There is usually only a small team in charge of managing and cleaning public sanitation facilities (one manager per facility). In addition to the questionnaire, it is therefore advisable to spend time holding individual interviews to assess the manager's knowledge of safety and hygiene and ascertain how the facilities are cleaned.
HOUSEHOLDS	Heads of households	Questionnaires + Focus group discussions	The heads of households are usually responsible for investing in the household. Using questionnaires makes it possible to ascertain why latrines are not considered a priority investment. Heads of households' arguments for and against the use of latrines can then be debated in focus group discussions.
	Mothers	Questionnaires + Focus group discussions + Direct observation	Focus group discussions supplement the questionnaires as they can cover topics that are difficult to broach within the family setting (such as defection practices or menstrual hygiene, for example). Direct observation also helps by making it possible to check that the practices identified through the questionnaires are actually being carried out within the household.
	Young children	Focus group discussions/ Individual interviews (mothers) + Direct observation	The health problems encountered by young children are determined through interviews with their mothers. Additional information can be obtained by observing the children's behaviors.
	The elderly	Individual interviews	Along with young children, the elderly are most at risk of falling ill. In most cases, individual interviews are the best way of obtaining information on their hygiene practices.

What data needs to be collected?

The aim of the surveys is to **identify and map unsafe health and hygiene practices.** The people carrying out the survey, whether through observation or discussion, therefore at least need to be aware of the 'most common' unsafe practices, so they know what to look out for. At the same time, they should also be able to identify the less commonly encountered, but equally unsafe, poor practices. Some of the most commonly encountered unsafe practices are listed in the table below.

As a minimum, the field survey should help identify and map inhabitants' hygiene practices. Ideally, it will also enable you to **identify the main drivers for behavior change**. In other words, what are the triggers that will encourage inhabitants to swap an unsafe practice for a practice that is healthy and hygienic? These triggers usually vary according to the population group and individual: their perception of the health risk; the social view of hygiene; beliefs and local customs, etc. The task of identifying these drivers for change is relatively complex and should be undertaken by a qualified expert. During the strategy design stage, you will then be able to use your knowledge of these drivers for change to devise relevant and effective messages for each of your target groups.

How to analyze the data collected

The **quantitative data** undergoes a statistical analysis to produce figures to identify the unsafe practices most commonly used by each segment of the population surveyed.

The **qualitative data** is analyzed for each of the population segments surveyed to identify the main trends as regards willingness to change and the enabling – and adverse – factors relating to this change, etc. The information obtained from this analysis will be vital for the strategy design stage, where it will be used to produce the messages to be communicated to the target audience.

It is essential that the two analyses (qualitative and quantitative) be cross-referenced to check there are no discrepancies between the figures in the statistical analysis and the information collected through observation and discussions with inhabitants.

Table 4: The most common unsafe practices

SANITATION AND HYGIENE PRACTICES	• Open defecation • Sanitation facilities are not kept clean (latrines, showers, handwashing facilities) • Water points are not cleaned or maintained • Young children's feces is not disposed of safely • Latrine pits are not emptied hygienically • Little to no handwashing • 'Illegal' dumping of greywater (from showers, washing up and laundry)

Mobilize the human and financial resources required

What skills are required?

At the very least, a hygiene and sanitation specialist will be required to work on the diagnostic stage. This specialist should have experience of developing survey protocols (methods, questionnaires), supervising enumerators and analyzing data. It is also vital that they are familiar with using Excel spreadsheets (or equivalent) for 'basic' data management. For extensive surveys that collect large amounts of data, an understanding of specialized software (such as SPSS©, Stata©, Sphinx©, etc.) would be a considerable advantage. In most cases, it will also be necessary to train the enumerators and pilot the questionnaire to ensure it contains no errors or inconsistencies.

It is also advisable to involve staff from devolved technical departments, particularly those who work on social and hygiene issues. This is both to draw on their valuable knowledge of the field and to ensure they are involved in the awareness-raising and promotion strategy from the outset.

The hygiene practices survey can be carried out by a team of locally recruited enumerators with a minimum level of training. A mixed gender team will help facilitate contact with respondents; it being particularly useful to have a woman lead the women's focus group discussions on hygiene practices, for example.

How to fund the diagnostic

The diagnostic stage is the cornerstone of any relevant awareness-raising and promotion strategy. It is therefore important to ensure it is adequately funded. The cost of this stage can vary, being dependent on the size of the target area, as well as on the level of accuracy required. Depending on the situation, the consultation period can last from a few days to a few weeks.

The diagnostic stage provides the data required to both outline the hygiene awareness-raising and sanitation promotion strategy and determine the size of the budget required to implement this. Once these two elements have been defined (the type of awareness-raising and promotion strategy and its cost), they can be incorporated into the project document as an additional component to support the construction of water supply and sanitation infrastructure. It is this project document that will then be submitted to donors when applying for funding. The issue for many project initiators and development actors is thus how to carry out a diagnostic without upfront funding. One relatively simple and low-cost option involves conducting a preliminary diagnostic, in conjunction with local stakeholders, paid for out of the project initiator's own budget. This preliminary diagnostic will then be further refined during a more in-depth assessment carried out as part of the project.

Area used to demonstrate and promote the use of sanitation facilities to households

Madagascar, Méddea project, Gret

STAGE 2

Set the objectives and define the strategy's target groups

Build consensus with local stakeholders

Before defining a strategy, it is first necessary to set clear, specific and realistic objectives. When defining objectives that relate to public health, you will need to consult with and obtain approval from the stakeholders involved.

Although national sector frameworks can provide benchmarks and recommend priorities for action, a local hygiene awareness-raising and sanitation promotion strategy's objectives need to be set in agreement with local stakeholders, under the leadership of the local authority.

It will be necessary to meet with a number of different local stakeholders to discuss the strategy objectives:

- Water supply and sanitation service users (households, nursing staff, teaching staff, etc., depending on the strategic settings covered by the diagnostic);

- Health workers (doctors, healthcare center staff);

- Local media (radio stations, local newspapers) can also be approached;

- Representatives from the local authority and its technical departments.

In addition to providing an opportunity to meet all stakeholders, the meetings held to build a joint consensus can also be used to present the findings of the diagnostic stage to those people that took part in the survey.

Prioritize the health and hygiene issues identified

Should a number of unsafe practices be identified (as is usually the case), it can be difficult to determine which of these health and hygiene issues pose the greatest risk. This challenge can be overcome by a rational and objective analysis of the data collected during the diagnostic stage. Analysis of the quantitative component of the diagnostic, in particular, will enable you to clearly rank the prevalence of unhygienic and poor behaviors.

As an indication, a number of studies have concluded that the unhygienic practices most damaging to health are often:

- The unhygienic disposal of feces;
- Not washing hands with soap after coming into contact with fecal matter;
- The unhygienic collection and storage of drinking water.

Box 2: Practices causing diarrheal diseases in Bobo Dioulasso

In Bobo Dioulasso, Burkina Faso, diarrheal diseases are one of the leading causes of death among children aged 0 to 3 years. A study was undertaken as part of the Saniya program that identified the following main unsafe practices and risk factors:

- Unhygienic household water sources;
- Animals being raised within the family plot;
- Unsafe disposal of children's feces;
- The way children are fed;
- Mothers have had no hygiene education;
- Environmental factors (poor disposal of wastewater and excreta).

Furthermore, the field study identified a significant statistical link between the outbreak of diarrhea in children and the following three practices: 1) the unsafe disposal of children's feces (left outside or with the household's solid waste); 2) using a bottle to feed young children; 3) lack of handwashing by mothers.

The statistical analysis also made it possible to conclude that, in order to reduce diarrheal diseases in children under 3, priority needed to be given to changing two of these practices in particular: the **disposal of feces** and the **mothers' failure to wash their hands after changing their young children's diapers.**

Set the strategy objectives and define the target groups

The objectives of the hygiene awareness-raising and sanitation promotion strategy stem directly from the priority health issues identified during the diagnostic stage. For hygiene awareness-raising and sanitation promotion, any given objective needs to address at least two questions: which unsafe behaviors need to be changed or eradicated? Who will be affected by this required change (target group)?

The diagnostic makes it possible to link the various unsafe behaviors to specific segments of the population surveyed. It therefore makes logical sense to convert these population segments into awareness-raising and promotion activity target groups. There are a number of reasons why it is important to set up specific target groups:

- Not all target groups will be receptive to the same messages and communication tools (for instance, young people and the elderly will generally have different motivations and use different types of media).

- Within a strategic setting where poor behaviors have been observed, it is often possible to divide target groups into those directly affected by the need to improve behaviors (the primary or priority groups) and those able to positively influence this behavior change in others (secondary and tertiary groups, see Box 3).

It is therefore necessary to set a 'reasonable' number of objectives, in line with the potential budget available, without at this stage theorizing as to the types of activity required to achieve them.

Box 3: Prioritizing the target groups

The **primary/priority target group** contains those people who use the identified unsafe practices.

The **secondary target group** consists of people able to influence and facilitate behavior change within the primary target group.

The **tertiary target group** contains intermediaries and opinion leaders (teachers, religious heads and elders) able to influence a community's beliefs and behaviors.

STAGE 3

Design the Strategy

Once the hygiene priorities and behavior changes that you want to promote with the target groups have been defined, you will need to determine how these changes are to be achieved. In other words, what awareness-raising and promotion activities are required and how are these to be implemented?

A hygiene awareness-raising and sanitation promotion strategy should focus on two key aspects: communicating relevant messages and using the appropriate tools and methods for the target audience and situation.

Define the key messages

Devise messages that draw on people's actual motives

Regardless of whether your aim is to raise people's awareness of good hygiene behaviors or encourage them to purchase sanitation facilities, it is essential that you use the information provided by inhabitants and water and sanitation service users when creating your awareness-raising messages.

If carried out correctly, the diagnostic will not only have provided information on social and cultural perceptions of hygiene and sanitation, but will also have given you an insight into what would motivate people to adopt new practices. Messages should thus be devised based on this information, as it provides the levers for change likely to have the greatest influence on each identified target group. These levers for change can vary for each population segment and can be health-related (improving the health of young children), social (social belonging, prestige), financial (reduce wages lost through illness) or religious (the notion of physical and spiritual purity).

The failure of numerous hygiene message-based awareness-raising campaigns has revealed that health is often not the primary motivating factor for adopting new hygiene behaviors. Instead, modernity, self-esteem and eliminating bad smells are all factors frequently cited as being powerful drivers of change for improving hygiene and sanitation practices.

Table 5: Drivers motivating latrine adoption in rural Benin

CATEGORY	DRIVE
PRESTIGE	• Affiliate and identify with urban elite • Express new experiences and a lifestyle acquired outside the village • Leave a permanent legacy for descendants • Aspire to Fon royal class status
WELL-BEING	• Protect family health and safety from mundane dangers, accidents, snake bites, crime and diseases associated with open defecation • Increased convenience and comfort • Protect personal health and safety from supernatural dangers associated with open defecation • Increased cleanliness • Visual, social or informational privacy
SITUATIONAL	• Provide an alternative for individuals with restricted mobility (aged or disabled) • Increase rental income

Source: Jenkins, WSP, 2004

Keep it simple and do not use too many messages

The lessons learned from past sanitation and hygiene activities have shown that it is the simplest messages that people are most likely to assimilate and retain.

Messages therefore need to be easy to understand and the desired behavior change should be simple to adopt and not require people to learn new complex practices that they find difficult to assimilate into their everyday lives. Changing behavior should be perceived as being more beneficial than not changing anything at all. To increase its chances of being retained by its target audience, a message needs to:

- Target only one practice at a time.

- Be unique: using multiple messages with variations on content within the same hygiene awareness-raising and sanitation promotion program is actively discouraged as this can reduce the effectiveness of the communication campaign.

Choose the appropriate hygiene awareness-raising and sanitation promotion methods

Use a 'turnkey' approach

There are a large number of methods already being used in the field, for which detailed methodologies are available in various guides and manuals. In practice, these turnkey methods will still require some fine-tuning to tailor them to your specific target area (particularly as regards aspects such as the organization of local communities and cultural sensibilities, etc.). These turnkey methods tend to follow two main trends: awareness-raising and the more recently developed marketing approaches.

Awareness-raising approaches aim to encourage groups to think about and question their way of doing things in order to trigger community ownership of their health and hygiene issues. These approaches often assume that knowledge is the first step towards behavior change. They are implemented by a person who has the required knowledge (the teacher or facilitator) and a target audience who as

yet does not. In essence, these approaches involve telling people about good hygiene behaviors and the advantages of using these practices. Some of these methods assume that the target population has the ability to identify problems and come up with solutions. They mainly involve the use of educational and participatory tools and aids that give each member of the target group the opportunity to express their views. These awareness-raising methods include (see Annex 2):

- WASH in Schools;
- Child-to-Child approach;
- PHAST (Participatory Hygiene and Sanitation Transformation);
- Community Health Clubs;
- CLTS (Community-Led Total Sanitation).

The marketing approaches are direct variations of methods developed for mass communication. These approaches consist of 'sales' arguments, which are constructed using messages that are not always rational or objective (what drives someone to buy soap or a latrine can have little to do with health and hygiene considerations). These methods involve using highly visible communication aids displayed in the public sphere (billboards, the media, etc.). These marketing approaches include (see Annex 2):

- Handwashing with soap;
- Sanitation marketing.

Carrying out a comparative analysis of the various methods to inform your choice is not particularly straightforward. Thus, an overview of the most common methods is provided in the table below. Factors likely to influence your decision include the target audience (as some methods focus specifically on schoolchildren and on children in general) and the type of approach – awareness-raising or marketing – preferred by the project leaders in the field.

Table 6: Detailed overview of the seven main awareness-raising and promotion methods

	PHAST	COMMUNITY HEALTH CLUBS	CLTS
TYPE OF APPROACH	Community mobilization		
TARGET AUDIENCE	The entire community and households		
METHOD OBJECTIVES	Improve hygiene behaviors + encourage the procurement of sanitation facilities		
AVERAGE LENGTH OF IMPLEMENTATION PERIOD	4 days' facilitation **over 1 to 2 months** + monitoring & evaluation	Between **6 and 18 months** of 1 to 2 hour weekly meetings + monitoring & evaluation	Between **3 weeks and 1 year** + monitoring & evaluation
EXPERTISE REQUIRED FOR IMPLEMENTATION	**- Participatory tools and techniques**		
	- Facilitation techniques: speaking and listening skills, patience and ability to adapt and to facilitate rather than lecture. **- Knowledge of diarrheal diseases, their transmission and prevention**		
COST	**US$3 to $4 per person involved** (figures from the World Bank project in Kyrgyzstan and the Caritas project in Uganda). No. of people participating in each awareness-raising session: **10**	**US$2 to $3 per person involved** (figures from the AHEAD project, Zimbabwe). No. of people participating in each awareness-raising session: **30 to 300**	**US$2 and $14 per person** (an average of US$3.20 in West Africa. USAID and UNICEF figures).
POTENTIAL FOR SUSTAINABILITY	**Low:** rarely sustained beyond the end of the project due to high cost of human and financial resources required.	**High:** post-project, clubs can become fully-fledged community organizations.	**High:** by definition, CLTS aims to trigger a community-based virtuous circle that promotes hygiene and the use of sanitation facilities.

WASH IN SCHOOLS	CHILD-TO-CHILD APPROACH	PROMOTING HANDWASHING WITH SOAP	SANITATION MARKETING
Educational		Marketing	
Schoolchildren (aged between 6 and 12)	Pre-school age children and schoolchildren (aged between 5 and 12)	The entire community	Households
Improve hygiene behaviors			Improve hygiene behaviors + encourage the procurement of sanitation facilities
Between **12 months and 2 years** + monitoring & evaluation	Between **12 months and 3 years** + monitoring & evaluation	Between **6 months and 3 years** + monitoring & evaluation	Between **6 and 16 months** + monitoring & evaluation
- Educational tools and techniques		**- Sales and marketing techniques:** planning and designing communication campaigns, client prospecting.	
- Facilitation techniques: speaking and listening skills, patience and ability to adapt and to facilitate rather than lecture. **- Knowledge of diarrheal diseases, their transmission and prevention**			
From US$2 to $16 per child involved (IRC figures).	**Insufficient data**	**Cost varies according to the communication tools used.** Cost per person is lower than that of community-based and educational methods.	**Between US$0.5 and $3** per person (WSP figures), excluding household subsidies for purchasing latrines.
High: awareness-raising activities can be incorporated into the school syllabus and teachers and children can volunteer to set up hygiene clubs.	**Variable:** depends on the institutional set-up/project initiator.	**Variable:** depends on the institutional set-up/ project initiator.	**High:** can be sustained beyond the end of the project through latrine construction and sales points (sanimarchés).

Attention: The figures in this table (cost and length of implementation periods) are provided for indicative purposes only and, as such, are in no way definitive.

Develop a 'tailor-made' approach

This involves moving away from existing standards and benchmarks and combining several facilitation tools and communication aids to create totally unique strategies that are perfectly attuned to the target audience's attitudes and therefore more likely to achieve the desired outcome.

In the majority of cases, the designers of personalized approaches draw on existing materials, tools and methods to come up with innovative combinations. The aim of these 'creative' strategies is to devise an approach that is as closely aligned to the specific requirements of the target area and objectives as possible.
They are often based on past experiences and the designers' preferences.

Box 4: Examples of combining existing methods

Inter Aide has piloted an approach in rural areas of Malawi that combines the CLTS and PHAST methods. Initially, CLTS 'triggering' takes place to stimulate demand for sanitation within the communities involved. The second stage involves carrying out PHAST activities, not only to ensure inhabitants remain motivated to construct latrines, but also to effect behavior change with regard to other key hygiene practices (drinking water hygiene, handwashing).

The Water and Sanitation Program (WSP) has launched a number of projects, notably in Cambodia and Tanzania, that examine how CLTS and sanitation marketing can complement each other: CLTS, which aims to eradicate open defecation, is implemented first and stimulates the demand for sanitation; the marketing approach is then initiated to create or develop the supply of sanitation facilities and services that are tailored to households' needs and ability to pay.

In addition to the established and proven methods outlined above, the hygiene awareness-raising and sanitation promotion sector also has a comprehensive array of communication tools available, which can be divided into two categories:

- **Interpersonal communication tools**, which are those that encourage interaction between people to develop their knowledge and help them learn new behaviors (illustrations, picture cards, street theater, etc.).

- **Mass communication tools**, which are, above all, used to convey information. They are used to disseminate and pass on messages and information to the general public (radio, television, press, etc.).

On the following two pages, you will find comparative reviews containing more detailed information on the most commonly used interpersonal and mass communication tools.

Box 5: Example of combining interpersonal and mass communication tools

Implemented under a decentralized cooperation (twinning) arrangement between Tessaoua (Niger), Conflans Sainte-Honorine and SIAAP (France), the PHAT project is an interesting example of the range of tools that can be combined to reach different social groups (women, children, etc.) as part of an awareness-raising strategy. The approach used a combination of several types of complementary tools and aids:

- House-to-house awareness-raising;
- Forum theater performances;
- Billboards;
- Radio messages;
- Activities in schools;
- Mobile digital cinema;
- Religious sermons (given the importance Islam places on hygiene);
- Training of focal points in each neighborhood.

(Source : Hydroconseil, Evaluation Report on the Sanitation Sector in Niger)

Table 7: Comparative review of interpersonal communication tools

	VISUAL AIDS (PICTURE CARDS, COMMUNITY MAP, BOOKLET, ETC.)	FORUM THEATER, ROLE PLAY	MOBILE CINEMA
TARGET	Entire community + children	Children + schoolchildren	Entire community
ADVANTAGES	**(+)** An easy-to-use tool that enables hygiene messages to be delivered simply and which can be used to reach people with low levels of literacy. **(+)** Can be personalized: illustrations can be drawn to cover the most pressing health and hygiene related topics/problems within a community.	**(+)** A dynamic and participatory tool that can be used with a large number of people at the same time. **(+)** The sketches involve audience participation and thus help people identify with the scenarios being portrayed (which are based on everyday health and hygiene situations).	**(+)** A dynamic tool that can be used to reach a large and varied audience. **(+)** Effective means of dealing with sensitive or taboo subjects as situations are dramatized or portrayed using humor.
DISADVANTAGES	**(-)** Can become static and theoretical if used in a non-participatory manner.	**(-)** Requires a theater group able to create and perform sketches. Takes a long time to prepare (defining the messages, writing the sketch, rehearsals, etc.). In addition, its sustainability is limited. It is also important to ensure that the theater group itself has understood the messages it is to convey.	**(-)** It is a high-cost tool, which limits its sustainability. **(-)** Movies are not always translated into the local languages.
SKILLS REQUIRED	A local artist to create the picture cards and booklets. Facilitators trained on using community facilitation techniques to use the picture cards and community maps.	A theater group that specializes in participatory activities and trained on sanitation and hygiene.	A team composed of a community facilitator and a projectionist.
COMMENTS	The effectiveness of visual aids is highly dependent upon the facilitation skills of the community facilitator.	Feedback shows that this tool leaves a lasting impression on the audience, notably because they are invited to take part and find solutions to the health issues being portrayed.	The movies are followed by debates, which enable the audience to better assimilate the messages conveyed. Feedback from the field reveals that children are usually highly receptive to this tool.

MODELS, LATRINE SALES AND DEMONSTRATION AREAS	VILLAGE OR NEIGHBORHOOD MEETINGS	MEETING /FOCUS GROUP DISCUSSION	HOME VISITS, HOUSE-TO-HOUSE
Households	Entire community + households	Entire community + households	Mothers + households
(+) A practical tool through which latrines are attractively presented and where the potential user takes on the role of customer, reviewing the pros and cons of a range of possible options. **(+)** The demonstration areas can be transformed into permanent information and sales points.	**(+)** Traditional place for sharing information and holding debates and which can be used to involve large numbers of community members or a neighborhood's residents in discussing sanitation and hygiene-related topics. **(+)** Enables group decisions to be made regarding the activities to be carried out to improve sanitation and hygiene practices.	**(+)** A participatory activity that can be used to target specific groups, with the awareness-raising messages being tailored to the health and hygiene issues encountered by these groups. **(+)** Topics can be discussed in depth.	**(+)** A local communication activity in which the messages delivered can be adapted to each individual household. **(+)** Acts as a decision-making aid for households when purchasing a latrine, for example.
(-) Substantial initial investment is required to set up a demonstration and sales area, which also incurs running costs that will need to be covered by a sustainable and profitable economic activity.	**(--)** This method of social mobilization can result in certain groups being excluded: marginalized groups and people reluctant to speak in public, housewives, young people, etc.		**(--)** An activity that requires a lot of time and human and financial resources, so it is not particularly sustainable. **(--)** When house-to-house visits are conducted by community focal points who receive no remuneration from the project, there is a risk that these focal points will lose interest over time.
Artisans or masons trained in low-cost latrine construction techniques and in sales and marketing (planning and designing a local promotion strategy, client prospecting).	Facilitators trained to use community facilitation techniques.	Facilitators trained to use community facilitation techniques.	Workers trained in house-to-house awareness-raising techniques and sales and marketing techniques (client prospecting, supporting households with their purchase, following up and providing latrine cleaning and maintenance advice).
Latrine demonstrations can take place using the facilities of a community leader, local crafts or tradesman (mason or ironmonger), or in markets or a specially created latrine production and sales area.	Community mobilization does not suit all contexts, such as socially mixed urban areas in which there are no strong community ties. This method can be used to convey information and generate interest, but further regular meetings/discussions will need to be scheduled, which should be supplemented by individual communication campaigns (house-to-house, mass media, etc.).		House-to-house is particularly effective for stimulating household demand for sanitation facilities, as well as for raising mothers' awareness of key domestic hygiene practices, such as water treatment and storage and properly cleaning latrines.

Table 8: Comparative review of mass communication tools

	RADIO	TV	PRESS
TARGET	Entire community	Households + children	Literate population
ADVANTAGES	**(+)** A communication medium that can reach a large audience, including those with few or no literacy skills, at a low cost per person. **(+)** The repetition and simplicity of radio spots makes them easy for people to remember and assimilate long-term. **(+)** Can help improve sustainability of the hygiene awareness-raising and sanitation promotion approach.	**(+)** An attractive medium that can reach a large audience (including those with no literacy skills) at a low cost per person. **(+)** Helps make messages modern and attractive and can heavily influence children and young people. **(+)** The repetition and simplicity of TV spots makes them easy for people to remember and assimilate long-term.	**(+)** An effective means of influencing and raising the awareness of leaders of opinion (local elected officials, religious and community leaders, who are usually the best educated and informed members of the population) on the importance of sanitation and hygiene.
DISADVANTAGES	**(-)** A one-way communication tool, which does not enable the public to give feedback on the messages they receive.	**(-)** A one-way communication tool, which does not enable the public to give feedback on the messages they receive. **(-)** Communication is restricted to certain segments of the population (those with electricity and TV sets). **(-)** Producing TV spots requires considerable investment.	**(-)** Communication restricted to certain population segments only (urban, literate, with a certain amount of purchasing power).
SKILLS REQUIRED	A behavior change social marketing and communication expert to develop the communication strategy and radio spot content. The local radio station's technical team to broadcast the radio spots.	An advertising agency with social marketing expertise or scriptwriters for programs or series.	Journalism skills and an awareness of sanitation and hygiene issues.
COMMENTS	Radio is the main mass communication medium: it can be used to deliver awareness-raising messages to people in both urban and rural areas and across all social groups. The effectiveness of this communication tool can be increased by developing a long-term partnership with local radio stations.	Overall, TV is a powerful tool through which to shape and introduce new values and social norms, with the aim here being to turn good hygiene and sanitation practices into a social norm among the target audience.	Access to this medium is confined to certain population segments (i.e. messages will not reach those with no literacy skills or people living in remote rural areas, etc.).

POSTERS, BILLBOARDS	PROMOTIONAL MATERIALS (T-SHIRTS, BROCHURES, SOAP, ETC.)	ICT (INTERNET, CELL PHONES)
Entire community	Entire community	Entire community
(+) Can reach a large audience at a low cost per person. **(+)** Simple messages can be communicated quickly: can reach a large audience in a wide variety of places (shopping areas, markets, stations, administrative buildings, schools).	**(+)** Can reach a large audience at a low cost per person. **(+)** Provides people with a permanent reminder of the need to use good hygiene practices.	**(+)** Can reach a large audience at a low cost per person. **(+)** High potential for sustainability: long-term partnerships can be developed with national companies.
(-) A one-way communication tool, which does not enable the public to give feedback on the messages they receive or to ensure they have understood.	**(-)** A one-way communication tool, which does not enable the public to give feedback on the messages they receive.	**(-)** Communication restricted to areas that have access to telecommunications networks (urban, peri-urban, well-connected rural areas). **(-)** Excludes segments of the population that traditionally do not have access to these means of communication.
An advertising agency with social marketing expertise.	An advertising agency with social marketing expertise.	An advertising agency with social marketing expertise to develop the messages. National telecommunication and cell phone companies to communicate the messages.
This has the potential to generate a major impact, depending on how long the message is displayed and its visibility.	Distributed at events held in markets and public places and at community events (Global Handwashing Day, for example), these materials leave a lasting impression and make the messages delivered more attractive, as people generally react positively to free gifts.	The use of ICT for sanitation and hygiene promotion is still under-developed. However, this tool – and cell phones in particularly – has high potential as, in most countries, there is widespread coverage.

Discussions

A 'turnkey' or 'tailor-made' approach?

The method and combination of tools and aids to be used should be determined by the designer, based both on their awareness-raising and promotion experience and on the local opportunities available.

'Tailor-made' approaches, which involve adapting and combining methods or tools to align them with the target setting, usually take some time to design and require regular fine-tuning. Thus, attention needs to be paid to testing, evaluating and continuously improving the approach and ensuring that the tools and methods used are fully understood. However, this is not always possible due to a lack of local capacities.

Expertise is also required for the 'turnkey' methods. Nevertheless, as all these methods come with detailed manuals and protocols, the skill set required to implement them is less demanding.

Table 9: Advantages and disadvantages of 'turnkey' and 'tailor-made' approaches

	'TURNKEY' APPROACHES	'TAILOR-MADE' APPROACHES
ADVANTAGES	Use a detailed, step-by-step methodology, including activities and tools, which facilitates implementation.	Can be closely aligned to the specific features of the context and target audience.
DISADVANTAGES	Can prove overly rigid and poorly adapted to the context.	Has to include time for the design stage and, sometimes, a testing phase.

How do the specific characteristics of urban and rural areas affect the choice of strategy?

In urban and peri-urban areas, the reporting unit is usually the household and it can be difficult to encourage neighborhood-wide community mobilization and decision-making. Therefore, it is often better to focus on methods and tools that target individuals and households (rather than community mobilization activities): interpersonal communication, home visits, working with existing groups and organizations (public water point users' associations, for example). Inhabitants are also widely exposed to mass media, so using this type of communication tool can be particularly worthwhile.

Rural areas, and remote rural areas and close-knit villages in particular, can have extremely strong community ties. It can therefore be easier to mobilize inhabitants using traditional channels, such as village meetings or religious sermons. In this case, the strategy can focus more on methods and tools that involve a range of community-based activities, such as CLTS, PHAST or Community Health Clubs.

What are the benefits of using several different communication aids and tools?

Combining several different communication aids and tools to deliver similar messages enables you to:

- Diversify the approaches used to adapt the messages to the various target groups.

- Give credence and credibility to the messages delivered. When inhabitants are exposed to the same message through various channels and in a number of different places, they are more likely to buy into and assimilate it.

- Build a flexible approach that takes the availability of the various target groups into account.

This last point is particularly important. For example, the availability of target groups in rural areas is likely to vary according to the season and workload (people have less time available when there is work to be done in the fields).

In addition, the aids and tools used can become less effective over time. Feedback from the field has shown that house-to-house awareness-raising works well for the first 6 months of a project (as households are highly motivated), but tends to lose its impact thereafter. It is therefore important to develop combinations in which the strengths and limitations of each method and tool are maximized over the short, medium and long-term. Mass media, through which information can be rapidly disseminated at a low cost per person, can be used initially to introduce a new practice by making it sound appealing. Then, an interpersonal communication method could be rolled out to consolidate the message and encourage behavior change.

Although conveying messages through mass media can help you reach a wide audience, it is often not enough in itself to trigger action and effective behavior change. It is therefore important to bear in mind that communication can never replace direct contact and interpersonal relationships. A good hygiene awareness-raising and sanitation promotion strategy thus needs to properly balance these two types of approach.

Table 10: Example of complementary communication channels used in Haiti

TARGET GROUP TYPE	TARGET GROUPS	WHERE	COMMUNICATION CHANNELS	OBJECTIVES
PRIMARY	Poor mothers, children, care-givers	Homes, markets, vacant land, churches, schools	Home visits, street theater, movies, women's meetings	Change hygiene practices
SECONDARY	Fathers, mothers, mothers-in-law, teachers, neighbors, etc.	Neighborhoods, workplaces, meeting places, bars, churches, sports facilities	Radio, TV, meetings, newspapers, leaflets, movie screenings, community events	Support changes in hygiene practices
TERTIARY	Religious community and political leaders	Offices, churches, temples.	Radio, TV, brochures, press, seminars, print media, ceremonies, meetings	Support the hygiene promotion program

(source : Haiti WASH Cluster, Cholera Response Program, 2010)

Ensure the awareness-raising and promotion messages are consistent with the sanitation strategy

In most cases, a hygiene awareness-raising and sanitation promotion strategy will be developed to support water supply and sanitation projects. It can also be implemented in areas where WASH (water, sanitation and hygiene) activities have already been carried out or are still being conducted. In both of these cases, it will be necessary to ensure that the messages delivered through the awareness-raising and promotion strategy do not conflict with past or future activities and approaches. For instance, it would be counter-productive to encourage households to buy latrines using their own funds if people in a nearby village or neighborhood are being offered latrines for free.

Ensure the strategy is integrated by local stakeholders and there is a sustainable funding mechanism in place

Hygiene awareness-raising and sanitation promotion strategies are most often implemented in the same way as projects: international and ad hoc funding is obtained to carry out activities for a limited period of time. It is very rare for hygiene awareness-raising and sanitation promotion activities to be integrated into local municipal strategies, despite the fact that this would help improve their sustainability. It is not feasible to expect hygiene awareness-raising activities to resolve all health and hygiene issues within a few months or years. Hygiene promotion is a continuous and constantly evolving process.

The budget

Setting a budget can often be difficult and this is particularly true for awareness-raising and promotion activities: even using the same implementation method, the time required and costs incurred can vary considerably from area to area. There are currently no indicative costs available; however, a breakdown of the main costs to be taken in account is provided in the table below.

Table 11: Main hygiene awareness-raising and sanitation promotion strategy expenditure items

EXPENDITURE ITEM	EXAMPLES OF COSTS INCURRED
Human resources for designing the strategy	Payment of the service provider(s) (consulting firm, NGO, specialist communications agency, etc.).
Production of awareness-raising and promotion aids and tools (learning materials, communication aids, demonstration areas, etc.)	Graphic and educational design (local illustrators, audio recordings, theater groups, etc.). Printing visual aids, laminating posters, building models of latrines, etc. Advertising space (billboards, TV spots, etc.).
Training (if required) of providers recruited to implement the strategy	Room hire. Drinks and refreshments. Various equipment, materials and consumable items. Travel expenses.
Human resources for implementing the strategy	Payment of project coordinators, community facilitators, drivers.
Logistics	Daily expenses for travel, accommodation and meals. Fuel. Vehicle hire.
Monitoring	Monitoring expenses (survey materials, photocopying questionnaires, travel and logistics). Human resources.

There are several sources of funding that can be used to cover these costs, each of which has its own ramifications, particularly in terms of sustainability. A separate strategy can be defined for raising finance. For instance, combining short and medium-term funding (from external partners) with long-term financing (from local authorities, the state or private sector) can help ensure the social intermediation activities developed last beyond the end of projects (which are rarely longer than 2 to 3 years).

Table 12: Main sources of funding for awareness-raising and promotion activities

SOURCES OF FUNDING	LEVEL OF SUSTAINABILITY	USED TO FINANCE:
State	**High.** Substantial contributions can be obtained from the national budget, provided there is a specific budget heading for this.	Nationwide hygiene awareness-raising projects.
Local Authorities	**High** where local authorities have a budget and staff trained on conducting awareness-raising and promotion activities.	Hygiene awareness-raising campaigns in schools, public places and healthcare centers.
External Partners	**Limited.** Development partners are not always prepared to commit funds to the same area for long periods, which considerably limits the sustainability of awareness-raising activities.	Vocational training and capacity-building.
Private Sector	**Variable.**	Marketing campaigns to stimulate household demand for sanitation facilities. Nationwide good hygiene practice promotion campaigns (handwashing).

Local authorities should be responsible for financing and managing hygiene awareness-raising and sanitation promotion activities. They therefore need to include this type of activity in their local development plan and set up a specific budget. However, local authority management of this type of activity is often hampered by the municipalities' lack of funds, skilled staff and means of transport, particularly in rural areas. In this situation, other sources of funding will need to be explored, such as a water and sanitation fee that is paid into a local authority hygiene and sanitation promotion fund.

It is also worthwhile investigating private sector funding opportunities, as these can be substantial. National and international companies (cell phone network operators, soap manufacturers, etc.) seeking to raise their profile may be willing to make funding available to support development projects. Another way in which the private sector can get involved in hygiene promotion is through public-private partnerships to promote handwashing with soap.

Is it possible to carry out awareness-raising and promotion activities with a small budget?

Although hygiene awareness-raising and sanitation promotion should be considered a highly strategic and necessary investment, it is still possible to carry out activities on a small budget. For instance, by:

- Making full use of existing focal points and organizations: local radio stations, neighborhood associations, water point management committees, influential community figures (priests, imams and traditional community leaders).

- Limiting the use of external service providers and designing the awareness-raising and communication aids and tools yourself (which will require a basic knowledge of the IT software commonly found on most computers).

STAGE 4

Implement the Strategy

Mobilize the key stakeholders

When implementing a hygiene awareness-raising and sanitation promotion strategy, it will be necessary to involve a number of key stakeholders from the water, sanitation and hygiene sectors, as well as from the health and education sectors. The roles and responsibilities of each party need to be clearly defined to facilitate cooperation between stakeholders, each of whom will specialize in different aspects of sanitation and hygiene. Hence, a distinction can be made between those stakeholders who should be responsible for supervising activities and those put in charge of implementing them.

Stakeholders responsible for supervising activities

Local authorities. Under the decentralization taking place in various countries, responsibility for water, hygiene and sanitation services often now lies with local authorities. Thus, their remit will usually include planning, organizing and monitoring awareness-raising and promotion activities, as well as coordinating the various stakeholders involved. In practice, however, their capacity for action is limited due to their lack of resources.

The devolved technical departments of the ministries of water, sanitation, hygiene, health and education are responsible for coordinating national strategies and policies at the regional and sub-regional levels. Their role notably involves ensuring the various local sanitation and hygiene strategies are compatible with each other.

Stakeholders responsible for implementing the strategy

Health officers are public servants that work for the devolved technical departments. They are assigned to local authorities or sometimes appointed to work within the local authority sanitation and hygiene departments (where these exist) as permanent technical staff. Health officers are responsible for delivering facilitation sessions and training and supervising facilitators and community focal points. They are also in charge of monitoring and evaluating awareness-raising and promotion activities.

Service providers (NGOs, consulting firms, etc.). Certain NGOs (and consulting firms) have drawn on their familiarity with the field and local inhabitants to develop specific social intermediation and community facilitation expertise. Some employ facilitators who have been trained on the most common awareness-raising and promotion methods (PHAST, CLTS) and are able to carry out local activities (group meetings, interpersonal

communication and home visits). These providers can either initiate an awareness-raising and promotion approach or be called upon to provide the services required to implement the strategy.

Other service providers can be recruited to provide specific services to help implement mass communication campaigns, develop materials to train stakeholders working in the field (focal points, local private sector) or deliver awareness-raising and promotion training to various target groups.

Community focal points are influential local groups or people chosen to help spread awareness-raising messages and act as the liaison between inhabitants and the project team. These focal points can be volunteers, religious and traditional authorities or teachers, etc. They can also be existing community organizations or organizations set up for purposes of the project (village WASH committees, for instance, which should ideally remain in place beyond the end of the project). However, care should be taken to ensure that this type of organization is relevant and representative of the community.

Small-scale private operators (masons, pit emptiers, public facilities' managers) are ideally placed to spread information and raise awareness. Masons and pit emptiers can help promote sanitation facilities and services and provide support and advice to households on using and properly cleaning latrines, etc. The managers of public toilet blocks also have a role to play raising users' awareness of good hygiene practices.

Use professionals

In order to successfully raise people's awareness of hygiene and promote sanitation, it will be necessary to call upon the expertise of professionals with experience of the hygiene and sanitation sectors, delivering vocational training to local stakeholders and social marketing, etc. Awareness-raising activities have traditionally been carried out by NGOs. However, as the sector has become more professional, new practitioners with the skills to perform these services have entered into this niche market.

An indicative list of the main types of service provider that can be used and their required skills is provided in the table opposite.

Table 13: Types of service provider that can be used and the skills required

	ROLES	REQUIRED SKILLS
NGOS	• Implementing awareness-raising and promotion activities; • Developing IEC materials; • Advocacy; • Activity monitoring.	• Expertise in using hygiene awareness-raising and sanitation promotion methods and tools; • Proven experience of using community facilitation techniques and participatory approaches; • Experience of hygiene and sanitation-related communications and advocacy.
CONSULTANTS	• Diagnostic; • Training; • Monitoring & Evaluation.	• Experience of conducting social and health assessments; • Expertise in using hygiene awareness-raising and sanitation promotion methods and tools; • Experience of delivering training; • Experience of evaluating IEC activities.
ARTISANS - MASONS	• Managing sanitation facility demonstration and sales points; • Client prospecting and promoting sanitation facilities.	• Expertise in using low-cost construction techniques (simple, VIP, pour-flush, dry pit latrines, etc.); • Familiarity with basic marketing and sales techniques.
COMMUNICATION AGENCIES	• Developing the communication strategy and plan; • Implementing mass communication campaigns.	• Expertise in using social marketing tools and techniques (market research, segmentation, creating demand, mass communication tools).

Monitor the activities

Due to their intangible nature, it may at first appear difficult to monitor and check that hygiene awareness-raising and sanitation promotion activities are being carried out correctly. However, all awareness-raising and promotion activities use tools and materials that can be used for this, such as household visit record sheets for house-to-house awareness-raising, the schedule for broadcasting spots on local radio stations, posters displayed in public areas and meeting minutes from village or neighborhood meetings, etc. Monitoring will therefore involve carrying out regular checks to ensure that these communication tools and materials are being used as intended. For large-scale and longer-term projects, external mid-term evaluations can often prove useful for updating and improving the messages being delivered and communication materials used.

STAGE 5

Evaluate and update the strategy

Evaluating the hygiene awareness-raising and sanitation promotion strategy is crucial as it enables you not only to assess the results obtained in terms of hygiene and sanitation practice and behavior change, but also to measure the effectiveness of the awareness-raising and promotion activities in relation to the budget invested.

Evaluate strategy implementation

Evaluation of the hygiene awareness-raising and sanitation promotion strategy can initially focus on assessing the way in which the strategy has been implemented. In particular, it is possible to use simple indicators to build an objective picture of project delivery. The number of days worked (on carrying out awareness-raising activities, for instance) can be used to determine whether the human resources allocated to tasks are in line with commonly used standards. Another useful indicator to consider is the cost per person, i.e. the overall cost of the activity divided by the number of people participating. However, it is to be noted that great care needs to be taken when interpreting these types of indicator (especially those related to the cost of activities), particularly when comparing them against similar activities. Whereas some implementation costs could include the overheads of an NGO based in the capital city or a northern country, for example, others may include only the costs of activities carried out in the field. It is therefore essential to check how each evaluation indicator has been calculated.

Evaluate the impacts

Evaluating the impacts of hygiene awareness-raising activities is difficult for a number of reasons:

• Household behavior change takes place within dense and complex environments: in addition to the messages conveyed through the awareness-raising campaign(s), there are also numerous other influencing factors (neighborhood, social and economic, etc.). As such, the methodological protocols required to isolate the impacts specifically generated by a given awareness-raising campaign are highly complex.

• Assessing household behavior change either involves the direct observation of households or requires household members to respond to a questionnaire. However, both of these methods involve entering the house, leading to interview bias: respondents often want to show themselves in a good light by displaying the correct behavior or giving the right answer during the evaluation (such as "yes, I use soap at home") without necessarily always practicing these behaviors every day.

• In addition, the assessment itself is often difficult: how do you assess handwashing

with soap? Open defecation? Using and cleaning latrines? The practice of hygienically handling and storing water? Although various methods exist, the reliability and ease of implementing these is still the subject of much debate among experts.

• Finally, sustainable behavior change means that these new behaviors continue to be practiced, not for six months or one to two years after the project, but for 10, 20 years and more. As such, any evaluation of behavior change needs to have modest aims.

Are we to conclude from this that an evaluation of behavior change is to be avoided? There is no clear answer to this, particularly as recent research has suggested that the external signs of behavior change can be used to confirm there has been an effective change in behaviors. For instance, the fact that a household has soap in their home can statistically prove that the members of the household effectively wash their hands with soap. This type of approach helps simplify the evaluation methodology and removes any survey bias.

At first glance, evaluating sanitation promotion activities is more straightforward as it is possible to count the number of latrines sold and households that have had latrines installed. However, in this particular instance, more detail on the beneficiary households will be required. Most access to sanitation programs (and their accompanying promotion campaigns) tend to focus on the most disadvantaged population groups, as these often have the least awareness of the health risks and little access to healthcare. Nevertheless, even if the number of latrines sold one to two years after the project corresponds to the initial objectives, it will still be necessary to check who has received these facilities. For projects that provide subsidies for sanitation facilities, in particular, the most disadvantaged population groups are very rarely the first to be informed about the project or the first to receive facilities.

More broadly, there is also an issue of timing. The evaluation will be most relevant and worthwhile if it is carried out, not immediately after the project, but after a substantial period of time has elapsed (a minimum of 1 to 3 years after the end of the project, depending on the project type). This enables the sustainability of both increases in access to sanitation and behavior change to be properly assessed (provided that, for behavior change, certain 'technical' difficulties have been resolved, such as those outlined above).

Box 6: Overview of UNICEF Mali's evaluation protocols

For handwashing with soap in schools:
- Are handwashing stations in working order? Do they all have soap and water available? During the visit, did you observe signs that these were being used?
- Observe schoolchildren during break times and count the number of children washing their hands with soap after leaving the latrines.

In CLTS villages:
- Check there is water and soap or ash in the latrines.
- Use triangulation to look for signs of open defecation.

In the latrines:
Through observation, check latrines are being used, cleaned and are in working order. Does the latrine have a properly closing door? Does it have a roof, walls and slab and are these acceptably clean? Are there any signs of urine and excreta on the slab? What does it smell like? Are kettles available for anal cleansing?

Overall, the evaluations conducted by UNICEF Mali do not test people's knowledge but instead focus on their actual practices. As such, they rely on direct observation rather than on households' self-reporting.

Update the strategy

As with improving access to water and sanitation (whether expanding access to keep up with population growth or improving the quality and level of service), hygiene awareness-raising and sanitation promotion forms part of a never-ending process that should not be confined to one-off activities. Also like water and sanitation, hygiene awareness-raising and sanitation promotion is a sector in its own right and, as such, a municipal strategy and specific action plans with medium and long term goals need to be put in place. In this regard, evaluation is a tool that enables you not only to assess the quality of an activity, but also to update the local hygiene awareness-raising and sanitation promotion strategy as it provides information that can be fed into the management tools of the municipality in charge of monitoring the sector.

Annexes

Annex 1
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Annex 2
Hygiene awareness-raising and sanitation promotion methods

Note: The methodologies presented below are for illustration purposes only and in no way provide an exhaustive list of the range of methods being used in the field.

PHAST (PARTICIPATORY HYGIENE AND SANITATION TRANSFORMATION)

DESCRIPTION	PHAST (Participatory Hygiene and Sanitation Transformation) is a participatory method that involves working with communities to identify their health and hygiene issues and helping them to plan projects to improve their situation. This method was initially designed for rural areas and small groups of people. However, it can also be used in urban and peri-urban areas within small neighborhoods that have strong community ties. The method is still implemented with small groups, but these will consist of representatives (religious heads, water supply service users' associations) chosen to deliver messages to the rest of the target population. The participatory activities are led by a facilitator using a PHAST toolkit, which is adapted to the cultural and social context of the target area. The role of the facilitator is central to the success of the approach as the quality of community mobilization to initiate behavior change is highly dependent upon the facilitators' ability to 'trigger awareness' rather than teach and lecture.
OBJECTIVES	• Improve hygiene practices; • Provide sanitation services and facilities.
TARGET AUDIENCE	• The entire community; • Households.
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	WHO, the World Bank, AFD, UNDP, UNICEF, WaterAid, ACF, the Red Cross, World Vision (indicative).

IMPLEMENTATION REQUIREMENTS	• Average number of participants per facilitation session: between 10 and 20 people. • Number of facilitators: 1 • Facilitation tools: PHAST tools (picture cards, community map).
AVERAGE IMPLEMENTATION PERIOD	**6 months** on average: • 4 days of facilitation (about 30 hours in total) spread over 1 or 2 weeks; • 3 to 4 months of monitoring and support to implement changes (construction, cleaning and maintenance of latrines and handwashing facilities); • Survey to monitor changes in practices at the end of the six months.
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Basic knowledge of diarrheal diseases, their transmission and prevention; • Familiarity with PHAST participatory tools and techniques; • Community facilitation skills: speaking and listening skills, patience and ability to adapt.
COST	**€2.5 to €3.5 per person attending awareness-raising sessions** (figures: the World Bank project in Kyrgyzstan and the Caritas project in Uganda).
POTENTIAL FOR SUSTAINABILITY	**Low.** PHAST is a time-intensive method that requires facilitators to pay frequent visits and undertake regular monitoring of the communities involved.
FURTHER INFORMATION	*PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease,* WHO

COMMUNITY HEALTH CLUB

DESCRIPTION	Health clubs are community organizations that provide information and raise awareness of good hygiene practices. This approach is unique in that membership of the 'Community Health Clubs' is voluntary and free: all community members are able to join the club and attend its regular meetings on household and community-related hygiene topics. As with the PHAST method, there is a facilitator who coordinates discussions. At the end of the meetings, participants are asked to come up with 'homework' activities to put the lessons learned during the session into practice at home. The clubs vary in size and can have from 30 to 200 members. The aim of these clubs is to effect collective change of WASH-related social norms. Initially developed for rural areas, Community Health Clubs are now also being used to improve health and hygiene conditions in challenging environments, such as informal urban settlements and refugee camps. The advantage of this approach is that the Community Health Clubs often remain in place beyond the end of the project.
OBJECTIVES	• Improve hygiene practices; • Provide sanitation services and facilities.
TARGET AUDIENCE	• The entire community; • Households.
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	The NGO AHEAD (*Applied Health Education and Development,* the Zimbabwean NGO that invented the approach), DFID, the World Bank, USAID, CARE.
IMPLEMENTATION REQUIREMENTS	• Average number of participants per facilitation session: the size of the clubs can vary, containing between 30 and 200 people; • Number of facilitators: usually one facilitator per club; • Facilitation tools: PHAST-type participatory tools.
AVERAGE IMPLEMENTATION PERIOD	**Between 6 and 18 months**, with a 1 to 2 hour meeting held once a week.
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Basic knowledge of diarrheal diseases, their transmission and prevention; • Familiarity with participatory tools and techniques; • Community facilitation skills: speaking and listening skills, patience and ability to adapt.
COST	**From €1.5 to €2.5 per person involved** (figures: AHEAD project, Zimbabwe).
POTENTIAL FOR SUSTAINABILITY	**High.** The clubs created can become fully-fledged community organizations post-project.
FURTHER INFORMATION	• *The 'Community Health Clubs' approach* developed by the NGO AHEAD • *ZimAHEAD project case study,* Zimbabwe

WASH IN SCHOOLS

DESCRIPTION	This method aims to encourage children to learn good hygiene practices in schools. It mainly focuses on primary school children – aged between 5 and 12 years old – as well as on the teachers, whose task is both to set an example by using good hygiene behaviors and to raise the schoolchildren's awareness. This method is usually combined with a school sanitation facilities' (latrines and water points) construction or improvement component so as to enable the children to apply the good hygiene practices they are being taught. The awareness-raising activities carried out with the children are fun exercises facilitated by the teachers, who have all received facilitation techniques and hygiene education training. Activities are conducted during school hours using learning materials such as posters, songs on hygiene and games, etc. In order to increase the sustainability of behavior change in schoolchildren, hygiene awareness-raising can also be incorporated into the school curriculum, as in Uganda, for example.
OBJECTIVES	• Improve the hygiene practices of schoolchildren and teaching staff.
TARGET AUDIENCE	• Schoolchildren between the ages of 5 and 12; • Teaching staff (headteacher and teachers).
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	UNICEF, WHO, IRC, USAID, WaterAid, the World Bank - WSP, GIZ
IMPLEMENTATION REQUIREMENTS	• Average number of participants per facilitation session: varies based on the number of schoolchildren in each class (between 50 and 80 on average in sub-Saharan countries); • Number of facilitators: one teacher/facilitator per class; • Facilitation tools: teaching materials for children (posters, songs, picture cards, games).
AVERAGE IMPLEMENTATION PERIOD	**Between 12 months and 3 years**
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Basic knowledge of diarrheal diseases, their transmission and prevention; • Familiarity with participatory tools and techniques; • Community facilitation skills: speaking and listening skills, patience.
COST	**€1.5 to €13 per schoolchild involved** (figures: UNICEF).
POTENTIAL FOR SUSTAINABILITY	**High.** Hygiene awareness-raising activities can be incorporated into the school syllabus and sustained through hygiene clubs of volunteer teachers and children.
FURTHER INFORMATION	• *Manuel sur l'hygiène et l'assainissement en milieu scolaire,* UNICEF • *Guide pratique pour la promotion de l'hygiène scolaire,* UNICEF Mali • *Case Studies*

CHILD-TO-CHILD APPROACH

DESCRIPTION	The 'Child-to-Child' approach is used in various projects, such as education or health promotion programs, for instance. When applied to the WASH sector, it aims to teach children about the risks associated with poor hygiene behaviors and empower them to promote good hygiene practices to their friends at school, younger children, their family and the wider community. Awareness-raising activities can be carried out not only in schools, but also in other places that children regularly use or visit, such as village playgrounds or healthcare centers. This notably ensures that those children who do not attend school are also included. The people responsible for facilitating child-to-child awareness-raising activities will vary according to the setting: in schools, activities will usually be facilitated by the teachers whereas, in other settings, this role is often taken on by community health workers.
OBJECTIVES	• Improve the hygiene practices of children and their families.
TARGET AUDIENCE	• School age children and pupils (between the ages of 5 and 12).
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	UNICEF, Plan International, Save the Children, WaterAid.
IMPLEMENTATION REQUIREMENTS	• Average number of participants per facilitation session: variable; • Number of facilitators: one facilitator per group of children; • Facilitation tools: teaching materials for children (posters, songs, picture cards, games).
AVERAGE IMPLEMENTATION PERIOD	**Between 12 months and 3 years**
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Basic knowledge of diarrheal diseases, their transmission and prevention; • Expertise in using learning techniques and tools; • Community facilitation skills: speaking and listening skills, patience and ability to adapt.
COST	Insufficient data.
POTENTIAL FOR SUSTAINABILITY	**Variable.** Depends on the institutional set-up/project initiator.
FURTHER INFORMATION	• *Child to Child website*

CLTS (COMMUNITY-LED TOTAL SANITATION)

DESCRIPTION	CLTS is a method that focuses on access to sanitation. Its aim is to eradicate open defecation by encouraging the construction and use of household latrines. CLTS involves making communities aware of their defecation practices and triggering a sense of disgust and shame that prompts community members to change their behaviors and install sanitation facilities. CLTS is less intrusive than traditional participatory methods. The role of the facilitator is to initiate discussions among members of the community on sanitation issues and ways to address them; the decision whether or not to construct latrines ultimately rests with the community. In addition, households usually have to cover the cost of the latrines themselves and receive no external subsidies. CLTS was initially designed for rural areas, in regions where open defecation is common and creates serious health problems. Although the method has subsequently been piloted in urban and peri-urban neighborhoods, CLTS remains best-suited to socially and culturally homogeneous small rural communities. As a general rule, just one day is required to trigger awareness and commitment from communities. However, it is often necessary to follow-up with these communities over the medium and long-term to check that their behavior change is being sustained.
OBJECTIVES	• Provide sanitation facilities; • Improve hygiene practices.
TARGET AUDIENCE	• The entire community; • Households.
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	WaterAid, AFD, UNICEF, Plan International, the Red Cross, the World Bank - WSP, DFID, the Gates Foundation.
IMPLEMENTATION REQUIREMENTS	• Average number of participants per facilitation session: variable; • Number of facilitators: there are usually 4 to 5 people in each 'triggering group' in charge of facilitating and supervising CLTS activities; • Facilitation tools: community mapping, transect walk through OD areas, evaluating health costs, demonstrating oral-fecal methods of contamination.
AVERAGE IMPLEMENTATION PERIOD	**Between 3 weeks and 6 months.**
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Basic knowledge of diarrheal diseases, their transmission and prevention; • Community facilitation skills: speaking and listening skills, patience and ability to adapt.
COST	**€1.5 to €12 per person involved** (an average of €2.5 in West Africa. Figures: USAID and UNICEF) Average cost per village, CLTS program in the region of Koulikoro (Mali, 2011): • Triggering: €3.8 per person and per day; • Follow-up: €4.30 per person and per day; • ODF certification: €3 per person and per day.
POTENTIAL FOR SUSTAINABILITY	**High.** CLTS aims to trigger a community-based virtuous circle that promotes hygiene and the use of sanitation facilities.
FURTHER INFORMATION	*Handbook on Community-Led Total Sanitation,* IDS-Plan International

PROMOTING HANDWASHING WITH SOAP

DESCRIPTION	This approach aims to encourage handwashing with soap. It uses communication methods taken from mass marketing (radio and television spots, billboards). Promotion campaigns focus on a single message – the importance of handwashing with soap – and draw on people's subjective reasons for wanting to adopt a new hygiene behavior (social status, being a good parent, etc.). Handwashing programs can be implemented under public-private partnership arrangements with soap manufacturers. In this instance, programs have both a health and hygiene goal and a commercial end: that of selling soap. Communication campaigns led by public-private partnerships are usually rolled out nationwide or across several regions and can last anywhere from between 6 months to two years.
OBJECTIVES	• Improve handwashing practices.
TARGET AUDIENCE	• The entire community.
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	The World Bank, AFD, the Gates Foundation, USAID, UNICEF, GIZ.
IMPLEMENTATION REQUIREMENTS	Methods and tools used: • Mass communication: television and radio spots; educational sketches in schools and markets; discussions (in small groups) in healthcare center waiting rooms; billboards; community events (handwashing days and contests); promotional materials; print media; SMS. • Interpersonal communication: house-to-house.
AVERAGE IMPLEMENTATION PERIOD	**Between 6 months and 3 years.**
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Social marketing tools and techniques (market research, segmentation, creating demand, developing mass communication campaigns).
COST	**Costs vary according to the communication tools and methods used.** Mass communication methods can reach a large audience at a lower cost per person than interpersonal communication tools (which require considerable time and human resources and reach a smaller audience: a household, village or neighborhood meeting, etc.). • Saniya Program (Burkina Faso): €0.30 per person over a period of 3 years. • National handwashing promotion campaign, Kenya (WSP, 2008): €170,000 over a period of 3 years.
POTENTIAL FOR SUSTAINABILITY	**Variable.** Depends on the institutional set-up/project initiator.
FURTHER INFORMATION	*The Handwashing Handbook: A Guide for Developing a Hygiene Promotion Program to Increase Handwashing with Soap,* the World Bank

SANITATION MARKETING

DESCRIPTION	Sanitation marketing involves using communication methods borrowed from commercial marketing with the aim of improving households' access to sanitation. This approach operates on two levels: (i) on supply by developing local private sector capacities (masons, pit emptiers) to provide good quality, low-cost sanitation facilities and services; (ii) on demand by encouraging households to invest in these sanitation facilities and services. This is a market-driven approach with the 'products' (latrines, pit emptying services, etc.) being promoted through various channels (radio messages, posters, demonstration areas, etc.). Households are no longer beneficiaries but potential clients who need to be given information on these products and persuaded to purchase facilities. Under this approach, households' needs, preferences and the amount they are willing to invest all need to be identified upfront, as do the motivating factors that will encourage them to install household latrines. Urban areas are particularly suited to marketing-based approaches as, in towns and cities, there is often both demand and ability to pay, along with a private sector able to meet this demand. The latrine production and sales points that are set up to meet the ongoing demand for sanitation facilities should ensure that the market created through the sanitation marketing approach remains sustainable and in place far beyond the end of the project.
OBJECTIVES	• Provide sanitation services and facilities.
TARGET AUDIENCE	• Households.
ORGANIZATIONS THAT FUND AND IMPLEMENT THE METHOD	AFD, the World Bank – WSP, USAID, WaterAid, UNICEF.
IMPLEMENTATION REQUIREMENTS	• Mass communication tools: television and radio spots; discussions; posters and billboards; brochures; fliers. • Interpersonal communication tools: latrine demonstration and sales points; home visits.
AVERAGE IMPLEMENTATION PERIOD	**Between 6 and 12 months.**
EXPERTISE REQUIRED FOR IMPLEMENTATION	• Low-cost construction techniques; • Social marketing tools and techniques (market research, segmentation, creating demand, mass communication tools).
COST	**Between €0.3 and €2.5 per person** (WSP figures). This cost does not include any subsidies provided to households to purchase a sanitation facility. • Cost of market research and a communication campaign: between €65,000 and €250,000. • Cost of a focus group discussion session in Ghana: between €400 and €800 (source: USAID, 2010).
POTENTIAL FOR SUSTAINABILITY	**High.** A marketing initiative can be sustained beyond the end of the project through latrine construction and sales points.
FURTHER INFORMATION	• *Introductory Guide to Sanitation Marketing,* WSP • *Sanitation Marketing Toolkit,* WSP • *Case Study: Social Marketing of Latrines and Promotion of the Private Sector,* Benin

Annex 3
Summary comparison of the seven methods

	OBJECTIVE		TARGET SETTING		
	Improve hygiene practices	Increase access to water supply and sanitation facilities	Households	Schools	Public Places
PHAST	•••	•••	•••	•••	
COMMUNITY HEALTH CLUBS	•••	•••	•••	•••	
WASH IN SCHOOLS	•••			•••	
CHILD-TO-CHILD APPROACH	•••		•••	•••	
CLTS		•••	•••	•	•••
PROMOTING HANDWASHING WITH SOAP	•••		•••	•••	•••
SANITATION MARKETING		•••	•••		•••

CONTEXT			SOCIAL CONTEXT		RESOURCES USED	
Urban	Rural	Small Towns	Social Homogeneity	Social Heterogeneity	Financial	Human
•	•••	•	•••	•••	€€€	€€€
•	•••	•••	•••	•	€	€
•••	•••	•••			€	€€€
•••	•••	•••			€	€€€
•	•••	•	•••	•	€€	€€
•••	•••			•••	€	
•••	•			•••	€€	

••• Conditions under which the method is considered effective
• The method can be adapted to the context but there is little available evidence of its effectiveness
€€€ Requires extensive resources (relatively high-cost)
€ Requires modest resources (relatively low-cost)

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TOOLS & METHODS

Designing and implementing **a hygiene awareness-raising and sanitation promotion strategy**

Guidelines for action

Over the last few years, the sanitation sector has developed and improved two fundamental and complementary approaches: hygiene awareness-raising to improve people's hygiene behaviors and sanitation promotion to encourage households to install sanitation facilities, particularly toilets, showers and sinks, in their homes.

This document is intended for all sector stakeholders interested in learning more about these approaches.
It provides an overview of the most commonly used hygiene awareness-raising and sanitation promotion methods and tools, as well as a rational and methodical approach to implementing these.

For more information, please visit: www.pseau.org/fr/iec

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