

**WATER AND SANITATION EXTENSION PROGRAMME (WASEP)
The Aga Khan Planning and Building Service for Pakistan (AKPBS)**

TRAINING WORKSHOP ON HEALTH AND HYGIENE EDUCATION

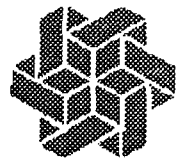
**MONDAY, 23 MAY TO 27 MAY 2000
GILGIT**

BY

Haider Raza and Dr. Tameez Ahmad



WASEP



**TRAINING WORKSHOP ON HEALTH AND HYGIENE EDUCATION
TUESDAY 23 MAY-FRIDAY 27 MAY 2000
SEREENA HOTEL, GILGIT, PAKISTAN**

LIST OF PARTICIPANTS

INSTITUTIONS	NAME	REGION
AKCSP	Jamila	Hunza
	Majeeda	-do-
	Nahida	-do-
	Malika	-do-
	Hoorul Ain	-do-
	Gul Zadi	-do-
AKESP	Gulnar	Gupis
	Sahib Jehan	Singul
	Farkhanda	Oshikhandaas
	Mehar Parveen	Hunza
	Fida Bibi	Gilgit city
AKHSP	Khushnuma	Hunza/Nagar
	Tai Qayum	Gilgit
	Nargis Nayab	Yasin/Gupis
	Shakira	Punyal/Ishkoman
LB&RD (Govt.)	Bibi Madina	Gilgit
	Malika Mehar	Nomal
	Nisema	Gilgit
	Sahida Begum	Gilgit
	Shaher Gul	Gilgit
WASEP (AKPBS)	Suraiya	WASEP
	Yasmin Baig	-do-
	Yasmin Ansa	-do-
	Maryum	-do-
	Nahida Khan	-do-
	Himat Zareen	-do-
	Dur Pari	-do-
Aqleem	-do-	
PDCN (AKU)	Safida	Gilgit

COMMUNITY

Village Name	Name	Region
Barkulti	Nahida	Yasin
Goranmar	Qimat Zareen	Punyal
Goranmar	Gul Aorse	Punyal
Gulakhmoli	Naroze Bibi	Gupis
Hoppy	Tahera	Bagrote
Hamardaas	Janat Gul	Gupis
Hasis Bala	Shamim	Punyal
Kalti	Gul Jehan	Gupis
Shishkat	Shahida	Gojal
Sassi	Tahoor	Haramosh
Thingdaas	Junan	Punyal

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

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Executive summary

WASEP has been running its health and hygiene education component since 1998 as an integral part of its other interventions. The health and hygiene section of WASEP is unique in its strategies as compared to the other institutions working in this sector, because of adopting modern strategies and methodologies on health and hygiene education and assessing impact both at household and village levels through well developed monitoring and evaluation systems supported by computerized management and information system of the WASEP. One of the major achievements, which also attracted other sectors involved in the water and sanitation projects, was the CHIP and SHIP programme initiated in July, 1998 and September, 1999 respectively. The SHIP was developed with the collaboration of IED Karachi. Looking at the visible impact that CHIP and SHIP interventions produced in the partner villages, other Govt and NGOs sectors showed great interest in this programme and requested to arrange a training programme for their field workers so that they can also start similar activities in their respective villages. The workshop was co-financed by IRC, International Water and Sanitation Centre, The Netherlands, and Local Bodies and Rural Development (LB&RD).

Keeping in view the interest of other organizations in this component, WASEP decided to arrange a training workshop. The overall aim of this training workshop was to enhance the existing knowledge/skills of the participants on health and hygiene promotions. About 40 participants (5 from AKES, 4 from AKHSP, 6 from AKCSP, 5 from LB&RD, 1 from PDCN, 8 from WASEP and 11 WSIs from WASEP's partner villages) with different professional background of the mentioned institutions attended this workshop. Although it was a difficult task for WASEP to design a curriculum that could be digestible for each participant, however it is worth mentioning that training section of the WASEP managed to make this workshop successful.

This four days workshop includes 9 sessions and a day field visits to two villages one with and one without WASEP interventions. In three days in house training sessions the main topics covered were include Necessity of health and hygiene, Water and sanitation related diseases, its transmission routes and remedial measures, Communication, CHIP and SHIP activities and strategies of WASEP.

The final evaluation and feedback from the participants was quite encouraging. 81 percent of the participants found the training content and material interesting and useful. 61 percent of the participants indicated the training standard as excellent. 81 percent of the participants indicated that the course was very much relevant to their expectations and their institutions future plans. It is worth mentioning that 38 percent of the participants urged on holding this type of workshops twice a year to update their skills and knowledge.

However, WASEP feels that real usefulness of the training in term of applications will whole solely depend upon the strategies, support and interest of the relevant organizations on how to involve the currently trained staff in the process of hygiene education programme to achieve significant impacts similar to WASEP.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

OBJECTIVES OF THE WORKSHOP

Overall Objective: To enhance the existing knowledge/skills of the participants on health and hygiene education

Specific Objectives:

- To provide relevant background to the participants on the importance of health and hygiene and water and sanitation related diseases, mode of transmission, prevention and control.
- To provide theoretical background on how to influence traditional beliefs and behaviors to pave the way for adoption of healthier behaviors.
- To enhance the communication skills of the participants
- To familiarize the participants with the Community Health Intervention programme (CHIP) and School Health Intervention Programme (SHIP) of WASEP so as to help them plan and carry out similar activities in their respective areas to improve health and hygiene status of the target population.
- To exchange and sharing of knowledge/experiences on health and hygiene.
- To reinforce the level of existing collaboration among all stake holders working area in order to develop synergy and to establish holistic approach towards health and hygiene interventions.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session A

Subject title : Introduction/welcome

Type of session : Participatory

Objectives **Welcome to the participants; placing the workshop in context, some WASEP staff were introduced, the participants introduced themselves and indicate the fear and expectations regarding the workshop.**

The first session of the workshop was started with the recitation of Holy Verses by Munawar Abbas. Dr. Karim Aliboy welcomed all the participants and invited them for their brief introduction. He requested to the assistant director of Local Bodies and Rural Development (LB&RD) , Mr Kazmi to express his views on this unique integrated workshop on health and hygiene. He thanked WASEP for organizing this workshop and said that this could be a solid ground for different institutions attending the workshop towards real collaboration. He ensured that in future his department will be happy to be a partner in the activities like this. He expressed that his departments participants will learn more and specific knowledge on health and hygiene. After introductory and welcome session Dr. Karim over the session to Dr. Tameez and Haider Raza, to conduct the training sessions as planned. He also introduced Dr. Tameez and Haider to the participants and thanked for conducting and arranging the workshop. Tameez Ahmad explained the workshop's contents and time frame to the participants.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session B

Subject title : Common Terminologies

Type of session : Lecture/Discussions

Objectives **Introducing common terminologies related to health and hygiene education to the participants in order to enhance their level of understanding the forthcoming sessions.**

Haider Raza led this session and introduced different terminologies selected for the target group (participants). At the end of his lecture he distributed the handouts to all participants of the same.

Hand outs : Common terminologies

COMMON TERMINOLOGIES

Attitude:

The feeling and/or point of view which a person or group has relating to people, events, opinions.

Behaviour:

The way people act in general, especially in relation to the situation they are in or the people they are with.

Average:

The sum of a group of measurements divided by the total number of measurements

Bacteria:

One-celled micro-organisms, some of which are harmless and some of which cause disease

Base-line information:

Information which provides a basis for planning programme development and evaluation progress.

Community:

Territorial settlements, such as a village or neighbourhood.

Contamination and pollution:

The presence of chemical or infectious impurities such as bacteria that may be harmful to health;

Pollution; process of making water, air, people, etc., dirty, impure, or dangerous

Hygiene:

The practice of keeping oneself and one's surroundings clean, especially in order to prevent illness or the spread of diseases.

Hygiene education:

The creation of learning experiences to facilitate the sustained adoption of behaviours which help to prevent water and sanitation-related diseases.

Indicator:

Something that act as a sign, and that provides information about what you want to know. For example water and soap near the latrine may be an indicator(sign) for hand washing after defecation.

KAP survey:

A survey which measures Knowledge, Attitude and Practices in an individual or group in relation to a specific purpose.

Morbidity:

Rate of sickness in the community.

Mortality:

Death rate in the community.

Pathogens:

A disease-causing micro-organism

Prevalence:

Number of person sick with specified disease at a particular moment in time, usually expressed in cases/100,000 (By comparison, incidence measures new cases)

Health:

According to the constitution of WHO and a revision of its definition, Health is a state of complete physical, mental and social well being and ability to function, not merely absence of disease or infirmity.

Disease:

Disease is a defined as a condition in which body health is impaired (damaged or weaken)

Environment

All the circumstances, people, things and events around them that influence their life; the particular surroundings in which they live.

Faecal-oral cycle

The process by which faecal material gets into the mouth.

Impact

The effect of a certain action.

Incidence

Number of new cases of a specified disease during a defined period of time, usually expressed in cases/100,000.

Observation

Action or process of carefully watching someone or something, especially in order to learn or understand something about them.

Participatory Approach

A systematic learning process in which participation is sought in initial decision-making, planning, implementation, summary and analysis, and in the use of results.

Percentage (%)

The number of people with a particular characteristic in a group, divided by the total number in the group and multiplied by 100.

Qualitative Data

Data not measurable in numerical terms.

Quantitative Data

Data measurable in numerical terms.

Study

The process of systematic learning about a particular subject.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session C

Subject title : Why health and Hygiene

Type of session : Lecture/Participatory discussion

Objectives To show the participants that without adopting healthier behaviors significant reduction in water and sanitation related diseases is not possible.

Dr. Tameez Ahmad conducted this session. He explained the participants the importance of behaviors and its relation to changing the existing health situation of the target area. He also stressed on the need of knowing the cultural believes and barriers that may influence on adaptation of intended healthier behavior.

Hand out : Why health and hygiene

IMPORTANCE OF HEALTH AND HYGIENE EDUCATION

1. **80 % DISEASES IN DEVELOPING COUNTRIES ARE WATER AND SANITATION RELATED (WHO)**
2. **50 % OF MORTALITY RATE DUE TO W&S Ds. (AKHS)**
3. **IN PAKISTAN DIARRHOEA ALONE KILLS 26 CHILDREN/HOUR**
4. **BASIC INDICATORS OF DEVELOPMENT FOR DIFFERENT COUNTRIES (Please see Tables)**
5. **PREVENTION IS BETTER THAN CURE**
6. **REDUCTION IN WATER AND SANITATION RELATED DISEASES IS DIRECTLY LINKED WITH HYGIENE BEHAVIOURS**
7. **IMPROVEMENT IN QUALITY OF LIFE**
 - **Improving public health and personal well-being**
 - **Reducing costs of curative health services**
 - **Higher productivity of school children and working people because less energy is lost from poor health and illness.**
 - **Less burden of water collection, reducing the overall workload, especially of women and children.**
 - **Time and energy gains used for better family care, schooling and productive activities.**
 - **A clean environment through the safe disposal of human and animal wastes, and solid waste.**
 - **Suitable locations and facilities for bathing and clothes washing.**
 - **A private and safe convenient place to relieve oneself.**
 - **Increased social status and self-esteem through an improved living environment.**
8. **HYGIENE EDUCATION IS MUST FOR BEHAVIOURAL CHANGE**

Vital Statistics on Importance of Hygiene

Typhoid

- In Philadelphia typhoid cases reduced from 685 per 100,000 in 1905 to 80/100,000 in 1906 when slow sand filter were placed in service and to 10/100,000 in 1935 when disinfection with chlorine was introduced.
- Typhoid is slowly disappearing from the U.S. because of the prevalence of preventive measures; the number of cases dropped from 5,595 in 1942 to about 500 in 1979.

Malaria

- Since 1950 malaria has been eliminated from almost all of Europe and from large areas in Central and South America. It remains a major problem in parts of Africa and in southeastern Asia. About 100 million cases of human malaria develop each year; about 1 percent cases are fatal.

Smallpox

Millions of death before vaccination but now almost eliminated.

Cholera

- The importance of drinking water as vehicle for the spread of cholera was first shown by Snow, a British physician, in 1853-54 even without any knowledge of the bacterial causation of the diseases. The results of Snow's survey revealed that there were 315 deaths per 10,000 houses supplied the Southwark and Vauxhall Company and only 37 deaths per 10,000 houses supplied by Lambeth Company.
- As a results of cholera outbreak in Northern Areas in 1999 47,000 cases and 113 deaths were reported in different hospitals. The actual figure (both reported and unreported) could be many times higher.

ORS

20 % of world pop. Use ORS which saved 600,000 children/year.

Growth Rate In Pakistan

One child is born every 10 seconds in Pakistan. One born child dies every 40 seconds (WHO Report). The report also say the government planned to reduce the annual population growth rate from 2.4 per cent to 2 per cent during the next five years. The sources claim that the population growth rate had reduced to 2.4 per cent from 3.1 per cent annually during the last few years.

Death due to Waterborne Diseases in Pakistan

Waterborne diseases are responsible for 60% of the total number of child mortality cases in Pakistan (Editorial, Daily Dawn, November 19, 1999).

جدول نمبر ۱: عالمی ممالک کے ترقی کا تقابلی جائزہ

نمبر شمار	ملک کا نام	۵ سال سے کم عمر چوں کی سالانہ اموات فی ہزار		زچگی کے دوران ماؤں شرح اموات فی لاکھ	شرح خواندگی (فیصد)	سالانہ فی کس آمدنی (ڈالر)
		1995	1960			
1	سوئڈن	5	20	7	100	23530
2	سینگاپور	6	40	10	91	22500
3	جاپان	6	40	18	100	34630
4	برطانیہ	7	27	9	100	18340
5	فرانس	9	34	15	100	23420
6	امریکہ	10	30	12	100	25880
7	ملائیشیا	13	105	80	84	3480
8	کویت	14	128	29	79	19420
9	سرینان	19	130	140	90	640
10	عمان	25	300	190	90	5140
11	مصر	51	258	170	100	720
12	انڈیا	115	236	570	52	320
13	بھارت	115	247	850	38	220
14	پاکستان	137	221	340	38	430
15	مالی	210	400	1200	31	250
16	سومالیہ	211	294	1600	24	120
17	افغانستان	257	360	1700	32	280
18	موزمبیق	275	331	1500	40	90
19	انگولا	292	345	1500	42	—
20	نائیجر	320	320	1200	14	230

جدول نمبر ۲: عالمی ممالک کے شرح پیدائش، اموات اور اوسط عمر کا تقابلی جائزہ

اوسط عمر (سالوں میں)		سالانہ شرح اموات (فی ہزار)	سالانہ شرح پیدائش (فی ہزار)	لہادی میں اضافے کا سالانہ شرح (فیصد)		ملک کا نام	سیریل نمبر
1995	1960	1995	1995	1980-95	1965-80		
79	74	11	14	0.4	0.5	سوئڈن	1
75	65	6	15	1.1	1.7	سنگاپور	2
80	68	8	10	0.5	1.1	جاپان	3
77	71	11	13	0.2	0.2	برطانیہ	4
77	71	10	13	0.5	0.7	فرانس	5
76	70	9	15	1.0	1.1	امریکہ	6
71	54	5	27	2.5	2.5	ملائیشیا	7
75	60	2	26	0.8	7.1	کویت	8
73	63	6	20	1.4	1.9	سری لنکا	9
70	40	5	43	4.5	3.7	عمان	10
65	46	8	28	2.4	2.2	مصر	11
62	44	9	28	2.0	2.2	اٹلیا	12
57	40	11	35	2.1	2.8	بنگلہ دیش	13
63	44	9	39	3.3	2.7	پاکستان	14
47	35	13	49	3.0	2.2	مالی	15
48	36	18	50	2.1	3.1	صومالیہ	16
34	45	21	52	1.5	1.9	افغانستان	17
47	38	18	44	1.9	2.5	موزمبیق	18
48	33	18	50	3.1	2.0	انگولا	19
48	36	18	52	3.3	2.8	نائیجر	20

Table 1: Prevention of transmission of water and sanitation-related diseases

<i>Disease</i>	<i>safe drinking water</i>	<i>safe excreta disposal</i>	<i>personal and domestic hygiene*</i>	<i>food hygiene</i>	<i>wastewater disposal/drainage</i>
Diarrhoeas	●●	●●●	●●●	●●●	-
Poliomyelitis and hepatitis A	●	●●	●●●	●●	-
Worm infections:					
ascaris, trichuris	●	●●●	●●●	●●	●
hookworm	-	●●●	●	-	-
pinworm, dwarf tapeworm	-	●●	●●●	●	-
other tapeworms	-	●●●	●	●●●	-
schistosomiasis	-	●●●	●●●	-	●
guinea worm	●●●	-	-	-	-
Skin infections	-	-	●●●	-	-
Eye infections	-	●	●●●	-	●
Insect-transmitted diseases:					
malaria	-	-	-	-	●
urban yellow fever, dengue	-	-	●**	-	●●
bancroftian filariasis	-	●●●	-	-	●●●

Based on: WHO (1983), Esrey et al (1990) and Cairncross and Ouano (1991).

Importance of preventing disease transmission: ●●● high ●● medium ● low to negligible

* Personal and domestic hygiene often require use of more water.

** Vectors breed in water storage containers.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session D

Subject title : Introduction to water and sanitation related diseases

Type of session : Lecture/ Participatory discussions

Objectives To define the different categories of diseases and their root causes, to elaborate the water and sanitation related diseases and their potential origin, to define different life cycles of common parasitic infections in northern Pakistan, to high light the common diseased endemic in northern Pakistan, Prevention and control measures of these diseases

Haider Raza conducted this session. He showed the participants different categories of occupational agents or factors that may cause disease and ill health. On next slide he elaborated the need of safe water and as well as the WHO recommendations for safe drinking water both on bacteriological and chemical side. He also explained the environmental classification of water and sanitation related infections developed by WHO and World Bank. On next few slides he simply explained life cycles of different parasitic infections common in northern Pakistan. He also showed the results of a case study on water sanitation related infections and its relationship with infantile diarrhoea.

Handouts:

- Categories of occupational agents or factors that may cause disease and ill health.
- Safe water
- Environmental classification of water related infections
- Classification of excreta related infections
- Life cycles of round worm/hookworm
- Common diseases in northern Pakistan
- Case study results

CATEGORIES OF OCCUPATIONAL AGENTS OR FACTORS THAT MAY CAUSE DISEASE AND ILL HEALTH

CATEGORY	Examples of types of agents or factors
PHYSICAL	Radiations High and low atmospheric pressures High and low temperatures Noise, Vibration
CHEMICAL	Drugs Dyes Explosive Fertilizer Fibrogenic mineral dust Paints Pesticides Plastics Solvents Wood plant and organic dusts Many others
BIOLOGICAL	Viral diseases: rabies Hepatitis A and B & many others Bacterial diseases: Anthrax Brucellosis Leptospirosis Tetnus Tuberculosis Fungal diseases Dermatophytoses Histoplasmosis Parasitic diseases: Ancylostomiasis Schistomiasis & Many others
PSYCHOSOCIAL	Work organization Leadership style Communication Worker participation and fulfillment Security Type of work Repetitive Overloaded Underloaded Shift work

What do we mean by a safe and potable drinking water ?

- 1. Free from disease causing organisms (pathogens)**

WHO Guidelines:

**zero E.coli/100 ml of water sample
less than 10/100 ml for developing countries**

- 2. Low in concentration of chemicals that are acutely toxic or have serious long-term effects,**

**Arsenic
Cyanide
Lead
Cadmium
Mercury etc.**

- 3. Clear (non-turbid/non-colored)
Turbidity less than 5 NTU**

- 4. Not saline (salty)**

- 5. Free of compounds that cause an offensive taste or odor (smell)**

- 6. Non-corrosive, non alkaline**

Table 1.2 Environmental classification of water-related infections

Category	Infection	Pathogenic agent
1. Faecal-oral (water-borne or water-washed)	Diarrhoeas and dysenteries	
	Amoebic dysentery	P
	Balantidiasis	P
	<i>Campylobacter</i> enteritis	B
	Cholera	B
	Cryptosporidiosis	P
	<i>E. coli</i> diarrhoea	B
	Giardiasis	P
	Rotavirus diarrhoea	V
	Salmonellosis	B
	Shigellosis (bacillary dysentery)	B
	Yersiniosis	B
	Enteric fevers	
	Typhoid	B
	Paratyphoid	B
	Poliomyelitis	V
	Hepatitis A	V
Leptospirosis	S	
2. Water-washed: (a) skin and eye infections (b) other	Infectious skin diseases	M
	Infectious eye diseases	M
	Louse-borne typhus	R
	Louse-borne relapsing fever	S
3. Water-based: (a) penetrating skin (b) ingested	Schistosomiasis	H
	Guinea worm	H
	Clonorchiasis	H
	Diphyllobothriasis	H
	Fasciolopsiasis	H
	Paragonimiasis	H
	Others	H
4. Water-related insect vector (a) biting near water (b) breeding in water	Sleeping sickness	P
	Filariasis	H
	Malaria	P
	River blindness	H
	Mosquito-borne viruses	
	Yellow fever	V
	Dengue	V
	Others	V

B = Bacterium

R = Rickettsia

H = Helminth

S = Spirochaete

P = Protozoan

V = Virus

M = Miscellaneous

See Appendix C for further details.

1: Classification of Excreta-related Diseases

Category	Disease	Type of pathogen	Dominant transmission routes	Major control measures
I Faeeco-oral (non-bacterial)	Polio-myelitis	V	Person-to-person contact Domestic contamination	Provision of toilets Domestic water supply Improved housing Health education
	Hepatitis A	V		
	Rotavirus diarrhoea	V		
	Amoebic dysentery	P		
	Giardiasis	P		
	Balantidiasis	P		
	Enterobiasis	H		
II Faeeco-oral (bacterial)	Diarrhoeas and dysenteries:		Person-to-person contact Domestic contamination Water contamination Crop contamination	Provision of toilets Domestic water supply Improved housing Excreta treatment prior to land application Health education
	<i>Campylobacter</i> enteritis	B		
	Cholera	B		
	<i>E. coli</i> diarrhoea	B		
	Salmonellosis	B		
	Shigellosis	B		
	Yersiniosis	B		
	Enteric fevers:			
	Typhoid	B		
	Paratyphoid	B		
III Soil-transmitted helminths	Ascariasis (roundworm)	H	Yard contamination Ground contamination in communal defecation area Crop contamination	Provision of toilets with clean floors Excreta treatment prior to land application
	Trichuriasis	H		
	Hookworm	H		
	Stongyloidiasis	H		
IV Beef and pork tapeworms	Taeniasis	H	Yard contamination Field contamination Fodder contamination	Provision of toilets Excreta treatment prior to land application Cooking and meat inspection
V Water-based helminths	Schistosomiasis	H	Water contamination	Provision of toilets Excreta treatment prior to discharge Control of animals harbouring infection Cooking
	Clonorchiasis	H		
	Diphyllobothriasis	H		
	Fasciolopsiasis	H		
	Paragonimiasis	H		
VI Excreta-related	Filariasis (transmitted by <i>Culex</i> <i>quinquefasciatus</i> mosquitoes)	H	Insects breed in various faecally contaminated sites	Identification and elimination of potential breeding sites Use of mosquito netting
	Infections in Categories I-V especially I and II, which may be transmitted by flies and cockroaches	M		

B = Bacterium; H = Helminth; V = Virus; P = Protozoan; M = Miscellaneous

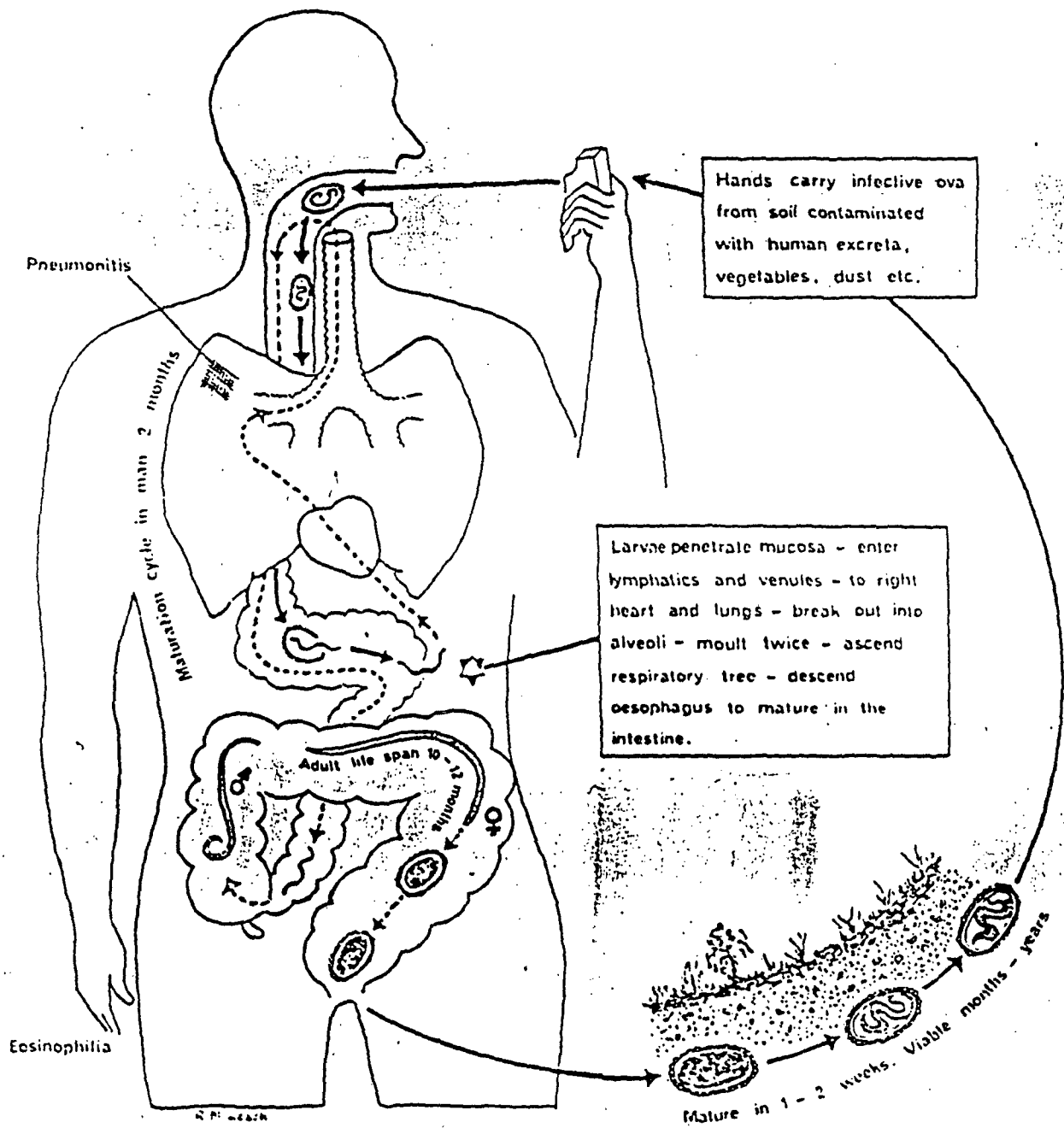


Figure D1 The life cycle of *Ascaris lumbricoides* (the round worm). *Trichuris trichiura* (whipworm) has a similar life cycle

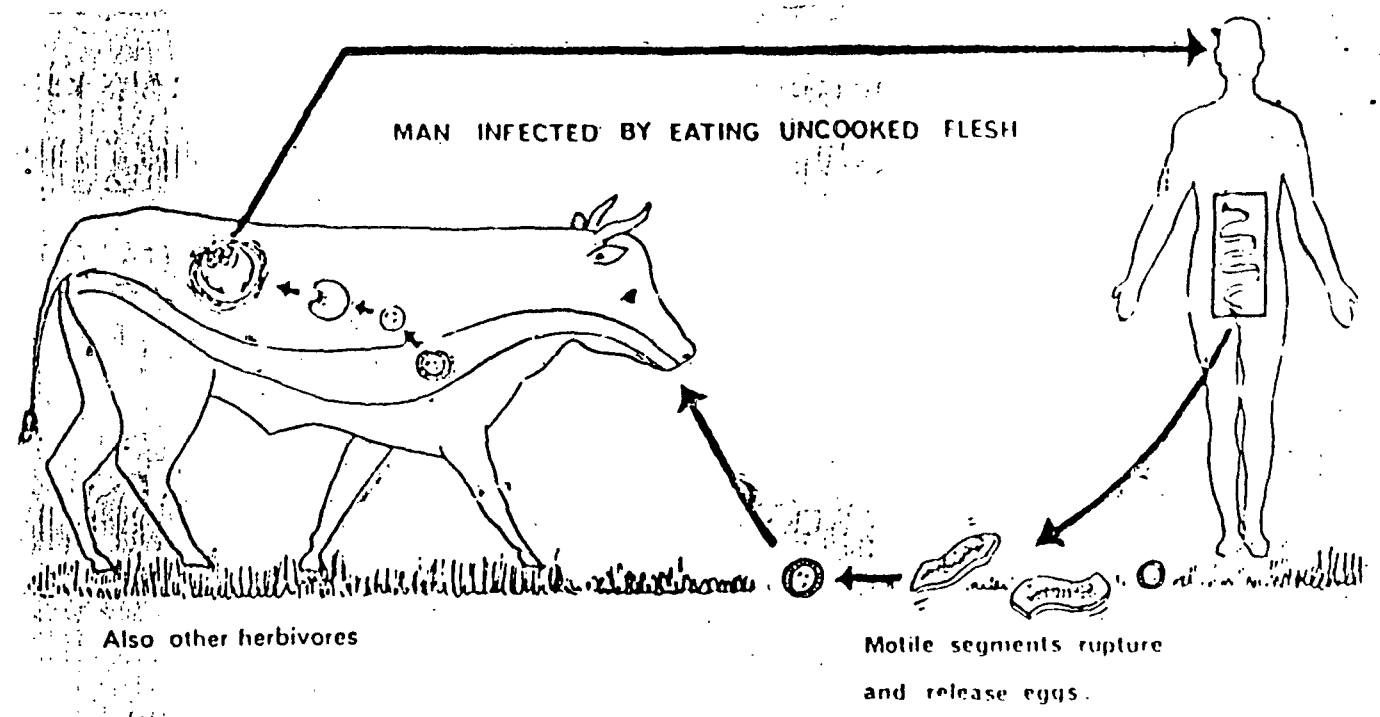


Figure D4. The life cycle of *Taenia saginata* (the beef tapeworm)
Source: From Jeffrey and Leach (1975). Reproduced by permission of Churchill Livingstone

**WATER AND SANITATION DISEASES COMMON IN NORTHERN
PAKISTAN**

Diseases	Pathogens	Transmission Routes	Control Measures
Diarrhoea and dysentery	E.coli V.cholera Bactria Amoeba Crypto Gardia	Water Faeco-oral	Safe disposal of excreta personal hygiene Protecting food and water from flies and animales Use of treated water especially that given to babies
Wormis	Round wormes Tape wormes Thread wormes Hook wormes whip wormes	Faeco-oral	As above Avoiding the use of untreated faeces as fertilizer
Typhoid	Salmonella typhi & para typhi	Food & Water	As above
Hepatitis	A/E	water faeco-oral	As above
Malaria	Malarial parasite	water biological vector	Improve surface water management Use mosquito netting & killing of adult mosquito Reduce need to visit breeding sites

STOOL BACTERIOLOGY

n=386

ORGANISM	CASE	CONTROL	OR	p-value
<u>Pathogenic <i>E.coli</i></u>	71 (36.8%)	47 (24.4%)	1.81	0.008*
a) ETEC ¹	35 (18.1%)	25 (12.9%)	1.49	0.160
b) EPEC ²	24 (12.4%)	14 (7.3%)	1.82	0.088*
c) EIEC ³	12 (6.2%)	8 (4.2%)	1.53	0.359
d) EHEC ⁴	0	0		
<i>Campylobacter</i>	10 (5.0%)	3 (1.0%)	3.46	0.048*
<i>Salmonella</i>	4 (2.0%)	2 (1.0%)	2.02	0.411
<i>Shigella</i>	0	0	0	0

* = Significant

1. ETEC = Presence of LT or ST toxins
2. EPEC = Presence of LA or AE toxins
3. EIEC = Presence of DA, IPA or EAggEC toxins
4. EHEC = Presence of SLT-1 or SLT-11 toxins

STOOL PARASITOLOGY

n=386

Positive samples = 226 (58.5%)

PARASITES	CASES	CONTROLS	OR	p-value
<i>Cryptosporidium</i>	48 (24.8%)	6 (3%)	10.32	<0.001*
<i>G.lambli</i> a	16 (8.3%)	4 (2%)	4.27	0.006*
<i>E.histolytica</i>	12 (6.2%)	3 (2%)	4.20	0.018*
<i>T.hominis</i>	18 (9.3%)	6 (3%)	3.21	0.012*
<i>Entamoeba coli</i>	14 (7.3%)	3 (2%)	4.95	0.006*
<i>A.lumbricoides</i>	56 (29.0%)	83 (43%)	0.54	0.004*
<i>H.nana</i>	18 (9.3%)	10 (6%)	1.88	0.12
<i>T.trichiura</i>	23 (11.9%)	24 (12%)	0.95	0.88

* = Significant

WATER MICROBIOLOGY

n=380 Cases=189 controls= 191

ORGANISMS	CASES	CONTROLS	OR	p-value
<i>Cryptosporidium</i>	32 (17%)	6 (7%)	2.79	0.002*
<u>Pathogenic <i>E.coli</i></u>	15 (7.9%)	15 (7.8%)	1.01	0.976
a) ETEC ¹	3 (1.6%)	4 (2.1%)	0.75	0.714
b) EPEC ²	4 (2.1%)	3 (1.6%)	1.35	0.693
c) EIEC ³	5 (2.6%)	7 (3.7%)	0.71	0.570
d) EHEC ⁴	3 (1.6%)	1 (0.5%)	3.06	0.310

* = Significant

1. ETEC = Presence of LT or ST toxins
2. EPEC = Presence of LA or AE toxins
3. EIEC = Presence of DA, IPA or EAggEC toxins
4. EHEC = Presence of SLT1 or SLT11 toxins

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session E

Subject title : **Transmission routes of diseases and intervention**

Type of session : **Participatory discussions/Group presentations/Lecture**

Objectives **To define and elaborate the five behavioral domains, to define different routes of transmission of diseases, intervention and control.**

This session was conducted by Dr. Tameez Ahmed. He initiated the session through brainstorming technique on water and sanitation diseases transmission routes. Later on he divided the participants in 8 groups and asked them to come up with their own ideas on the main routes and potential source of diseases. After 25 minutes given time for this activity each group was asked to make a presentation on their findings. After presentation of each group Dr. Tameez showed different slides on same subject and explained the F-diagram in detail with the help of flip chart.

Handouts: Five behavioral domains
Why assess hygiene practices
Faeco-Oral Routes of Disease Transmission (F-diagram)

FIVE BEHAVIOURAL DOMAINS

- 1. DISPOSAL OF HUMAN FAECES**
- 2. USE AND PROTECTION OF WATER SOURCES**
- 3. WATER AND PERSONAL HYGIENE**
- 4. FOOD HYGIENE**
- 5. DOMESTIC AND ENVIRONMENTAL HYGIENE**

FIVE DOMAINS OF HYGIENE BEHAVIOUR*

1. Disposal of Human Faeces

- **choice of place for defaecation**
- **disposal of faeces**
- **anal cleansing**
- **disposal of anal cleansing material**
- **handwashing**
- **cleaning of the latrine**
- **maintenance of latrine**
- **Other activities related to faecal matter**
 - **use of faeces as fertilizer**
 - **manure handling**
 - **animals eating faeces**

2. Use and Protection of Water Sources

- **choice of water sources**
- **water collection**
- **water transport**
- **water use of the source**
- **wastewater disposal and drainage**
- **water source protection and maintenance**

3. Water and Personal Hygiene

- **handling practices**
 - **water handling**
 - **water storage**
 - **water treatment**
 - **water re-use**
 - **wastewater disposal**
- **personal hygiene**
 - **washing of hands/cutting of nails**
 - **washing of face**
 - **body wash/bathing**
 - **hygiene after defaecation**
 - **washing and use of clothes, towels, and bedding**
- **personal hygiene during natural events, such as birth, death, illness.**

* Source: pp.35-48 of *Actions Speak* edited by M.T. Boot and S. Cairncross.

4. Food Hygiene

- **handling practices**
 - **cleaning of kitchen/food preparation area**
 - **handwashing/use of clean hands**
 - **use of clean work-top and kitchen utensils**
 - **use of clean dishcloths/kitchen towels**
 - **use of safe water**
 - **disposal of wastewater and garbage**
- **preparation practices**
 - **washing of raw food and fruits**
 - **cooking and re-heating practices**
- **storage practices**
 - **duration of storage time**
 - **location and coverage of stored food**
 - **storage of eating/kitchen utensils**
- **eating and feeding practices**
 - **handwashing/use of clean hands**
 - **use of clean utensils**
 - **feeding of babies and small children**
 - **washing of eating/kitchen utensils**

5. Domestic and Environmental Hygiene

- **Household hygiene**
 - **wiping of surfaces**
 - **sweeping and cleaning of floors/compounds**
 - **removal of shoes before entering the house**
 - **cleaning of children's play objects**
 - **insect control**
- **Environmental hygiene**
 - **street cleanliness**
 - **wastewater disposal & drainage**
 - **solid waste (garbage & rubbish) disposal**
 - **hygiene at public places (schools, worship places, communal stand post)**
- **animal management**
 - **control of animals**
 - **safe disposal of animal faeces**

Why Assess Hygiene Practices?

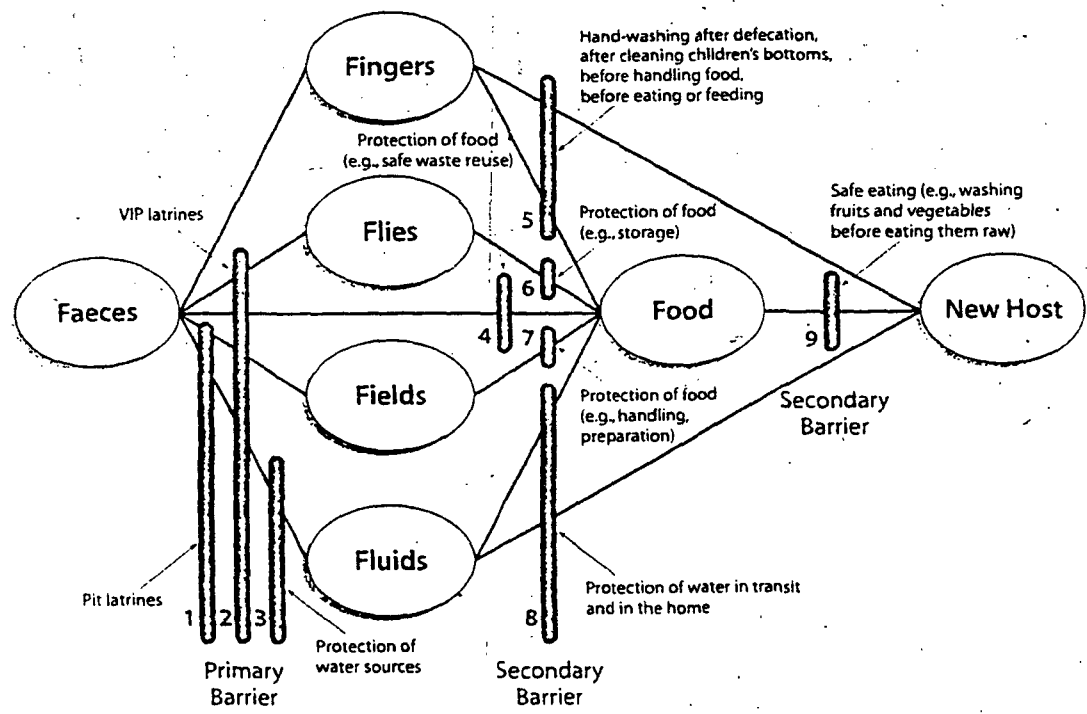
For a long time, project planners have appreciated the value of improving water supply and sanitation facilities. Improved facilities reduce contamination of drinking water and of the environment, and reduce diarrhoeal disease transmission and worm infestations. Even so, World Health Organization and World Bank statistics show that as many as three million children still die from intestinal infections every year, and a third of the world's population is still infected with parasites. The main reason for this is not that *too little* has been invested in technological improvement of facilities, but that the facilities are often inappropriate, unaffordable, or unacceptable to the intended users. All of these result in no use, limited use, or inappropriate use of facilities.

For example, pit latrines are widely promoted in both urban and rural regions in many parts of the world, in order to prevent faeces from contaminating the environment. However, having the facility does not in itself guarantee the isolation of faecal contamination. Even where pit latrines are in use, faecal contamination can get into drinking water and food and thereby into the mouth, or directly from fingers into the mouth. Various routes of transmission, such as fingers, flies, soil, and water, may require different barriers if the spread of contamination is to be stopped. This makes the prevention of diarrhoea and worm infections complex, as shown in Figure 1.

This diagram, often called the *F diagram*, clearly shows the different transmission routes whereby pathogens can get from the faeces of an infected person through *fluids* (mainly drinking water), *fields* (soil), *fingers*, and *food*. Some of the most effective primary and secondary (behavioural) barriers are indicated. You can see that there are at least nine barriers/facilities associated with hygiene practices. Clearly, numbers 1 and 2, pit latrines and Ventilated Improved Pit (VIP) latrines respectively, are very important physical barriers. If they are constructed and used properly, they can prevent faeces from contaminating water sources, soil, and food. The rest of the barriers relate to hygiene practices such as the protection of water sources (4) irrespective of the existence of latrines; hand-washing at critical times—after defecation, after cleaning children's bottoms, before handling food, and before eating and/or feeding (5); protection of food by safe storage (6); safe handling (7); protection of water in transit and in the home (8); and, washing raw foods before eating them (9).

Do improved hygiene practices really make a difference to health? Research shows that hygiene-related practices such as the safe disposal of

FIGURE 1
Faeco-Oral Routes of Disease Transmission



faeces and hand-washing after contact with faecal material can reduce the rates of intestinal infection considerably. Consider the following figures:

- *Hand-washing* with soap and water can reduce diarrhoeal disease by 35% or more. Hand-washing can also help to reduce the prevalence of eye infections such as conjunctivitis and trachoma.

- *Safe disposal of faeces* serves as a primary barrier to prevent faeces from contaminating the environment. It is particularly important to isolate the faeces of people with diarrhoea, most of whom are usually young children. Pit latrines, when used by adults and for the disposal of young children's stools, can reduce diarrhoea by 36% or more.

- *Protection of water* from faecal contamination can also reduce diarrhoea, because some diarrhoeal infections are water-borne. Water quality in the home can be improved by using only a protected water source for drinking purposes; by keeping water storage vessels clean, covered, and out of the reach of young children and domestic animals; by boiling water where practical; or by putting water in clear plastic containers and exposing them to sunshine for several hours in the special case of guinea worm, filtering with a cloth filter can provide complete protection. Improved water quality can be associated with up to a 20% reduction in diarrhoea. However, increased quantity of water used, which results from better access to water, can bring about still greater reductions.

However, much remains to be learned about the links between improved water supply and sanitation facilities, and well-designed and implemented health/hygiene promotion and health. What is clear is that good hygiene practices are necessary for maintaining good health.

Who is This Handbook For?

This handbook was developed primarily for field level personnel in water supply, sanitation, and hygiene education projects. These include water and/or sanitary engineers, public health technicians, community workers, health educators, communication specialists, health workers, and other public health practitioners as well as project planners, managers, and trainers. If you are one of these, and want to design your own assessment of hygiene practices in your project site, this handbook is for you. This handbook may also be useful to students and researchers in public health and other academic institutions interested in interdisciplinary enquiries into health behaviour.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session F

Subject title : Making acquired knowledge digestible for others

Type of session : Group presentation/Story/ role play

Objectives : How can you make acquired knowledge easy and understandable for different target groups.

This session was facilitated by Dr. Tameez Ahmed. The main theme of this session was to present practical examples of the previous lectures held and participatory discussion to make it easy and understand able for different participants having different background. To get this objective and made the session interesting the participants were divided into different groups. Each group was asked to develop stories and role plays on germ concept based on the knowledge they got in the previous sessions. They were asked to develop a story or role play on germ, as a common community female member can not know about germ. How do they explain them the germ concept. After 25 minutes given time each group was asked to come and present what they have prepared. Dr. Karim was also present in this session he announced that a special gift will be given to the best performer group. He maintained that WASEP HHPs will not be considered for this competition. Different groups presented their own way of communicating the germ concept to female community members. In order to provide further background and methods to the participants on the same subject WASEP HHPs presented different types of activities on communicating the health messages to the community women. At the end of all these activities Dr. Karim announced that LB&RD group was the best in performance and as well as in developing the story. After this announcement HHPs showed different materials prepared by WASEP health and hygiene education session for communicating health messages.

Handouts:

None

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session G

Subject title : Influencing Health Behaviours

Type of session : Participatory discussions/Lecture

Objectives Provision of theoretical background on ways of influencing behavior through hygiene education planning and implementation. To define different stages/phases of planning health and hygiene education programme from identification of specific behavior to out come evaluation: To give participants the idea on the factors that could be influence on a particular behavior. To prioritize and develop the specific messages with respect to the target population to influence the health behaviors.

Dr. Tameez Ahmad initiated this session by brain storming of the participants on this topic and later on with the help of transparencies explained the variables and stages whilst communicating the health education messages. After discussion he elaborately highlighted the different steps and phases that could be part of an effective health and hygiene education programme to change the existing behaviors. He used flip charts and transparencies and also encouraged the participant's questions.

Handouts : Influencing health behaviors
Common traps in hygiene education
Phases in health education planning
Matrix of health behaviors (Green et al, 1980, p.63)
Three categories of factors contributing to health behaviors
Three levels of evaluation in relation to the health education planning framework.
Green's Framework for latrine promotion

INFLUENCING HEALTH BEHAVIOURS

Objective: Provision of theoretical background on ways of influencing behaviour through hygiene education planning and implementation.

WHY: To achieve programme objectives.

HOW: Health and Hygiene Interventions

Hygiene Education: All activities aimed at encouraging behaviour and conditions which help to prevent water and sanitation-related diseases. (specific form of a wider health education).

Health Education: All activities that promote health and reduce health risks.

Framework for Health Education Planning

Phase 1: Identification of problem (improvement in the quality of life).

Phase 2: Nature of Problems

Phase 3: Identification of Specific Behaviours Linked to the Chosen Health Problem. (Matrix of Health Behaviours.

Phase 4. Determination of Factors Contributing to the Health Behaviour in Phase 3 (Predisposing factors, Enabling factors, and reinforcing factors).

Phase 5. Decision Making on How to Start the Process

Phase 6. Health Education Strategy

Phase 7. Evaluation (Process, Impact, Outcome)

Common Traps in Hygiene Education

- 1. The Trap of Doing Without Thinking**
- 2. The Empty Vessel Fallacy**
- 3. The Fallacy of the Inherent Superiority or Inferiority**
- 4. The Fallacy of the More, the Better.**

Measuring of Behavioural Changes

- 1. Comparison of the data from the evaluation study to baseline data.**
- 2. Reduction of a risky behaviours (e.g., open defecation)**
- 3. Prevention of a new risk behaviours (lack of toilet cleansing),**
- 4. Increase in a hygienic behaviour (exclusive latrine use by all in the family)**
- 5. Prevention of a decrease in a hygienic behaviours (fewer people reverting to open field defecation)**

INFLUENCING BEHAVIOUR

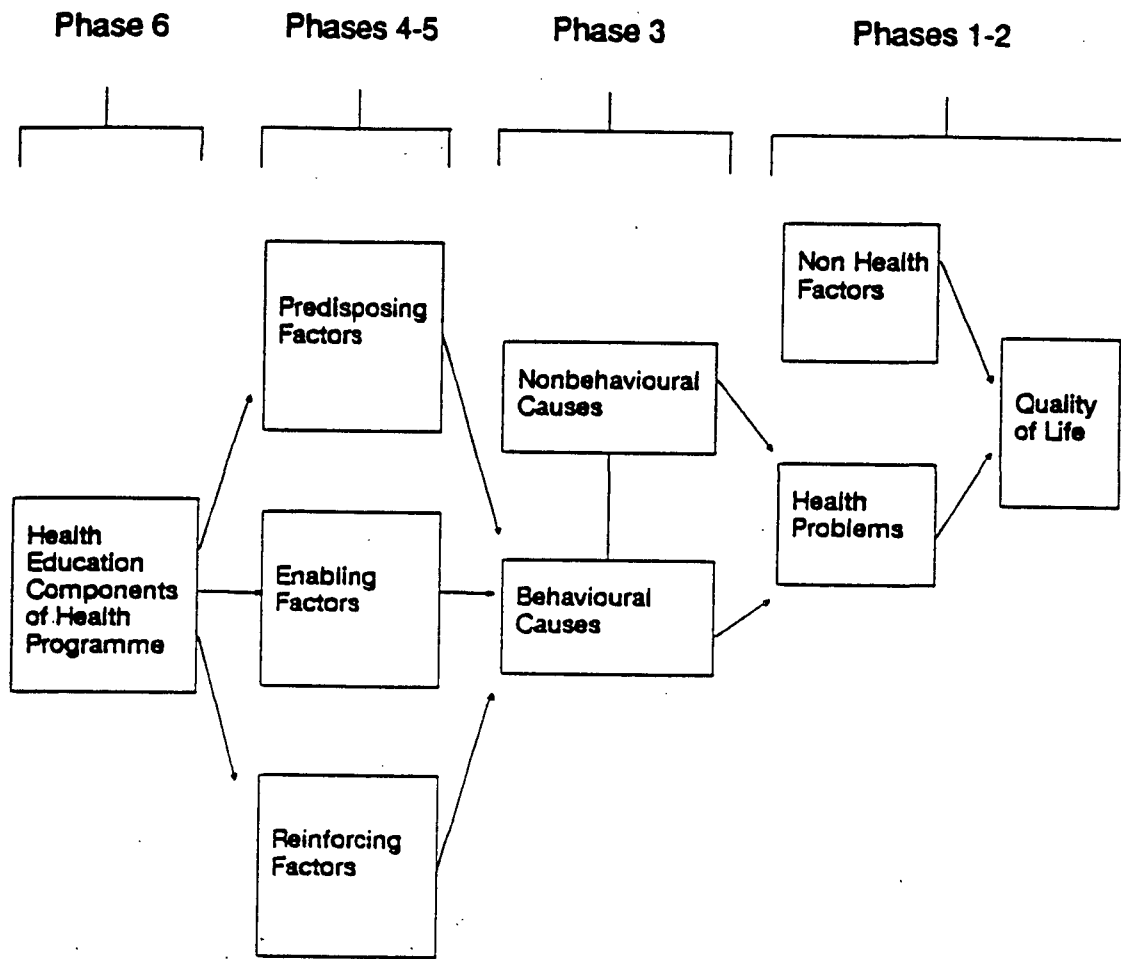


Figure 1: Phases in health education planning ((

	Important	Not/Less Important
Changeable	1. High priority for programme focus	3. Low priority except to demonstrate change for "political" purposes
Not/Less Changeable	2. Priority for innovative programme; evaluation crucial	4. No programme

Figure 2: Matrix of health behaviours (Green et al, 1980, p. 63).

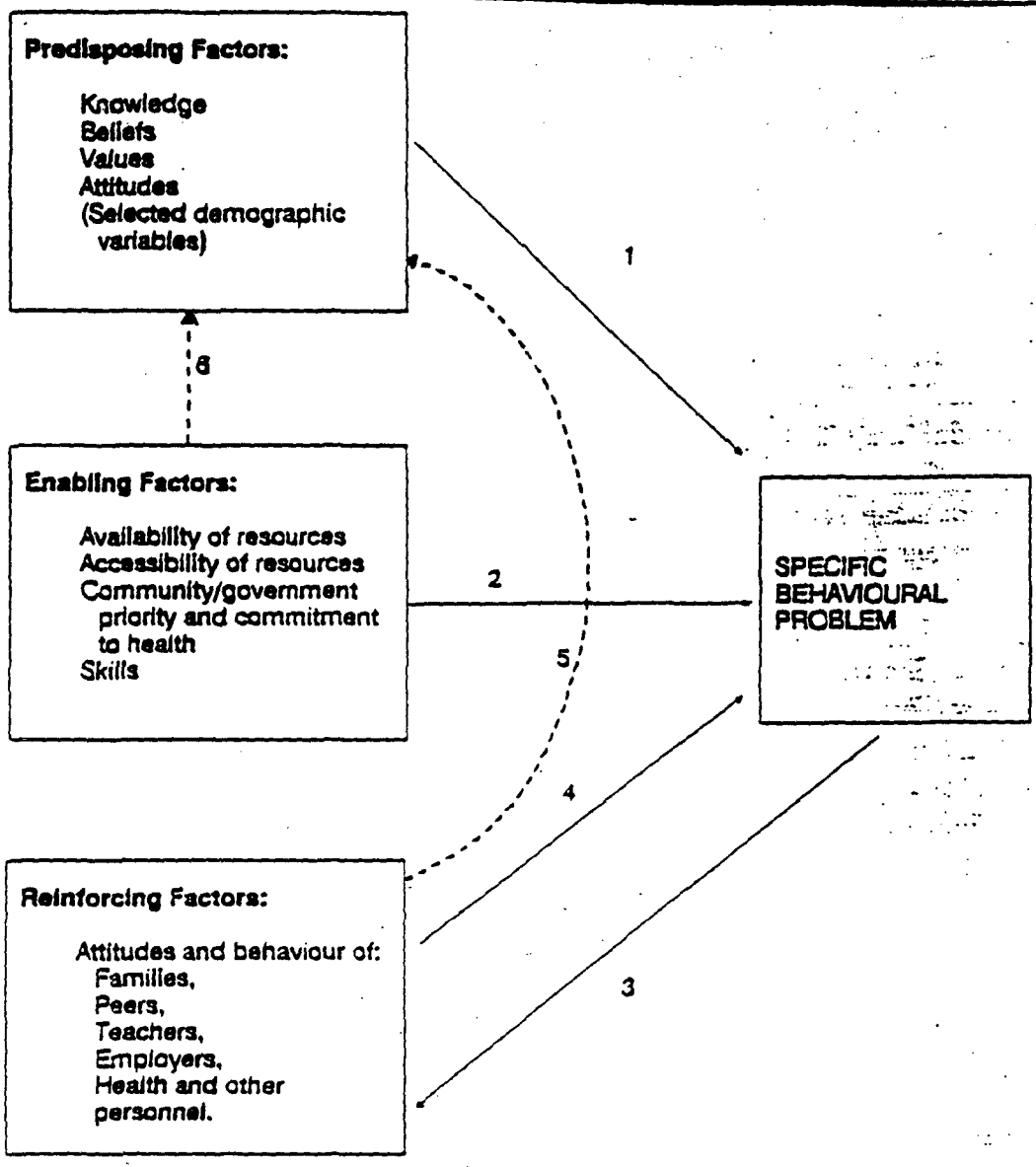


Figure 3: Three categories of factors contributing to health behaviour

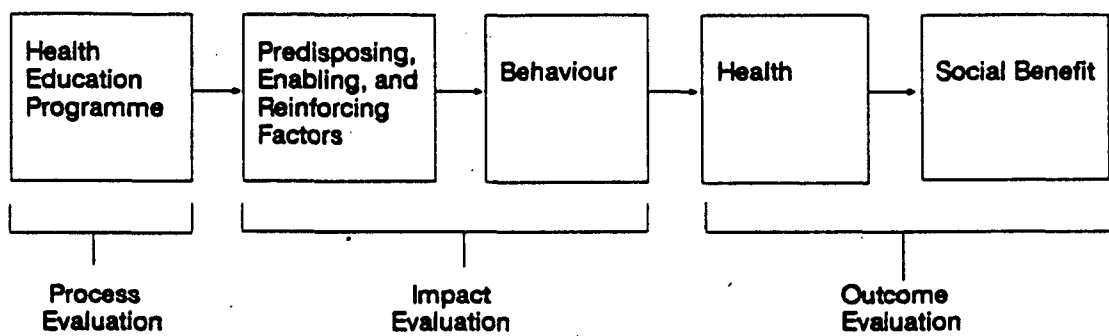
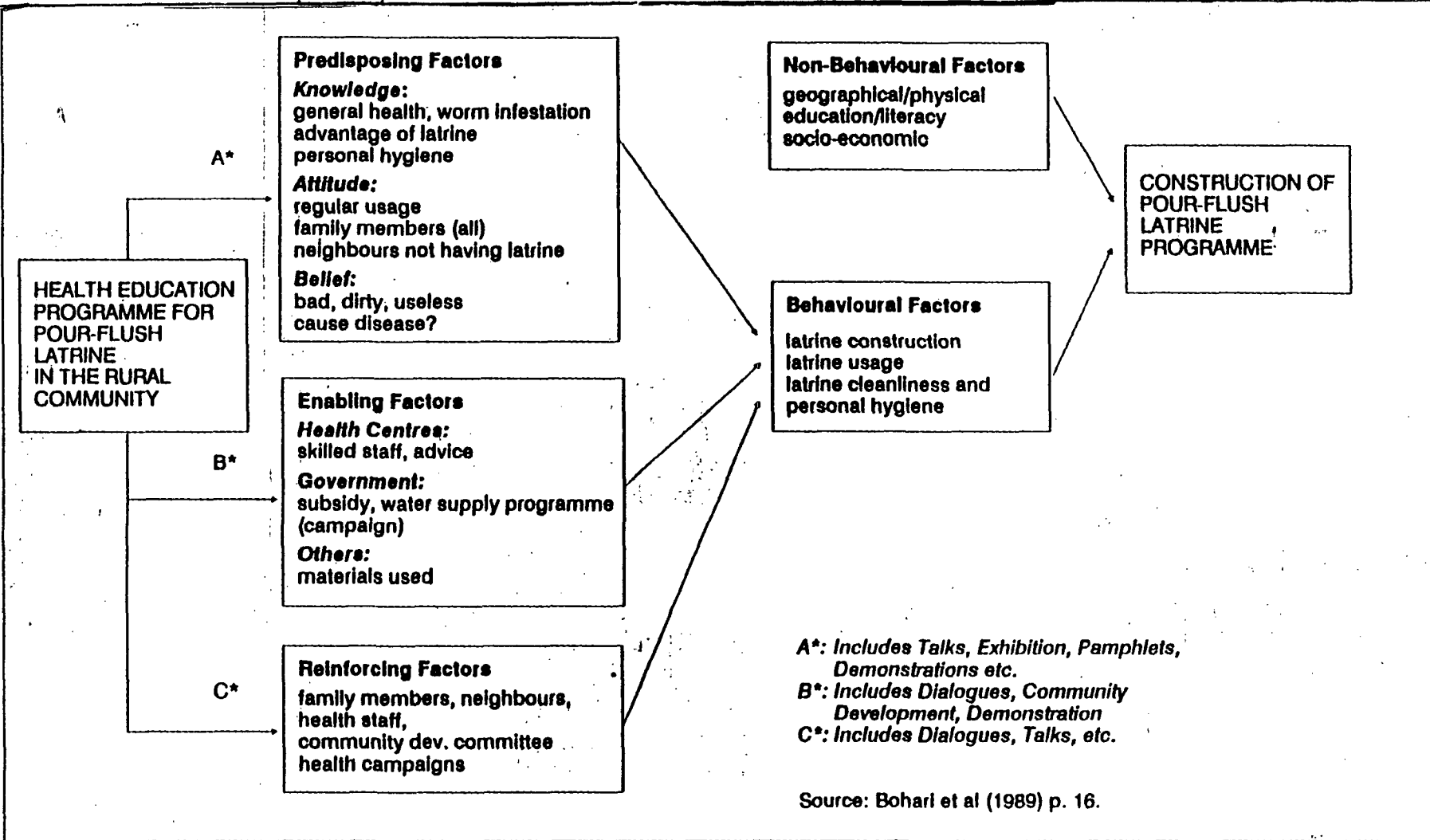


Figure 4. Three levels of evaluation in relation to the health education planning framework.

-: GREEN'S FRAMEWORK FOR LATRIENE PROMOTION :-

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INFLUENCING BEHAVIOUR

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session H

Subject title : SARAR resistance to change continuum (RTCC)

Type of session : Activity/lecture/Group assignment

Objectives To define and elaborate the five behavioral domains, to define different routes of transmission of diseases, intervention and control.

Dr. Tameez Ahmed and Haider Raza conducted this session. An activity was already planned by Dr.Tameez and Haider Raza practically familiarize the participants about different types of target groups that they could find in the community. This session was quite interesting and completely different in nature as compared to previous sessions. After this activity Dr.Tameez explained the RTCC in details and discussed each step elaborately. Soon after this lecture all participants were divided into five different groups each group was given different stickers and were asked to place those in order as per discussions held in the session.

**Handouts : Introduction to SARAR resistance to change
Seven stages of resistance to change continuum**

SARAR RESISTANCE TO CHANGE CONTINUUM (RTCC)

WHAT: An approach developed by UNDP/PROWESS¹ to facilitate community participation in the WSS known as SARAR

THE SARAR PROCESS

SELF-ESTEEM

The self-esteem of a group individual is acknowledged and enhanced by recognizing that they have the creative and analytic capacity to identify and solve their own problems

ASSOCIATIVE STRENGTHS

The methodology recognizes that when people from groups, they become stronger and develop the capacity to act together (union is strength).

RESOURCEFULNESS

Each individual is a potential resource to the community.

ACTION PLANNING

Planning for action to solve problems is central to the method. Change can be achieved only if groups plan and carry out appropriate actions.

RESPONSIBILITY

Responsibility to implement actions envisaged in planning.

¹ PROWESS = Promotion of the Role of Women in Water and Environmental Sanitation Services

SEVEN STAGES OF RESISTANCE TO CHANGE CONTINUUM

- Stage 1: Complete Denial of the Problem
- Stage 2: Problem is recognized but the will to act is missing due to a feeling of powerlessness, apathy (indifference/unconcern), dependence or fatalism.
- Stage 3: Problem is recognized but there are doubts and fears regarding proposed solution.
- Stage 4: Some interest in the proposed change but also fear of the social, economic or other risks involved.
- Stage 5: Real interest in learning more about the proposed solution with a view to adopting it.
- Stage 6: There is a readiness to adopt the change.
- Stage 7: Not only change is adopted and applied but also readiness to motivate others.

TAKE HOME MESSAGE

- One cannot use the same approach with people who are at stages 1 through 4 as with those at stages 5, 6, and 7. (Learner-centred material for 1-4, and straightforward message-focussed didactic materials for 5-7).

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session I

Subject title : Introduction to communication

Type of session : Lecture/Group Discussion

Objectives : To define what is communication, its importance in health and hygiene education; Characteristic of an effective health and hygiene educator; To define different type of communicating methods and their implications.

Haider Raza, proceeded the session by the introductory slide on communication in which he defined the important variables involved in communication. He also highlighted the need of an effective communication in delivering health and hygiene education messages to get better effect. Other important issues discussed during this sessions were identification of different target groups in the villages and how to utilize their capabilities for communicating the health messages. Different methods of communication and their characteristics were also discussed and explained with examples with respect to health water and sanitation. One of the most important segment of this session was on data management i.e. type and styles of observations and questions.

Handouts :

- : Communication & Basic characteristics**
- : Method of communications**
- : Communication support materials**
- : Sources of information**
- : Formulation of Questions**
- : Questioning styles**
- : Overview of common visual tools**

COMMUNICATION

OBJECTIVES:

To highlight the basic factors influencing successful communication

WHAT:

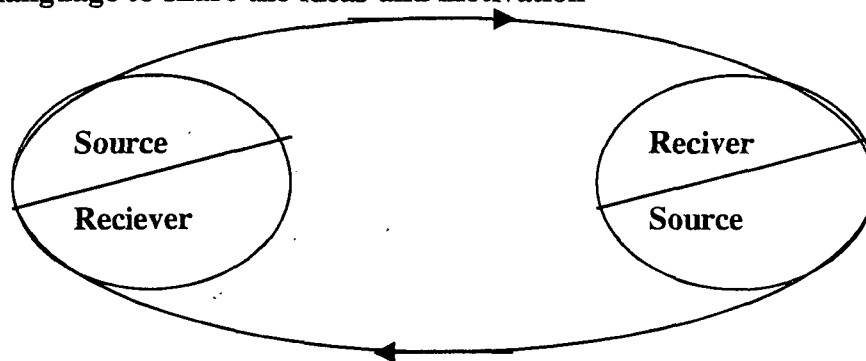
- Communication is the sharing of information (including ideas, emotions, knowledge and skills) among two or more person.
- Involves at least two persons. One person is telling or showing something to the other is known as source.
- Who reacts by showing or telling something to first is known as receiver.

BASIC CHARACTERISTICS:

1. Source and Reciver

Hygiene education works through communication. The aim of effective hygiene education depends on the quality of the communication. The quality of communication will be more effective when the source (hygiene promoter)

- is trusted by the reciever, being the target group;
- has important characteristics such as sex, age, culture, education, experiences in common with the reciever;
- tries to understand what people feel, think and are motivated by;
- has sufficient status and is considered reliable by the reciver
- has similar language to share the ideas and motivation



TARGET GROUPS:

Participatory (ask from participants for possible target groups for water and sanitation related messages)

2 MESSAGE:

The message is the content of the communication. Following points must be considered for an effective message;

- only one or a few are discussed at one time;
- they are target group oriented;
- they are positively oriented;
- they are repeated, preferably in different ways and in different settings

3. METHODS OF COMMUNICATIONS:

A. Interpersonal methods

It is characterized by direct contact between the hygiene educator and the target group. eg.

1. Person to person discussions, such as during home visits;
2. Small group discussions (up to 12 persons);
3. Large group discussions (between 12 and 30 persons);
4. Public meetings (above 30 persons).

Person-to-Person discussion

- Take place during home visits or at public meeting.
- Important to create an atmosphere of trust and understanding between the hygiene educator and members of target groups
- Time consuming

Group Discussion

- Participants directly communicate with each other
- Take care of possible formation of sub-groups
- Composition/Background of the participants should be kept in mind.
- Providing information and correcting wrong ideas
- Enable every body to speak up
- To stimulate shy person to become active
- Evaluating the discussions
- Gift story (sustainability and necessity of taking responsibility of new WSS)

Group/public meetings

- Quick information dissemination
- Limit the presentation 30 to 40 minutes
- Content should be target group oriented
- Take time for feedback, clarifications answering questions
- Summarize the main points at the end of the meeting.

B. Mass Media

1. Wall posters
2. Radio
3. TV
4. Cinema
5. Newspapers,
6. Books etc.

Comparison of Interpersonal Communication and Mass Media

Characteristics	Mass Media	Interpersonal
Speed to cover large pop.	Rapid	Slow
Accuracy and lack of distortion	High accuracy	Easily distorted
Ability to select particular audience	Difficult to select audience	Can be highly selective
Direction	One-way	Two-way
Ability to respond to local needs of specific communities	Only provides non-specific information	Can fit to local needs
Feedback	Only indirect feedback from survey	Direct feedback possible
Main effect	Increased knowledge/awareness	Change in attitudes and behaviour

COMMUNICATION SUPPORT MATERIALS

Objective: To have basic background on how messages are communicated through different techniques.

WHY: Health and Hygiene Education to Achieve Required Changes in Behaviours.

WHAT: Different Messages on H&H on Specific Behaviour

WHOM: Target groups in the project villages (especially)

HOW: Using the following tools:

Demonstration, models, poster series, games, dramas, and Leaflets, flashcards, cassette, slides, videos, songs, stories, chalkboard, flannel board, flipchart (see handout for definition, advantages, and disadvantages)

Pretesting:

- Do they like the materials?
- Are the symbols understood?
- Do they get the intended message right away?
- If the material built up from a series of pictures, do they interpret it as a whole or separately? Is the overall message understood?
- Does the material have relevance for their own situation, lives, needs?
- Does any part of the material embarrass people?
- What significant is attached to the use of colours?

Example: Health Communication

1. Diarrhoea (see handout/p.108)
2. Handwashing (see handout/p.112)
3. Use of Poster (see handout/p.114)

Characteristics of a Good H&H Promoter

1. Reliable and trustworthy
2. A skillful communicators
3. Knowledge about water and sanitation
4. Readily approachable by all community groups
5. Liked because of her positive personality and motives to support the community
6. Able to cooperate with technical staff
7. Able to voice the views and interests of the community to relevant organisations and authorities.
8. Report writing/Record Keeping/Data Management

DATA MANGEMENT

➤ SOURCES OF INFORMATION:

⇒ Observations:

- **Important source of information on hygiene behaviour.**
- **Advantage of providing first hand data.**
- **Reveals much more specific information than other methods.**

1. Open or unstructured observations:

- **Open or unstructured are not in a organized, complete or detailed way**
- **Unstructed observations provide qualitative data**
- **Helpful to understand behaviours in their physical and social context.**
- **Information could be collected through environmetal walks, visits to water collection points, and observations.**

2. Structrued observations:

- **Fixed number of points are used in observation list to pre-determined number of situations of people.**
- **List of points should be prepared after exploring the required needs**

a) Types of structured observations:

1) Continuous monitoring

- **Extended observation (structured formates)**
- **Time-point observation (Time specific visits)**
- **Requires close observation to the targeted person(s)**
- **Time consuming and complicated than others types (collection, analysis and interpretation)**

2) Spot checks:

- **Particular type of observation**
- **Used to collect signs of behaviours.**
- **Presence or absence of a behaviour or physical characteristic are observed (number of flies, drinking water container covered or not)**

3) Rating checks:

- Like spot checks physical clues related to specific behaviour is noted.
- Involves a clear judgement of observer regarding a specific behaviour.

◆ ROLE OF OBSERVER:

- The observer may begin as participant.
- Gradually become an onlooker (or the other way round)
- Do observations when the people concerned are fully informed and have given their explicit permission.

◆ DURATION & REQUENCY OF OBSERVATIONS:

- Could be set according to the needs of the study.
- Dependent upon the purpose of the study, time and resources available.

➤ INTERVIEWS:

- Second major source of information on hygiene behaviour.
- Interviews can be held with individuals or group of peoples.
- Used to collect information about past behaviours by asking questions..
- Meeting of two or more persons.(interviewer and respondent)
- Require skill to provoke people's views.
- Photos, Pictures, Maps, Objects etc may be used.
- Selection of individuals should be gender conscious.

TYPES OF INTERVIEWS:

1) OPEN OR UNSTRUCTURED INTERVIEWS.

- Respondent expresses his view in his own words.
- Purpose is learn about people's views, perceptions, local terminologies and judgements.
- ✓ Informal, conversational interviews:
 - ◆ With individuals
 - ◆ With groups
- ✓ Key informant interviews
- ✓ Topic focused interviews

- ◆ With individuals
- ◆ With groups
- ✓ Focused group discussions (6 to 12 persons participate)
- ✓ Topic focused interviews (done with the help of checklist of topics to be discussed, often combined with unstructured observations)
- ✓ Semi-structured interviews (done with the list of questions. Asked in the exact wording and order as they are written down. Can be done by less skilled person)

2) Structured interviews

- Structured interviews have closed ended questions
- Used to generate factual and quantitative data
- Useful to know about people's views and attitudes on issues of interest.

➤ FORMULATION OF QUESTIONS:

- Experience/behaviour questions:
 - Aimed at eliciting descriptions of experiences, behaviours, actions and activities eg. If I followed you to the water source, what would I see you doing?
- Opinion/Value questions:
 - Aimed at understanding people's goals, intentions, desires and values eg What do believe? What do you think about...? What is your opinion of..?
- Feeling questions:
 - Aimed at understanding the emotional responses of people's thoughts and experiences eg Do you feel satisfied with the new latrine?
- Knowledge questions:
 - Aimed to get the factual information from the respondent, eg, Do you know how children get sick with diarrhoea? Why do you wash hands?
- Sensory questions:
 - Questions about what is seen, heard touched and tasted and smelled. How does the water from the hand-pump taste?
- Background/demographic questions:
 - Aimed to relate the respondent to other people? Age, education, occupation, residence/mobility questions.

QUESTIONING STYLES

- **Open-ended questions:**
 - ✓ Open-ended questions should be asked in such a way that respondents can answer the question in their own terms. The direction of answer is not mentioned in the questions., eg How do you feel about...?, What is your opinion of?. In comparison How satisfied are you with...? Or Are you satisfied with ? is not truly open-ended question.

- **Neutral questions:**
 - ✓ Neutral questions give the interviewee the possibility to give answer freely. It is opposite of the leading questions, eg Where do you go for relieve yourself ?” is neutral question and “Do you use a latrine?” is leading question.

- **Singular questions:**
 - ✓ Singular questions contain only one idea. These are important to prevent confusing answers. For example, “Do you wash and bath at the water source ?” may give an answer related to bathing, to washing, or both, but we cannot be sure.

- **Clear questions:**
 - ✓ Clear questions are presented in the words and ways that are common with the interviewee. For example there may be special words for specific practices.

- **Minimize ‘yes/no’ answers to questions:**
 - ✓ “Are you satisfied from your latrine?” is the question that invite your respondent to reply with yes or no.

- **Minimize ‘why’ questions:**
 - ✓ Too many ‘why’ questions can be very boring and provide partial answers only. For example “Why did you construct the latrine?” What made you construct a latrine?

- **Include ‘presupposition’ questions:**
 - ✓ Presupposition questions are questions in which it is assumed, or presupposed that the interviewee has something to say. For example “What do you know about ?” is better from Do you know anything about ?

Table 4: Overview of common visual tools

<i>VISUAL AID</i>	<i>GENERAL DESCRIPTION</i>	<i>RECOMMENDED AUDIENCE SIZE</i>
Chalkboard	A rigid surface painted green or black; on which one can write or draw with chalk.	Up to 30 people. If used with more, a large board is needed and careful audience placement is necessary.
Flannel Board	A piece of flannel, flannelette, terry cloth or felt cloth attached to a rigid surface on which cut-out figures will adhere if backed with flannel or felt cloth, sandpaper or glued sand.	Up to 20 people. Audience size depends on the size of the flannel board and the size of the figures that are being used.
Posters	A message on a large sheet of paper, with an illustration and a simple written message.	No limit, because it is not necessary for everyone to look at a poster at the same time.
Flip charts	Illustrations on paper or cloth, usually larger than 21cm by 27cm; bound together with rings or strings. They flip over in sequence.	Up to 30 people. Audience size depends on the size of the flip chart illustrations.
Flash cards	Illustrations made on heavy paper that is usually smaller than 21cm by 27cm. The illustrations are not bound, but may be arranged in sequence.	Up to 15 people. Because the illustrations are small, no more than 15 people should be in the audience.
Bulletin Boards	A surface, at least 3/4m by 1m, into which stick pins can be placed. Drawings, photos and lettering can be displayed on the board.	No limit, because it is not necessary for everyone to look at the bulletin board at the same time.
Demonstration	Using actual ingredients, tools, or land, the educator shows how something is done. Either at that time, or soon thereafter, each audience member displays an ability to do the demonstrated activity.	1 to 30 people. Because it is difficult for an educator to follow up on more than 30 persons, this is the recommended limit.
Slides	35mm film in plastic or cardboard mounts 5cm by 5cm. In color or black and white, they are projected on a screen or a wall.	Up to 30 people. Though slides can be used with more people, the educator can stimulate better discussion among a smaller group.
Filmstrips	Strip of 35mm film, color or black and white. Photographs in sequence. Filmstrip projected on screen or wall. Uses projector with filmstrip adapter. Filmstrips horizontal or vertical format.	Up to 30 people. Though filmstrips can be used with more people, the educator can stimulate better discussion with a group of this size.
Film	Color or black and white, 16mm or 8mm cinema film, with sound, projected on a screen or wall.	30 to 100 people. Group can be larger than 100 but it is difficult to have any discussion with larger groups.

ADVANTAGES

Inexpensive, can be homemade, easily maintained, minimum of preparation. Enables audience participation. Used day or night.

Inexpensive, easily made from local materials. Easily maintained and transported in remote areas. Figures can be used in different presentations. Ideal for showing "sequence of events" and reviewing lessons, as figures can be brought back on the board.

Inexpensive, easy to make. Requires limited time to prepare and use. Easy to transport.

Inexpensive, can be homemade, and can be easily transported. Good way to discuss information in sequence. Because they are bound, illustrations stay in sequence.

Inexpensive, can be homemade, very easy to transport. Good way to give information in sequence to small groups.

Inexpensive, can be homemade from local materials. Useful for small group discussions.

Excellent way to use actual materials in real situation. Uses local materials. Easy to understand by people not used to looking at illustrations. Good way to get audience participation.

Dramatic, less expensive than cinema film, excellent way to bring distant things to audience and to show time sequence. Battery-operated projectors available. Local photos easily made.

Dramatic, less expensive than cinema film and slides. Once inserted correctly in projector, impossible to get out of sequence. Can show photos of the real thing and shows sequence in time. Battery-operated projectors available. Relatively easy to transport.

Dramatic and gets the audience's attention. Shows motion and therefore helps explain step-by-step, and time sequence very well.

DISADVANTAGES

Transport can be difficult in remote areas. Limited to the user's artistic ability.

Requires considerable advance preparation. Difficult to use out of doors if there is any wind. Some artistic ability is required if making homemade figures.

Deteriorate rapidly. Can confuse audience with too much or too little information. Need some artistic ability if making own posters.

Deteriorate with constant use. Some artistic ability required if making homemade flipcharts.

Deteriorate with constant use. Some artistic ability required if making homemade flashcards. Limited to small groups.

If out of doors, weather damages can occur. Constant supply of good educational material to put on the board is needed.

Takes some pre-planning and preparation.

Easy to damage, easy to get out of sequence and project upside down or sideways. Requires projection equipment, electrical outlets or batteries, and darkened projection area.

Can be damaged, requires projection equipment, requires either electrical outlets or battery-supplied electricity (Sometimes batteries are expensive). Requires darkened projection area. Limited appropriate filmstrips available.

Very expensive, requires expensive equipment, electricity and dark projection area. Difficult to transport and operate.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session I (continued on communication)

Subject title : Communicating Health Messages

Type of session : Lecture/ Role Play

Objectives : To define different approaches involved in communication and their pros and cons.

Dr. Tameez Ahmed led this session by showing a slide on different approaches of effective communication. Various methods and techniques were described to participants and elaborated with real examples. Different approaches discussed in this session were didactic approach, promotional approach and participatory approach. The pros and cons of each approached discussed in detail including the effective ways of communication. To make it digestible and understandable two role plays was also performed by HHPs of WASEP.

Handouts :

- : Communicating Health messages**
- : Approaches to communication (Picture, People and power)**
- : Health Communication (Example)**
- : Hygiene Education Plan for School Session in Nepal (Example)**
- : Extension Activity of a project in Zambia (Example)**

COMMUNICATIONG HEALTH MESSAGES

APPROACHES TO HYGIENE EDUCATION

1. Didactic Approach

Implementing agency defines the problems and solutions to be offered. Subsequently, efforts are made to convince the users to apply these solutions. Programmes using the didactic approach often only blame hygiene education itself or the target groups for not achieving change in behaviour.

2. Promotional Approach

The main characteristics of a promotional approach are identification (by the implementing agency) of specific target groups, study of the needs and means of each group, adaptation of programme contents and methods to the groups concerned, pretesting of messages on understanding and acceptability and continued monitoring of results to improve the programme. Social marketing is a special form of promotional approach (e.g. marketing of ORS & installation of household latrine).

3. Participatory Approach

This approach aims to assist the target groups to achieve what they themselves want to achieve. This approach starts with the question "How I help people achieve what they want to achieve?" The main characteristic of this approach is joint problem analysis and problem solving. The role of educator is to create conditions to help people solve their own problems.

WAYS OF COMMUNICATION

1. One-way/Authoritarian/Didactic Communication

2. People centred Approach/Two-way/Multi-way/Participatory Communication

Chapter 1 Approaches to communication

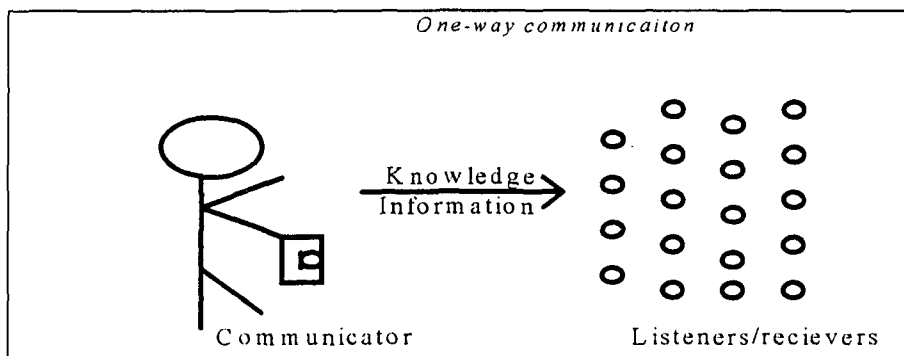
1. The authoritarian approach: One-way of communication

Some of the examples in a one-way communication are Posters that are displayed in a public places with bold images and slogans in order to attract attentions of the people.

e.g **Plant More Tree, Now Wash Your Hands.**

This method is usually used in an educational contex: the potential creativity of the student is, effectively, repressed.

Decisions are taken by the outsiders, not the people from the community e.g. trained artists, professional development communicators.



- *The communicator gives out the information*
- *The listeners receive informations from the communicator.*
- *The communicator is active, the listeners are passive.*
- *The communicator stands, the listeners sit in rows.*
- *The communicator posses "valuavble" knowledge.*
- *The knowledge and experiences of the listeners do not enter ^{into the} ~~the~~ communication process.*
- *There is a very unequall ditribution of power between the communicator and the listeners.*
- *Visual aids like billboards, display posters and flipcharts attempt to send "messages" to "target" audiences.*
- *Visual aids for one-way communicaton are usually designed by men.*

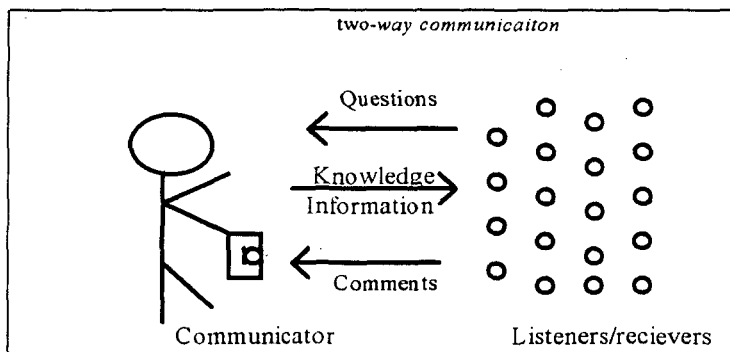
The approach is a top down approach. Local people make no significant input of messafe design and their own knowledge is not included in the communication process. This results from the producer's attitude that "we" know best what is good for "them".

Note: "The stages in development of one-way visual aids" is given at Page # 7 - 9 of the book.

2. People centered approach: two-way communication and multi-way communication.

2.1 Two-way communication

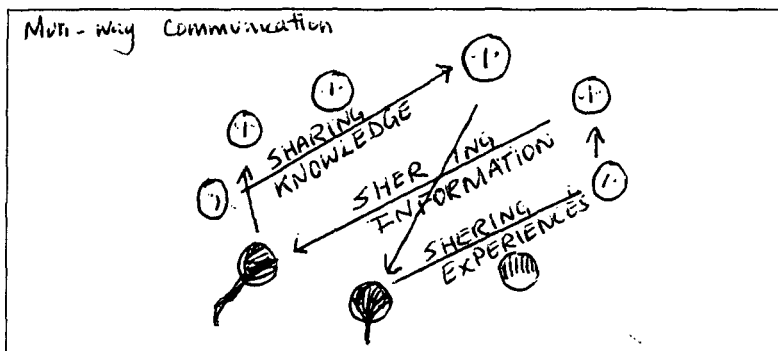
An Analogous to one-way communication, though less formal, structure is often adopted during educational session in the community. The community development worker, addresses a group of mothers. The development work stands, perhaps, while the mothers sit. Some questions may be asked or some comments made to the educator. This is a form of two-way communication, with dialogues always including the teacher.



- *The communicator does most of the talking*
- *The communicator stands, the listeners sit down.*
- *The listeners do not talk much but sometimes ask the communicator questions or make comments to the teacher.*
- *The listeners do not talk with each other.*

2.2 Multi-way communication

In multi-way communication which is relatively informal learning situation, the educator begins the session in one-way mode, transmitting information to the community. A little later, the community enters into a two-way dialogue with the educator. Later still, this two-way communication opens out into a more inclusive discussion.



- *Community and the facilitator sit together.*
- *Community participate actively.*
- *Everybody talks - no- one dominates the discussion.*
- *Everybody's knowledge and experience is valued.*

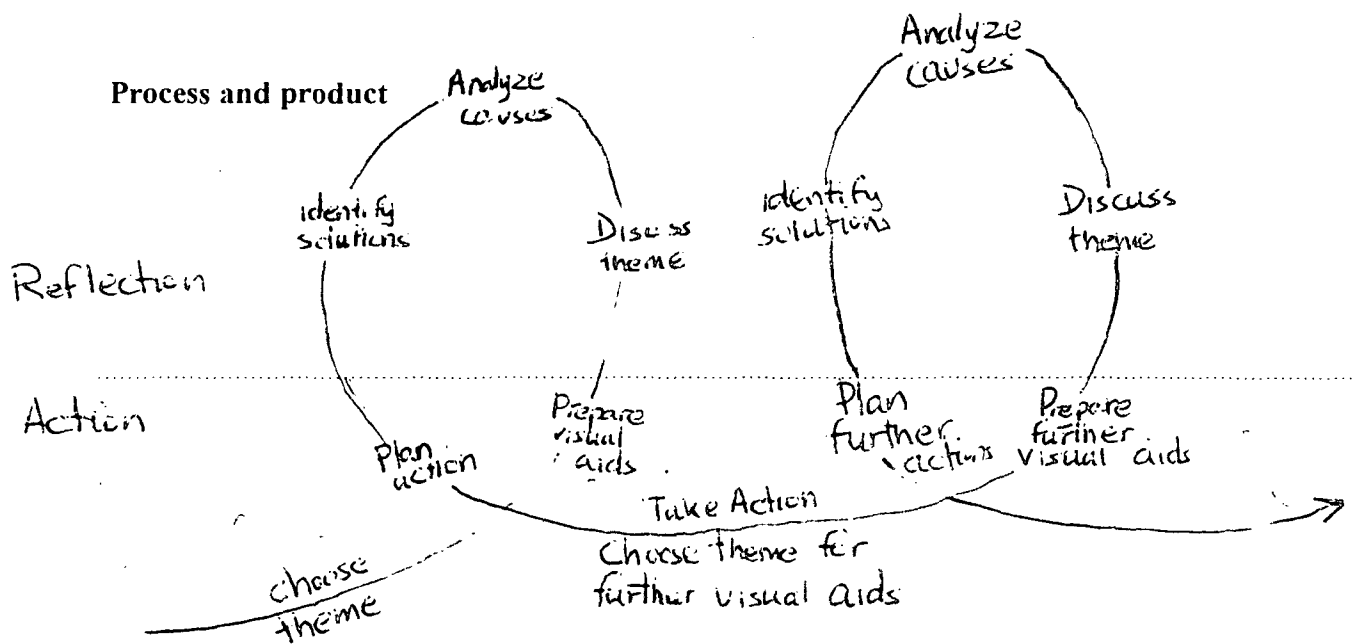
- *There is a relatively even distribution of power within the group.*
- *Nobody falls asleep.*
- *Uses pictures for critical awareness, such as discussion starters, picture cards and flannerboards.*
- *Visual aids for multi-way discussion are made by women.*

Principles of people-centred communication

There are three basic principles in people centred communication.

1. "Start where the learner are" i.e. starting with what already the learner know.
2. "Problem posing" communication or education, i.e. the instead of starting the dialogue or discussion, questions are asked to encourage interaction/discussion with the fellow learners.
3. Active participation on the part of the learners i.e. the active involvement of community members in each stage of communication.

Note: How can we relate these principles to our work with the visual aids? Please see Page # 13 - 16



Example: Health Communication

At the oral rehydration therapy unit in a rural Nigerian clinic, small group discussions are held after the health worker in attendance makes sure that all children have been given fluids and the mothers are at ease. Introduction and greetings are exchanged. An initial discussion about cause of diarrhoeal disease might proceed as follows:

Health worker: Please tell me some of the reasons why children get diarrhoea.

Mother A: Most children get diarrhoea when they are teething.

Mother B: Diarrhoea happens when children have dirty stomach.

Health worker: Please explain more about dirty stomach.

Mother B: When the stomach is dirty, the diarrhoea helps wash out the dirt.

Health worker: What makes the stomach dirty?

Mother C: Bad or dirty food is one reason. Some food just does not agree with some children.

Health worker: Remember one of you said that diarrhoea happens during teething. What do you observe about your children's behaviour during teething?

Mother C: They cry a lot.

Mother D: The child picks up anything to put in his mouth to suck on.

Mother B: My child sucks on her fingers.

Mother E: My child will pick up anything from the floor and put it in his mouth. He was chewing on my sandals yesterday and even picked up an old maize cob yesterday.

Health worker: You are right, children will chew on almost anything when they are teething. You noted that they even pick up things from the floor to chew. Many of these things are probably dirty.

Example continued

Mother C: They surely are. I caught my child with an old bone the dog had dragged into the yard.

Health worker: What do you think happens when children put dirty things in their mouths?

Mother D: Well they must swallow some of the dirt.

Health worker: Then their stomachs become dirty and they get diarrhoea. So maybe this is why we see so much diarrhoea when children are teething. Now from what we have just said, do any of you have ideas on how to prevent diarrhoea?

The discussion continues with mothers giving suggestions based on their earlier contributions.

Note that the health worker did not criticize the mothers or the beliefs they mentioned. Instead she sought a link between the mothers' ideas and her own knowledge of disease transmission. The mothers were then guided to develop their own conclusions and suggested action.

Source: Brieger, W.R. (1988).

Example: Hygiene Education Plan for School Session in Nepal

LESSON PLAN: HAND WASHING

Objectives:

- The students can explain why we should wash our hands, especially before handling food.
- The students can explain why hands should not be washed with soil.
- The students can mention at least two good alternatives to soil to wash their hands with.
- The students can explain why it is not sufficient always to wash their hands with water only.
- The students are motivated to wash their hands not with soil, but to use ash or soap.

Materials needed:

- These guidelines for the discussion.
- Ash, soap and in case there is no tapstand in the neighbourhood, a container with water.
- The song about hand washing.

Time needed:

- About 3/4 hours for the discussion.
- About 1/4 hour for the practice.

Questions for the discussion:

1. Why do we have to wash our hands?
2. How do our hands get dirty?
3. How often do we have to wash our hands?
4. When do we have to wash our hands?
5. Are your hands clean now? Please show me.
6. What do you use to wash your hands?
7. Who washes his/her hands with soil?
8. Is soil clean or dirty?
9. How does it get dirty?
10. What happens if we get soil in our stomach?
11. What happens if we eat with hands that are not washed at all?
12. What can happen if we eat with hands that are not washed or washed with soil?
13. Can we get sick if we eat with hands that are not washed or washed with soil?
14. What should we use to wash our hands?
15. Is ash clean or dirty?

Example continued

16. Does your mother clean the cooking pot with ash?
17. Do our hands get clean if we wash them with ash?
18. Do our hands get clean if we wash them with soap?
19. Is soap available here?
20. How much does it cost?
21. Do we have to buy ash?
22. If we cannot buy soap, what should we then use to wash our hands?

Practice:

Take the students outside. Select 6 or more students with dirty hands and divide them into three groups. One group should wash their hands with water only, one group with ash and one group with soap. The results have to be shown to everybody and discussed.

Sing and teach the song about hand washing.

Example: Extension Activity of a Project in Zambia

Title: At Home

Subject: Household hygiene practices

Setting: Classroom or village gathering

Duration: children: 15 minutes
adults: 20 minutes

Purpose: To investigate
knowledge of community on hygienic practices

To reinforce
sound practices in and around the home

To acquire
commitment of the men / boys where their assistance
is needed

Presentation: Use set of posters showing good and poor household
hygiene practices. The posters are put on a mat or table so
that everybody can see them. Participants are told that these
posters depict either 'healthy living' or 'living leading to illness'.
The posters are picked up one after another by participants
and described after which they are assigned to either pile.
Sometimes a third pile 'undecided' is needed when people
cannot agree.

The facilitator may decide to emphasize some points brought
up by asking questions, but normally people give quite
convincing explanations without being probed. Often
participants talk themselves into the benefits of having
potracks and latrines. You can then make links to visible
shortcomings in the village in a gentle or joking way.

Source: Zambia, Government of (1987).

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session J

Subject title : JOHARI'S window

Type of session : Roleplay/Lecture

Objectives : To facilitate communication between field workers and community members by creating greater awareness about degree of interpersonal communication.

This session was led by Dr. Tameez Ahmad and supported by HHPs. The main theme of this exercise was to show the participants that various kinds of communication gaps may occur whilst facilitating health and hygiene education sessions in the community. Before lecture to make it more interesting and understandable three types of different activities were designed for the participants. In one activity participants were asked to walk on a zig-zag path without touching the hurdles place in the passage with eyes folded. After this activity the participants were divided into two groups one group was asked to come in the conference room and give health massages, they (HHPs) were asked to pose that the target group is totally ignorant with the specific health messages and hygiene education. In third activity a pair of participant was selected form the whole group with folded eye. In the hands of both participants a piece of paper was given and they were directed to asked from each other about the things that hey have in their hands. The take home message of this exercise was to realize them that which type of people the may find in the community and how they can deal with them. Anther important message from this exercise was that it is very important to health educator and community members that they should know each others feelings, beliefs, values, fears etc.

**Handout : Matrix of JOHARI'S windows
: Adaption of JOHARI's windows**

JOHARI'S² WINDOW

PURPOSE: To facilitate communication between field workers and community members by creating greater awareness about degree of inter-personal communication.

MATRIX OF JOHARI'S WINDOWS

	Known to Self	Not known to self
Known to others	1 Open	2 Blind
Not Known to others	3 Hidden	4 Unknown

² The name JOHARI is derived from the names of two psychologists, Joe Luft and Harry Ingham

Adaptation of Johari's Window



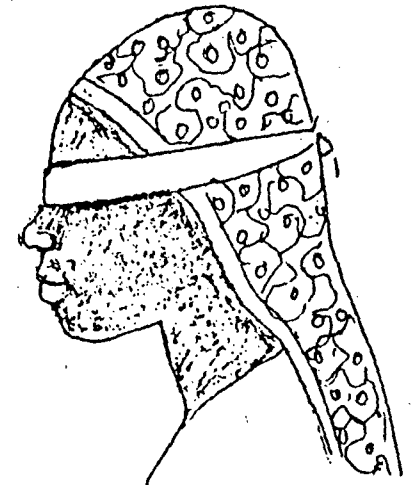
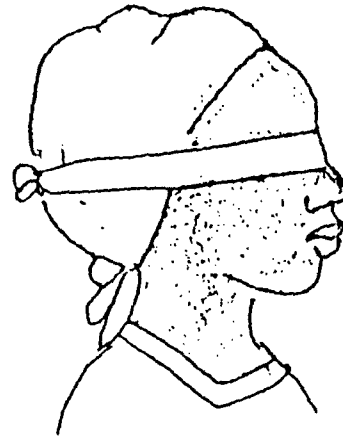
Open



Blind



Hidden



Unknown

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session K

Subject title : Influencing traditional beliefs towards diseases

Type of session : Debate

Objectives :How to influence the traditional beliefs of the communities towards preventable diseases so as to enhance the adoption of healthier behaviors.

This session was conducted by Dr. Tameez Ahmad. He asked the participants to form two groups debate in favor and against the issues. Two main issues were given for discussion 1. Can evil sight be a cause of disease? and 2. Who is responsible for high prevalence of water and sanitation diseases (i.e., preventable diseases): human or super natural forces? The participants were asked to come up with arguments on the given issues. All participants showed great interest and participated tremendously. After this activity Dr. Tameez elaborated the difference between the accidental and natural death. He maintained that we could avoid accidental deaths by taking preventative and curative measures. For example, if a kid has cholera and he is taken to the traditional religious person for casting spells as a treatment instead of hospital then the chance of possible death may increase drastically and in the case of death it would be injustice to attribute this to predestination or fate as the real treatment this kid needed was chemotherapy. This kind of death can be included in the category of accidental death as the environmental and human factors contributed to this. As per Quranic teachings it is possible to save human life and vice versa killing of a person. He further explained, let us assume that we put small kids (1-2 years) on the roof of this hotel and leave them alone without being taking care of than what will happen, certainly children will crawl and some will fall down form the roof and will die of. Who will be responsible for their death, a supper natural forces or we? He also gave many other interesting examples to make it clear that how can we change the traditional beliefs of the target group towards water and sanitation related diseases. At the end of this session all participants were strongly convinced that the risk of getting preventable diseases or deaths resulting from it could be minimized by following medically accepted preventive or curative measures.

Handouts

Characteristics of Natural and Accidental Deaths.

Major Characteristics of Natural Death

1. In case of natural deaths, man and environment do not have any role in becoming the causes for the death, and thus the death occurs due to natural failure of the system governing the human body e.g., death due to ageing. Similarly continuous gain of strength from birth to young age and loss of strength afterward till death are also part of natural system.
2. The occurrence of natural death is independent of the locality, degree of development, and availability of facilities i.e., it is more or less same worldwide
3. It cannot be stopped by any means.

Major Characteristic of Accidental Death

1. The causes of accidental deaths stem from human and mechanical errors, and from the environment in which a person lives.
2. The nature of occurrence of accidental deaths is directly related to the degree of preventive measures undertaken to reduce the risk of accidents. This simply means that occurrence of such deaths varies from one place to another, from one country to another, and from one culture to another. The main variables affecting the incidence rate are lack of knowledge, poverty, and absence of practicable legislation to protect human life from possible accidents.
3. By adopting internationally recommended preventive measures, occurrence of accidental deaths can be reduced significantly.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session L

Subject title : Community Health Intervention Programme (CHIP)

Type of session : Introduction/ Presentation by HHPs

Objectives : To share the components and strategies of CHIP, to define different ways of presenting health and hygiene education messages

In the beginning of this session Dr. Tameez presented the objectives of the CHIP programme to the participants and explained different phases and methods adopted during CHIP sessions in the community. He also mentioned different topics and methodologies on CHIP education sessions to the participants. Later on HHPs presented the materials to the participants on five different topics i.e. Latrine promotion, Diarrhoea, Worms, O&M of water supply scheme and safe water. They demonstrated that how they use these printed material in communities to convey health and hygiene education.

Handouts : None

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session M

Subject title : Microteaching

Type of session : Group Assignments & Presentations

Objectives : To enhance the basic skills of the participants regarding health and hygiene education

In this session the participants were divided into six groups, one HHP of WASEP was assigned as group leader to facilitate that group on the given topic. The topics given to each group were included diarrhoea, clean hands, worms, safe water, safe food and latrine promotion. Each group was asked to prepare a story on the given topic with the help of material provided by WASEP. After given time each group was asked to made presentation on the given topic.

Handouts : None

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session N

Subject title School Health Intervention Programme (SHIP)

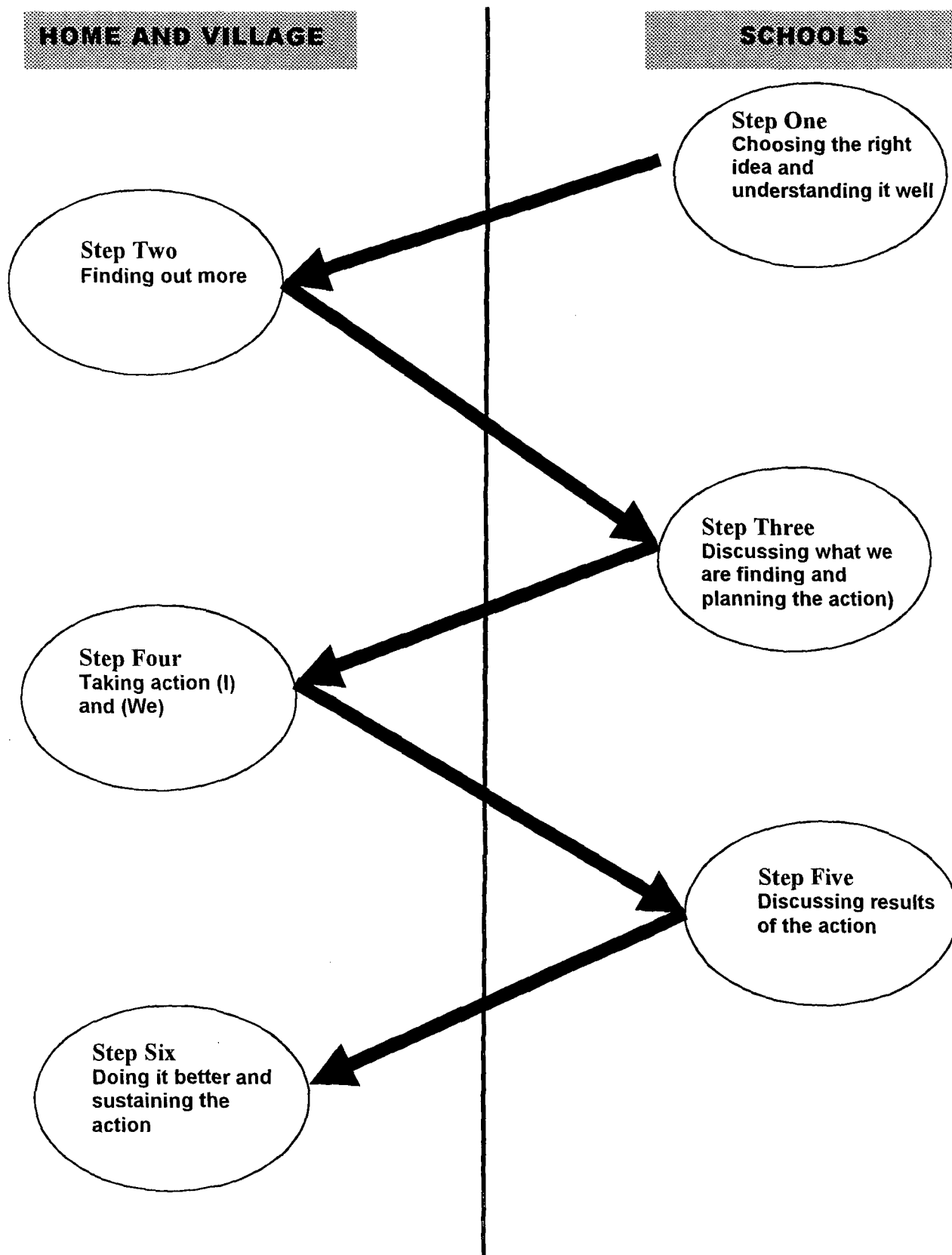
Type of session Presentation/ Lecture/Discussion/Video on CHIP & SHIP

Objectives : To familiarize the participants with the SHIP programme of WASEP as to help them to plan and carry out the same activities in their respective organizations

The session was started by a detailed presentation made by Dr. Tameez on the SHIP programme of WASEP. He explained the need of initiating this programme in the partner villages. He maintained that children could be the key actor in changing, enhancing and as well as motivating the other community members including their own family regarding adopting healthier health and hygiene behaviors. He told that currently they are running SHIP 32 schools of the programme area. Later on he showed data on the SHIP activity. He also explained the philosophy of the Child-to-Child (CtC) approach and the six stages involved to the participants by transparencies. After Dr. Tameez session Haider Raza presented the active methods that could be used to gain children attention and to make health and hygiene sessions interesting for children. After tea break an activity was being carried out by the participants to explain the germ theory. A video on CHIP and SHIP activities prepared by WASEP was also shown to the participants. After tea break the participants were divided into six groups and asked to prepare the given topic for delivering health and hygiene education in schools planned already. One WASEP, HHP was selected as a team leader and facilitator for each group. After preparations on the given topic each group was invited to make the presentation on the same. In the meanwhile Dr. Tameez separately discussed the diarrhoeal disease record formats with Water and Sanitation Implementers (WSIs) of the partner villages. At the end of the day discussion was made on next day's field visit of Khanabad and Mayoon for school education.

**Handouts : CtC Approach/sex septs
 : Lesson plans (Application of 6 steps in SHIP)**

Child to Child: Six Step Approach



LESSON PLAN

CLEAN SAFE WATER

School: _____

Village: _____

Class: _____

District: _____

Teaching Times: _____

HHP: _____

Objectives: By the end of this topic children should:

KNOW:

K1) Dirty water is dangerous.

K2) Which diseases can spread through dirty water.

K3) Water can be contaminated at source, when collecting, transporting and when stored

K4) Clear water is NOT clean water.

DO:

D1) Boil water for 20 minutes.

D2) Methods of filtering water.

D3) Choose a safe source.

D4) Keeping storage container clean.

D5) Help younger children understand not to put dirty hands in clean water but to use a ladle.

FEEL:

F1) Concern if they see their younger siblings contaminating water at source or storage.

F2) Reluctant to drink channel water.

F3) Responsible to keep drinking water at home & school clean.

FOOD AND FRUIT HANDLING

Village: _____ # of women _____

Time: _____ District: _____

Session Times: _____ HHP: _____

Objectives: By the end of this topic participants should:

KNOW:

- K1) Food can easily be contaminated by germs, which can make us ill.
- K2) Washing fruits and vegetables does not kill all germs and may introduce new ones if water is not clean.
- K3) The most common way for germs to enter food is through hands, so clean hands are important when eating and preparing food.

DO:

- D1) Wash their hands before eating and after defecating.
- D2) Wash fruits and vegetables with plenty of clean water.
- D3) Keep food at home clean and safe.

FEEL:

- F1) Responsible for protecting family and children from eating dirty food
- F2) Concern about unsafe practices of preparing food
- F3) Pride in keeping food safe and clean

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Friday 26 May

Session O

Subject title : Field visit to Khanabad and Mayoan

Type of session : Practical on SHIP techniques

Objectives : To familirize the participants practically on CHIP and SHIP session in villages; To show the real situation of villages with and without WASEP's intervention

The participants were divided into two major groups. Two groups were asked to conduct the health and hygiene education session in Government primary school whilst the other three groups were sent to DJ school for the same activity. Each group was facilitated by WASEP's HHP. Soon after microteaching activity in schools the same groups were asked to conduct CHIP session with female community members. After lunch break the participants were divided into six groups leading by one HHP to facilitate in field visit to Mayoan. On their return from the field the participants expressed their feelings; they maintained that they feel big difference in both villages i.e. one with WASEP intervention they found the environment was clean, taps were built very well however they felt smell in some TPCL latrines. Regarding SHIP materials they told that all materials were developed keeping in view the local situations and environment, which made it easy to convey the message in an effective and understandable way. They expressed that it would be nice and helpful for them to start the similar activities in their respective villages, if WASEP distribute the required material to other institutions. One of the AKHSP seneior LHV commented that she was very impressed to see the cleanliness of general environment of the Mayoan village, and congratulated WASEP for this change. She further expressed that AKHS health center is working in Khanabad village since the last 12 years but the health and hygiene situation is quite worst as compared to the WASEP village.

Handout : None

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Wednesday 24 May

Session K

Subject title : Influencing traditional beliefs towards diseases

Type of session : Debate

Objectives : How to influence the traditional beliefs of the community, so as to enhance the adoption of new healthier behavior

This session was conducted by Dr. Tameez Ahmad. He asked the participants to form two groups debate in favor and against the issues. Two main issues were given for discussion 1. Can evil sight be a cause of disease? and 2. Who is responsible for disease human or God? The participants were asked to come up with arguments on the given issues. All participants showed great interest and participated tremendously. After this activity Dr. Tameez elaborated the difference in between the accidental and natural death. He maintained that we can avoid from accidental deaths by curing the route causes, for example in one family if a kid has diarrhoea and he is taken to he traditional religious person for treatment instead of hospital and death may be certain. We can not blame this incidence on faith as the real treatment that this kid needs was chemotherapy instead of treated by a religious person. He further explained, lets assume that we put small kids on the roof of this hotel and leave them their alone without taking care off than what will happen, certainly children will crawl and will fall down form the roof and will die off. Who will be responsible for their death, we or a supper natural force? He also gave many other interesting examples to make it clear that how can we change the traditional beliefs of our target groups in the community. At the end to this session all participants were agreed that we could avoid or minimize the risks for death by adopting remedial and required measures.

Handouts : None

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Tuesday 23 May

Session G

Subject title : Influencing Health Behaviours

Type of session : Participatory discussions/Lecture

Objectives **Provision of theoretical background on ways of influencing behavior through hygiene education planning and implementation. To define different stages/phases of planning health and hygiene education programme from identification of specific behavior to out come evaluation: To give participants the idea on the factors that could be influence on a particular behavior. To prioritize and develop the specific messages with respect to the target population to influence the health behaviors.**

Dr. Tameez Ahmad initiated this session by brain storming of the participants on this topic and later on with the help of transparencies explained the variables and stages whilst communicating the health education messages. After discussion he elaborately highlighted the different steps and phases that could be part of an effective health and hygiene education programme to change the existing behaviors. He used flip charts and transparencies and also encouraged the participant's questions.

Handouts **: Influencing health behaviors**
Common traps in hygiene education
Phases in health education planning
Matrix of health behaviors (Green et al, 1980, p.63)
Three categories of factors contributing to health behaviors
Three levels of evaluation in relation to the health education planning framework.
Green's Framework for latrine promotion

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Saturday 27 May

Session P-1

Subject title : Presentations of participating organizations

Type of session : Presentations/Discussions

Objectives : To share the experiences/and working strategies of different participating institutions

This was the last session of the workshop. At the beginning of the session Dr. Tameez showed the participants a couple of slides of health and hygiene status indicators currently being used by WASEP staff to monitor and evaluation of health status of the partner villages. Later on Dr. Karim Alibhoy made a detailed presentation on WASEP's strategies and working style. After WASEP's presentation AKESP, PDC, LB&RD; AKHSP, AKCSP informed the participants about the activities of their institutions. In the last Dr. Tashmin from IED Karachi shared her experiences on Health Action School (HAS) programme activities being carried out in Karachi since the last two years. He also showed a couple of slides on SHIP.

Handouts : None

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

Day: Saturday 27 May

Session P-2

Subject title : Closing ceremony

Type of session : Speeches/ Feedback

Objectives : Certificate distribution

The closing session was started with the recitation of holy verses. After this Dr. Karim Alibhoy welcomed all the participants. Haider Raza presented the objectives and contents of the training programme. Fida Bibi from AKES expressed her feelings that she learnt a lot during this training workshop and hope that as a teacher she can use the knowledge gained here to improve the health and hygiene status of he school going teachers. She also expressed that she felt very proud that now we have the expertise locally to arrange this sort of workshops. Tai Bibi from AKHSP, maintained that this workshop was related to their work, and she is glad that WASEP has initiated to hold such type of workshop with integrated approach. Now we feel that we can work together to improve the quality of life especially the health and hygiene education sector. Shashzadi from AKCSP, told that she learnt a lot from this workshop and expect that in future similar workshop will be organize to enhance the acquired knowledge and skills. Similar feelings were come from other participants. The chairman of Aga Khan Planning and Building Service for Pakistan Mr, Karim Ajanee congratulated WASEP for arranging a successful training workshop. He also mentioned that despite of less cost incurred on health and hygiene education the impact and results coming are quite impressive. Dr. Tameez stressed on the need effective and practical collaboration. He also mentioned valuable data on water and sanitation related diseases. The chief guest, Mr, Mehar Dad expressed that he is quite impressed by the presence of the various institutions i.e. Govt. and NGOs. He mentioned that he hope that the participants of this workshop will now will implement the skills and knowledge in their respective communities. After his speech he distributed the certificates.

HEALTH AND HYGIENE EDUCATION-TRAINING WORKSHOP

WORKSHOP'S FINDINGS

Existing Scenario:

A comparison of WASEP's health and hygiene component (in terms of area focused, methodology of health and hygiene education, flexibility to meet the requirement of different target groups, frequency of hygiene education, monitoring and evaluation of the impact and uniqueness in launching CHIP and SHIP interventions) with other organizations working in the water supply and sanitation sector confirms WASEP's competitive advantages in this field. However it took WASEP one to two years to reach to this level. In order to provide as much information as possible about these components and WASEP's approach to the trainees the training contents were specifically selected and designed. The training sessions exposed trainees to all aspects of health and hygiene education programme. All topics of the training workshop were logically interlinked. Without knowing the health understanding behind a water supply system, such as water and sanitation related diseases and routes of transmissions one can not develop an effective health and hygiene programme. Similarly if one has the knowledge but does not effectively communicate with different target groups one can't get significant improvement in health and hygiene status. Similarly, without knowing the factors governing a given behavior one can not understand the mechanism of behavioral change.

Post workshop outcomes:

- **Multidisciplinary group:**

One of the major problem was the difference of background from one organization to another. In this training workshop we had varying levels of understanding, one group was extremely knowledgeable (i.e AKHSP who had a good background) whilst other side with limited knowledge(i.e AKCSP). Therefore we had to had start from the scratch i.e. the basic terminologies topic-1 of the workshop. After this workshop the participants understood the importance of health and hygiene education. During field visits and training sessions they not only observed others doing hygiene education, but also practically participated. If their relevant organizations provide them with material and other necessary support, they can implement the hygiene education sessions but not monitoring and evaluation. The participants from AKHSP had excellent knowledge of health topics relevant to health and hygiene education, but had limited background on how to develop and implement hygiene education progarmme in schools. They had also been not exposed to monitoring and evaluation techniques of health and hygiene

intervention at the household and community level. All other groups were in between of the two extreme levels.

- **Future role and responsibilities:**

The nature of expected roles and responsibilities were also different. For example AKCSP had no idea of their expected role following the workshop. AKESP participants were also confused. LB&RD participants were very clear of their expected roles and already had interaction with WASEP. They knew the problems they faced and where to go from here. The participants from PDCN after this training workshop have started implementing their hygiene education programme as part of their Whole School Improvement (WSI) programme, they were quite satisfied about their future roles and responsibilities. It is worth mentioning that they have adapted the WASEP approach, used WASEP's materials and have good interaction with WASEP. The participants from WASEP's partner villages (i.e. WSIs) were very clear on their future roles and responsibilities. One of them (WSI from Shiskhat) was found to perform her duty in excellent manner during a recent visit to the village.

Participant feedback:

WASEP has developed a format to judge the feeling of each participant at the training section. The outcome of the questions asked in the format are as follows:

Standard:

38 % of the participants found the workshop standard was good whilst the opinion of other 61% participants the standard of the workshop was excellent.

Interest:

According to 4% of the participants the workshop's content was partially interesting for them, as they didn't have a medical or previous background in health and hygiene. 54% of the participants expressed that the workshop content was interesting for them, whilst for the remaining 42% participants said the workshop content was informative for them.

Relevancy/usefulness:

19% of participants indicated that the topics were partially relevant to their current working designations. 81% participants found the training content fully relevant to their jobs and to fulfill their future needs.

School Health Intervention Programme (SHIP)				
Day 2 Thursday May 24, 2000	14:00-14:10	TA	Background	
	14:10-14:40	TA	CtC Approach/Six Steps	
	14:40-15:10	TA	Application of 6 steps in SHIP/Lesson Plans	
	15:10-15:20	HR	Active Methods	
	15:20-15:30	Tea Break		
	15:30-16:30	HHP/TA	Topic 1: Clean Hands with activity	
	16:30-17:30		Video on SHIP and CHIP	
	17:30-18:00	TA/HR	Preparation for field visit	
	18:00-18:25	TA	Discussion on WSI Format	
	18:25-18:30		Evaluation and feedback	
Day 3 Friday May 26, 2000	Field Visits Followed by Feedback			
Day 4 Saturday May 27, 2000	Last Day			
	8:00-9:00	TA	Monitoring and Evaluation of Hygiene Interventions	
	9:00-9:40	KA	Presentations: <ul style="list-style-type: none"> • WASEP • AKESP 	
	9:40-10:00			
	10:10-10:15			Tea Break
	10:15-10:35			
	10:35-10:55			
	11:00-11:30			
	11:30-11:55	TK	<ul style="list-style-type: none"> • PDC • LB&RD • AKHSP • AKCSP • IED (Karachi) on HAS 	
	12:00-13:00			
	13:00-14:00	Lunch Break		
	14:00-14:30	HR/TA	Final Evaluation & Rapporteur Report	
	14:30-16:00	KA	Chalking out Strategies for Real Collaboration on Health and Hygiene	
	16:00	Closing Ceremony		

HHPs = Health and Hygiene Promoters

HR = Haider Raza

TA = Dr. Tameez Ahmad

TK = Dr. Tashmin Khamis

KA = Dr. Karim Alibhoy