

# WaterAid's hygiene response to COVID-19

Programmatic  
technical  
learning brief

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# Contents

	<b>Executive summary</b>	<b>4</b>
<b>1</b>	<b>Introduction</b>	<b>6</b>
	Our phased approach	6
	Our scale and expertise	7
	Our overall expected outcomes	7
	Our focused behaviours	7
	Theory of Change	8
	Motives for our hygiene promotion campaign	9
	Rapid application Behaviour Centred Design approach	10
	Initial rapid assessment of context	11
	Previous research used to gain insight	11
	Designing innovative hygiene intervention packages and assets	12
<i>Developing creative and innovation hygiene intervention campaigns</i>	12	
Recommendations and learning from designing COVID-19 programmes	13	
<b>2</b>	<b>Innovative hygiene response</b>	<b>15</b>
	Implementing innovative hygiene response in multiple countries	15
	Our innovations in COVID-19 hygiene response	17
	Hygiene at scale	17
	<i>Hygiene at national and sub-national scale using non-contact methods</i>	17
	Mass media	18
	Radio and FMs	19
	Non-contact methods	19
	COVID-19 sensitive community-based hygiene campaigns	21
	Hygiene integration – health, immunisation, schools, workplaces and the private sector	25
	Hygiene integration in COVID-19 vaccinations	27
<b>3</b>	<b>Handwashing facilities</b>	<b>29</b>
	Innovative handwashing facilities in public places and institutions	29
	Innovation in handwashing facility design	29
	Construction, maintenance and sustainability	31

<b>4</b>	<b>Monitoring and evaluation</b>	<b>32</b>
	Methodology	33
	Mid-term Rapid Assessment (MTRA) and its results	34
	Reported barriers to practising key hygiene behaviours	35
	Conclusions and recommendations from MTRA	36
	Utilisation of MTRA findings and way forward	37
Ongoing monitoring	37	
<b>5</b>	<b>Partnerships, collaboration and sector coordination</b>	<b>38</b>
	Examples of various partnerships and joint initiatives	38
<b>6</b>	<b>Challenges and making hygiene responses sustainable</b>	<b>40</b>
	Challenges	40
	Sustainability	41
<b>7</b>	<b>Overall learnings and recommendations to build resilience and pandemic preparedness</b>	<b>42</b>
	What did and did not work well?	42
	From failure to success and lessons learned	44
	Building resilience and pandemic preparedness	44
	Final recommendations and learnings	45
	Where to focus in the future?	46



Students at a school in Zambia wash their hands with soap.

# Executive summary



◀ Working with sub-national government and WaterShed Ventures, images and reminders of key behaviours are placed in COVID-19 affected communities in Kampong Chhnang province, Cambodia. July 2021.

The COVID-19 global pandemic has been a monumental public health emergency, creating high levels of public anxiety and devastating impacts on people's health, education and livelihoods. Frequent and thorough handwashing with soap and water, together with wearing masks and maintaining physical distancing, have been the most effective ways to prevent the spread of COVID-19, and other infectious diseases.

It was evident throughout the pandemic that hygiene behaviour change is critical in all settings. Governments and partners should not wait for another health crisis to invest and promote hygiene behaviours at scale together with the COVID-19 vaccine.

Over the past year, we have been leveraging our ongoing hygiene behaviour change programmes across Asia, Africa and Latin America to respond to COVID-19, primarily focusing on **hygiene behaviour change** – including handwashing with soap.

We proactively scaled-up our hygiene behaviour change work through government-led mechanisms in 26 countries.

We rapidly applied a behaviour centred design (BCD) approach and targeted behaviours that are sensitive to prevent the spread of disease, including hand hygiene.

We re-activated our creative process to generate emotional assets and exciting promotional packages to reduce campaign fatigue – using them to repeatedly expose targeted populations multiple times.

Our branded and trusted **hygiene campaigns** reached 181 million people, distributed 1.8 million hygiene products, including soaps and sanitisers, and delivered 2,700 large-scale innovative handwashing facilities in key public places.

We have contributed to sectoral coordination mechanism through water, sanitation and hygiene (WASH) and health clusters, and through various international platforms including the Hand Hygiene for All (**HH4A**) initiative.

Our response to COVID-19 was on a wide scale, and we continue to respond by implementing COVID-19 sensitive hygiene behaviour change programmes – embedding key COVID-19 learnings and behaviour change principles:

These are the key **COVID-19 principles** to follow when implementing hygiene programmes:

- Clear **Theory of Change (ToC)** and process for design and implementation.
- **Focusing on key behaviours, behaviour change** is central to the response of health crises.
- **Integration** is key to improve programmes and reach larger numbers of people.
- A **system strengthening** approach should be followed.
- **Handwashing facilities** to be innovative in design and provision should have clear operation and maintenance plan.
- **Sustainability** must be the heart of the programme.
- **Equality and inclusion** to be imbedded from the start.
- **Monitoring and evaluation (M&E)** are key for long-term success.

**Behaviour change principles** can be followed, even during an emergency hygiene response:

- Campaigns should be evidence-based and backed by science.
- The focus should be on people's emotions, motivation, and changing behavioural settings and social norms.
- Ensure high exposure, high intensity and maintain fidelity.
- Hygiene response to be trusted and progressive to avoid campaign fatigue.
- Focus on inclusivity and sustainability.
- Think big, act at scale and ensure long-term financing.



This technical learning brief was produced for country programmes, technical staff, partners and donors, and relevant stakeholders to outline our at-scale implementation and learnings from our hygiene response to COVID-19.

**Our hygiene response**  
We have produced a range of **learnings**, technical **guides**, **case studies**, multiple **blogs**, and a 2-minute **video documentary** linked to our hygiene response.

◀ We worked with with sub-national government and WaterShed Ventures to provide hygiene materials to protect communities against COVID-19 in Kampong Chhnang province, Cambodia. July 2021.

# 1 Introduction

The COVID-19 global pandemic has been a public health emergency of international concern and continues to threaten our global community. Governments struggled to contain and respond to this challenge, which threatens to undo decades of progress on poverty, healthcare and education.<sup>1</sup> Never has good hygiene, alongside the water and sanitation services that support it, been more critical. Even with the vaccines being rolled out, there is huge disparities<sup>2</sup> in accessing them – especially in low-income countries. As the pandemic continues to escalate, the countries with fragile health systems are most at risk. We are continuing to promote hygiene behaviour change across the countries where we work to keep people safe and prevent the spread of COVID-19.

As leaders in the water, sanitation and hygiene (WASH) sector, we have always promoted handwashing with soap and water as part of our ongoing behaviour change programming. In-line with the epidemiological evidence and recommended preventive measures, we have positioned and promoted key hygiene behaviours including handwashing with soap, wearing a mask and maintaining physical distance to prevent the spread of COVID-19. We proactively scaled-up our hygiene behaviour change work through government-led mechanisms, using safe and appropriate modes of communication and adapted it with the aim of changing behaviours to contribute towards controlling and preventing the spread of COVID-19 in 26 countries. As we continue responding and move into the 'new normal' we are using experience, research and lessons learned to shape a 'COVID-sensitive' way of working on hygiene behaviour change.

This learning brief is for country programme, technical staff, partners, donors and relevant stakeholders, and outlines our approach to designing evidence-based interventions, our hygiene behaviour change response to COVID-19 and innovations over the past 18 months. Through this we will touch on lessons learned and key recommendations based on our experience.

## Our phased approach

Due to the dynamic nature of the coronavirus transmission, we took a **phased approach to respond** to the diverse needs of the countries we targeted initially. The first phase of our response focused on promoting key hygiene behaviours – such as handwashing with soap, covering the mouth and nose when coughing or sneezing, wearing a mask in public places, cleaning and disinfecting frequently touched surfaces and maintaining physical distance – to help reduce the risk of transmission in all 26 countries where we work.

We used 'do no harm' principles by ensuring our actions did not compromise safety or negatively impact on some groups of the population. First, we focused on using social, digital, mass media and non-contact methods to promote hygiene behaviours, in addition to installing handwashing facilities in public locations. Later, in our second phase, we also supported our community-based hygiene behaviour change campaigns for sustained hygiene outcomes and making these COVID-19 sensitive.

## Learning throughout our response

Originally, we put relatively equal weight on all hygiene behaviours, such as handwashing with soap, mask wearing, cleaning frequently touched surfaces and maintaining physical distancing.

Later, with emerging data, we recognised that while all were necessary, respiratory factors were a bigger driver of disease, therefore we put greater emphasis on respiratory hygiene behaviours (wearing a mask) together with handwashing with soap and physical distancing.

## Our scale and expertise

We have many years of expertise in implementing at-scale hygiene behaviour change programmes using an evidence-based, BCD approach. Drawing on those strengths, expertise, on the ground presence and government partnerships, we developed context-specific programmes that will lead to long term behaviour change in communities. COVID-19 changed the way we initially promoted hygiene, and while mass media was very new to the way we work, our country programmes were able to rise to the challenge.

As of April 2021, our hygiene behaviour change response to COVID-19 reached 181 million people through mass media and 3.2 million more through community-based intervention. We have distributed 1.8 million hygiene products, including soaps, sanitisers and menstrual hygiene products in schools, healthcare facilities, households and parts of the population that are facing marginalisation, and installed 2,700 large-scale handwashing facilities in key public places.



## Our overall expected outcomes

Our hygiene response to COVID-19 will achieve the following:

- Improved awareness and adoption of COVID-19 preventative hygiene behaviours.
- Improved access to handwashing facilities in public places and institutions.
- Contribute to WASH sector coordination for COVID-19 response.
- Contribute to reducing the spread of COVID-19 – secondary outcome (not attributable).
- Share institutional learning from our hygiene response to COVID-19 internally and externally.

## Our focused behaviours

### Primary behaviours:

- **Handwashing with soap:** Frequently and thoroughly washing both hands with soap and water for at least 20 seconds and/or using alcohol-based hand rub. Handwashing should be practised before eating and feeding; after defecation and handling child faeces; after exposure with any dirt/dust/fluids; after taking care of a sick person; after coming into contact with frequently touched surfaces, and before and after touching the nose/face.
- **Respiratory hygiene (wearing a mask):** Wearing a mask in public places. Covering the nose and mouth when coughing and sneezing (sneezing or coughing into the elbow and disposing of the tissue into a bin if it has been used) to be followed by handwashing with soap.
- **Physical distancing:** Avoid close contact and maintain two metre (one metre in some countries) distance between yourself and other people. Maintain physical distancing, such as avoiding group gatherings, reducing all non-essential travel and using non-contact greetings.

### Secondary behaviours:

- **Surface cleanliness:** Cleaning and disinfecting frequently touched surfaces regularly, such as door handles, mobile phones and light switches, using disinfectant.
- **Isolate/referral:** Stay at home if you feel unwell. If you have coronavirus symptoms (high fever, new continuous cough, difficulty breathing or loss of taste and smell) seek medical attention in advance. Follow your Ministry of Health's advice.

**Note:** Where we have implemented community-based hygiene intervention part of the ongoing COVID-19 hygiene response, in addition to above, we have also included our regularly promoted behaviours, including water treatment, safe use of toilets, food hygiene and menstrual hygiene as part of the full package.

We prioritise and promote behaviours based on disease epidemiology, WHO recommendations and our institutional focus. Throughout the pandemic, we have consistently realigned the key behaviours of focus based on WHO, Centres for Disease Control and Prevention (CDC) and the UK government's advice.

**Learning throughout our response**  
 Our focus and emphasis on primary behaviours increased due to data findings on the effectiveness of certain behaviours. For example, we learned the need to shift from focusing on mass media promotion to all people, to an emphasis on at-risk populations, such as older people, excluded groups, people who are immunocompromised and people with disabilities.

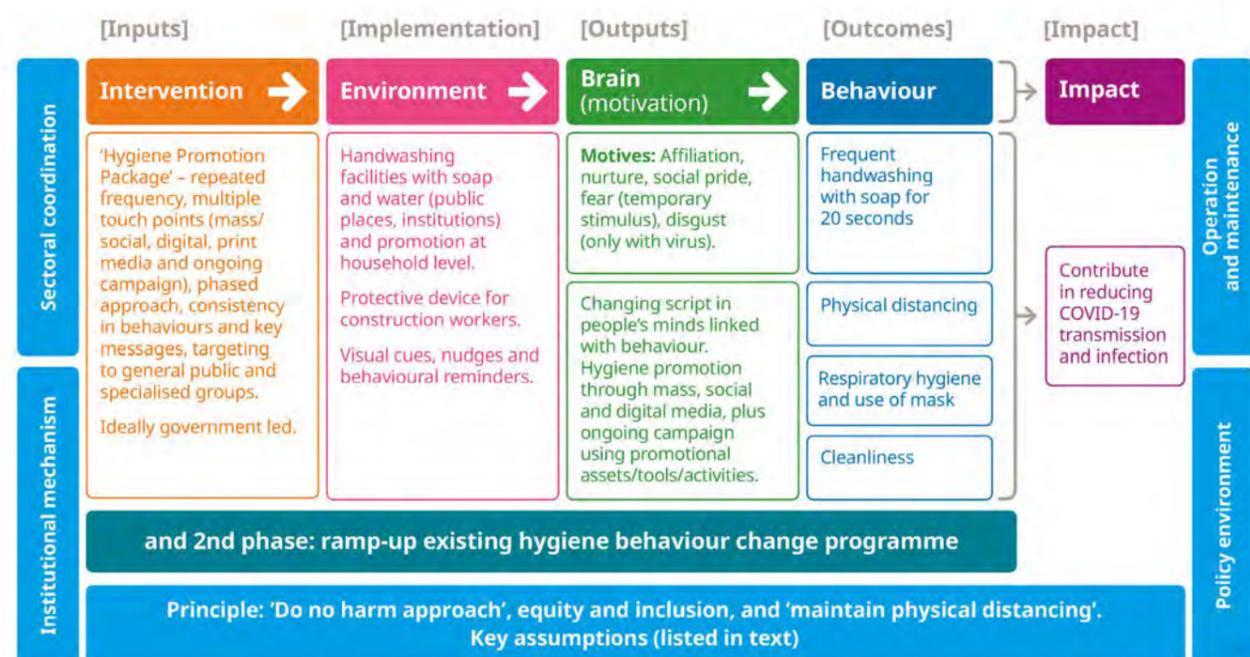
Our hygiene behaviour change intervention package inspires people by changing their thinking on a sub-conscious level. It motivates people to practise key preventative behaviours, changing the environment where the behaviour happens through the placement of behavioural products, such as handwashing facilities, visual cues and nudges to reinforce behaviours – along with changing social norms linked with specific behaviours for habit formation.

At WaterAid, we use a **Behaviour Centred Design (BCD)** framework to design hygiene behaviour change interventions. This follows a five-step process; Assess, Build, Create, Deliver, Evaluate (ABCDE) and focuses on behaviour change. The approach encompasses a Theory of Change (ToC), a suite of behavioural determinants and a programme design process.

Our ToC, derived from the BCD model, focuses on contributing to the improvement of the state-of-the-world (e.g., health, dignity and suppressing COVID-19). This is carried out through the design and implementation of a hygiene intervention that produces changes in the environment, which then causes changes in the sub-conscious of the target audience and leads to desired behaviours. Our COVID-19 hygiene intervention package was developed using a simplified BCD approach as shown in the following diagram.

### Theory of Change

Building on previous experience from our hygiene behaviour change campaigns in multiple countries, our in-house expertise on behaviour change, and what we know about behaviour during outbreaks,<sup>3</sup> we are focusing on changing key behaviours to help reduce the spread of COVID-19.



**Environment: Environmental settings** (physical, social and biological) determine behaviours. Changing the settings<sup>4</sup> where behaviour happens is therefore vital for behaviour change because the environment controls the majority of human behaviours. Much of human behaviour is regulated by the environmental choice architecture, where the physical space is arranged to unconsciously guide you to doing the behaviour.<sup>5</sup>

This is true of availability of behaviour change products in behavioural places<sup>6</sup> – such as availability of handwashing facilities with soap and water in public locations, along with visual cues and reminders on how to practise good hygiene. Dependent of the interventions used in the different settings, these cues and changes to the environment will add social value to the act of washing hands and make handwashing

something that is desirable, and these cues/nudges are being used to encourage and reinforce behaviours to fight COVID-19.

**Brain:** We know 'fear of getting coronavirus' initially acts as a stimulus<sup>7</sup> for people to practise handwashing and to use hygiene products such as soap. However, based on past experience and evidence,<sup>8</sup> we know this is only a temporary trigger/stimulus and when the threat of the virus leaves, so will the behaviours.

Where possible, we consider motivational drivers<sup>9</sup> and emotions that will change people's mindset and behaviours in the long-term as part of the intervention design process to make emotive and motivational content. Some examples of motives we have used part of the response are shown below.

### Motives for our hygiene promotion campaign

Motives	Definition	Application
<b>Affiliation</b>	The desire to be more like those around us.	Bringing a sense of belonging and solidarity in the home and in society by practising key behaviours to reduce the spread of COVID-19.
<b>Fear</b>	The internal process of moving yourself away from negative consequences or life-endangering behaviours.	Dirty hands and frequently touched surfaces can contain the virus. Washing hands removes the virus and wearing a mask and maintaining physical distancing can prevent you from getting the virus.
<b>Pride</b>	Feeling pleasure or satisfaction for one's achievements after practising behaviours.	Minimising the transmission of COVID-19 by practising key behaviours will be seen as collective pride in communities and nations.
<b>Nurture</b>	Setting a good example for children, protecting those that you love by practising behaviours.	Practising key behaviours will protect family, loved ones including children, community and the nation from COVID-19.
<b>Disgust (linked only with virus)</b>	A strong and visceral emotion that can engage behavioural response. Can help protect against infectious disease.	COVID-19 is a disgusting virus. Through droplets, they might land in our hands and in the environment, so let's clean them responsibly.
<b>Social status</b>	Desire to improve social standing and to be valued in society.	Practising key hygiene behaviours is all about respecting others and those who practise behaviours in the community are seen as role models and respected by others, which helps reduce COVID-19.

## Rapid application of BCD approach

Our experience developing and implementing hygiene behaviour change programmes and our strong grasp of the BCD<sup>10</sup> approach and its methodology, enables us to identify the most effective interventions, targeting the most influential motives for each of the settings. Additionally, we build the capacity of stakeholders including government, partners, public institutions and civil society.

Even during COVID-19, we have broadly used an evidence-based theoretical framework to design and implement our hygiene response as demonstrated below.

▶ WaterAid Nepal developed an illustration to promote physical distancing and mask wearing.



A	<b>Assess:</b> Contextual analysis/initial rapid assessment, defined design principles and target behaviours to find out what is already known on key behaviours.
B	<b>Build:</b> Defined ToC, identified behavioural determinants including motives, key barriers to practise behaviours, explored and agreed on key touchpoints (delivery channels).
C	<b>Create:</b> Worked with creative team, reviewed and re-designed comprehensive package materials/tools/assets in progressive order. Emphasis given to make trusted branded assets, emotive content and innovative, surprising activities/materials/assets and evidence-based campaign. Also developed handwashing facilities design, with an emphasis on hands-free and inclusivity working with experts and users to ensure that our communications and infrastructure are inclusive for all people.
D	<b>Deliver:</b> Implemented hygiene response to COVID-19 to repeatedly expose target population through mass, digital, social media, non-contact methods, installed handwashing facilities, ramped-up COVID-19 sensitive community-based hygiene campaigns and strengthen sector coordination. The scale of the implementation varies by countries based on the available resources.
E	<b>Evaluate:</b> Due to nature of the emergency response, we didn't conduct baseline evaluations, and instead carried out a mid-term rapid assessment (MTRA) in eight countries to learn and make the campaign progressive. Ongoing supportive supervision and monitoring was done, and learning was extracted from countries in various forms (case studies, learning brief and videos).

## Initial rapid assessment of context

Responding to COVID-19 required a rapid response, therefore **assessing** the situation and conducting **formative research** had to be adapted and streamlined. Previous research and rapid assessments and situational analysis were conducted to help provide information. Some examples include:

Assessment	Purpose	Key findings/actions
An assessment of handwashing promotion in South Asia during COVID-19	Are interventions reaching everyone, consistently understood and achievable?	Overall reach of mass media is high, key behaviours for COVID-19 prevention are clear, and most people know about the importance of handwashing with soap and water.  Identified gaps include awareness for critical times to protect against COVID-19 are low.  Many vulnerable people face challenges in accessing a reliable water supply and affordable soap. Key motives to practise handwashing identified.  Handwashing facilities in public places either do not exist or are not functional.
Rapid COVID-19 vulnerability assessment in Lusaka, Zambia	Worked with Ministry of Health to conduct rapid COVID-19 vulnerability assessment in Lusaka, Zambia to identify hotspots, gaps and targets for interventions.	Need to increase and prioritise investment in WASH services.  Need to scale up promotion of key behaviours in communities. Key barriers and motives identified.  Ensure coordinated multi sectoral efforts in the response to the pandemic.
MTRA conducted in eight countries	The aim was to assess uptake of key COVID-19 behaviours, norms, barriers, motivations, preferred touchpoints, sector coordination and functionality of handwashing facilities.	Campaigns had a high reach, touchpoint preference varied based on disability and age, campaign had high impact all across four behaviours including handwashing with soap before eating and after defecation. Some COVID-19 specific critical times for handwashing were low.  Insights and learning were used and adapted based on country context and incorporated into ongoing campaigns.
Ensuring gender equitable and inclusive access to WASH in the COVID-19 emergency response – East Africa	Provide evidence and highlight examples of what is needed in gender-responsive WASH programming in emergencies and give a snapshot of the direct impact of COVID-19 on women, girls and people with disabilities concerning WASH access.	Insights are being used to shape policy and practice, building alliances and allocating proper funding. Learning that without commitment at the beginning and the right partnerships, gender-responsive and inclusive programming was harder to incorporate consistently. In places where good partnerships already existed there were more examples of inclusive approaches.

## Previous research used to gain insight

Motives	Definition	Application
Regional state of hygiene – West Africa	Assess institutional arrangements in countries regarding hygiene promotion, availability of national hygiene policies, bottlenecks in key policies and programmes and motivation factors for government to invest in hygiene.	Proportion of people with access to adequate handwashing facilities is low. Low political commitment and very limited financing. Decision making is coordinated differently across the region.
Regional state of hygiene – Southern Africa	Assess terms of practice and policy inclusion of each of the five key hygiene components and main bottlenecks in the enabling environment for hygiene.	Handwashing access in the region is low, especially among rural populations and key bottlenecks such as inconsistent policy inclusion and limited data means there is no champion for greater inclusion of hygiene.
Previous formative research in 17 countries based on WaterAid's ongoing hygiene programmes – country-specific formative research reports	To understand status of the behaviours and their determinants, key motives, barriers, touchpoints focusing on multiple behaviours, including handwashing with soap.	Relevant behavioural determinants including motives for handwashing with soap, barriers identified, key touchpoints considered while designing the intervention.

## Designing innovative hygiene intervention packages and assets

### Developing creative and innovative hygiene intervention campaigns

We know from experience and previous evidence<sup>11,12</sup> that simply sharing knowledge of good hygiene behaviours rarely results in sustained behaviour change. So instead, we design hygiene behaviour change intervention packages based on evidence to motivate people, by understanding what they care about and their social norms.

We usually spend time learning from the community as part of our **formative research** process. This was adapted due to COVID-19, so we relied on previous formative research and rapid assessment surveys during COVID-19 period. Formative research is key as it helps to understand more about the lives of the target

groups, fill in information gaps, understand what barriers need to be addressed and which motives will work best.

When developing assets and behaviour change package materials, we worked with a multidisciplinary team, including design experts, behaviour change scientists, media/social media teams, artists, script writers, implementors and the target population, as part of the creative process. We extract findings from our initial assessment and turn this into insights (an appealing story), which includes the behaviour we want to change, the people we want to influence and the motives to encourage lasting change. Based on the insights, we have developed various, engaging, innovative and emotive (yet trusted) assets, activities and promotional package materials to promote the behaviour change. More insights on this is given in the next chapter.

▶ A health worker conducts a hygiene promotion session in Nepal.



This is linked together under a unifying concept, which allows the target audience to identify with the campaign and recall its benefits/motives linked to specific behaviours – helping to unite the different elements of an intervention.

We have an umbrella brand for the campaign based on our existing hygiene campaigns in many countries to accommodate multiple behaviours, targeting numerous settings such as households, communities, schools, healthcare facilities, public places and the workplace.

## Recommendations and learning from designing COVID-19 programmes

<b>Use a Theory of Change</b>	Having an explicit Theory of Change helps to clearly define pathways in which change occurs and allows you to define assumptions about cause-effect relationships between programme activities and behaviour change, and the operational/logistical expectations. Country-level ToC should then be developed for the specific context.
<b>Establish design principles</b>	The key to a well-designed and functioning programme is clearly defined behaviours, target group and settings, length of campaign, delivery channel, frequency of exposure, who and how it will be implemented, and how collaboration will be established.
<b>Target disease-sensitive behaviours in emergencies</b>	Throughout the pandemic, we have closely monitored the COVID-19 disease epidemiology, new/emerging evidence and only targeted disease-sensitive behaviours, such as washing hands, wearing a mask and physical distancing. While we have always promoted handwashing with soap, the other behaviours were new. We have continued to promote all five COVID-19 sensitive behaviours to have wider impact and to ensure our response was disease-sensitive.
<b>Learn from evidence and experience</b>	Interventions should always be based on evidence and previous experience. Reflect on what worked and didn't work in the past and use experiences that have been successful. Initially, with COVID-19 there was not much evidence available. However, now a lot of data, research and case studies exist which we have used to inform and adapt programmes.
<b>Make target behaviour aspirational</b>	All the promotional activities/assets should focus on behaviours and link to benefits and key motivation. Link target behaviour with motivational drivers so that people will aspire to practise key behaviours.

Motives such as nurture and affiliation will lead to sustained behaviour change than that of just fear alone. While people report handwashing with soap protects against COVID-19, they also stated they felt a sense of pride, attractiveness and cleanliness.

**Draw on a diverse team to help develop a creative intervention**

Creativity is hard to package into a simple process, but it is vital if programmes are to be engaging, motivating and context-specific, even during an emergency response. This can range from hiring a creative team (multidisciplinary team with multiple skill sets), including agencies, to working with subject experts, artists and creatives in the local community and representatives of hard to reach groups, or often excluded groups. The result of the creative process is a package of surprising, attractive and disruptive intervention materials/assets designed to have maximum effect on the target behaviour.

Ideally, it is best to have in-person workshops during a creative process. However, this can still be conducted virtually, or in a safe and physically distanced manner as long as proper planning is in place with the correct people. Use of diverse and influential characters in the package materials is important while targeting mass population. Trust is important. For example, when using mass media-focused intervention in the first phase, the use of celebrities and influencers was key.

**Be inclusive**

Recognise that people who are marginalised are likely to be missed out by mainstream key hygiene interventions unless you make sure it speaks to a diverse audience in different settings. Ensure the promotional campaign assets, materials and facilities are inclusive (representative and addressing the needs of different parts of the population, such as people living with disabilities, carers, etc.) and are visually appealing to all. Always be intentional to use an **Equality and Inclusion (E&I) framework** from the design phase to ensure the hygiene response is inclusive.

Initially, teams focused on quickly responding with hygiene promotion and making handwashing facilities available. Accessibility audits for handwashing facilities were conducted in hindsight and we realised material might not be best suited for all segments of the population. Furthermore, once evidence showed older people and the immunocompromised were more at risk, we **shifted to target that population**. Additionally, pandemics and health emergencies such as COVID-19 quickly showed that the burden of care and impact was unevenly distributed on women. Therefore it was important that materials and messages emphasised and promoted equal responsibility for measures such as handwashing and collecting water. Having relationships in place with Disabled People's Organisations (DPOs) and a set of inclusive, accessible design/assets can help ensure emergency responses are inclusive and can rapidly implement the intervention.

**Aim for a high level of exposure and reach with progressive assets**

It is important to expose people multiple times to the hygiene intervention, ensuring it reaches a significant number of the target population with repeated frequencies - helping change and reinforce the key behaviours and create social desire for new norms. It is also important to create assets that are progressive and engaging to help avoid campaign fatigue and saturation.

During the design phase, consider developing multiple activities/assets. Conduct an assessment to find out what touchpoints people prefer, what people are being exposed to, how this can help to reach the wider population, and understand who might be missed through the intervention. Based on evidence and context as this can change quickly in an emergency situation.

**Programmes should be designed to be multi-phased and based on evidence**

Due to the dynamic nature of COVID-19 and changing evidence, it was clear that the response needed to be flexible and adaptable. At the same time, behaviour change is an evolving process. Having a phased approach allowed us to tailor hygiene behaviour change programmes to each country context, to navigate and adapt to changing lockdown restrictions and support behaviour shifts.

# 2 Innovative hygiene response

## Implementing innovative hygiene response in multiple countries

We have implemented hygiene response to COVID-19 in 26 countries. The scale of the response varies from large national scale campaigns in 12 countries and smaller sub-national/district level in 14 countries.

When delivering hygiene response to COVID-19 campaigns, we target multiple settings, such as households, education (schools, informal learning centres), healthcare (local facilities, hospitals, care homes), public settings/workplace (markets, bus/rail stations, factories), and institutions (government and other health decision makers).

We put our intervention into action in these settings by using at least two or three different modalities or methods. Broadly, we utilised a two-phased approach, starting with mass, digital, social media, non-contact methods, and installing handwashing facilities followed by ramping-up community-based campaigns.



▲ Okyeame Kwame, a celebrity in Ghana, demonstrates how to properly wash hands at key moments.

◀ Hygiene promoters conduct a promotion session in Zambia.

▼ An infographic developed by WaterAid Ethiopia to remind people to wash hands.



Implementation modalities	Example
<p><b>Campaign modality:</b> Begin the campaign on a large scale (nationwide, district-wide, city-wide, region-/province-wide) to reach a larger number of people in a set timeframe.</p>	<p>We used campaign modalities in all countries, using mass media-focused interventions targeting the wider population at the beginning of the COVID-19 response. This involved exposing the wider population intensively within set period of time (for example, India conducted a hygiene behaviour change campaign over eight days in seven languages and other countries have done similar campaigns over several months).</p> <p>We worked with partner organisations, media outlets, community groups and other key stakeholders to promote the campaigns and encourage good hygiene behaviour change to prevent the spread of COVID-19.</p>
<p><b>Mainstreaming modality:</b> Combine campaigns with water supply and sanitation programmes for the most benefits.</p>	<p>We wanted to have a bigger impact by linking our COVID-19 response to national WASH behaviour change and hoped that the short-term COVID-19 work would lead to better long-term WASH behaviour change packages and capacities. For example, WaterAid Ethiopia worked with the Ministry of Irrigation and Energy and Ministry of Health to support the national TSEDU (Total Sanitation to End Open Defecation and Urination) campaign, Pakistan used the <b>Clean Green Pakistan</b> Campaign, Zambia used <b>Kutuba Campaign</b> and eSwatini used the Halentaka campaign).</p> <p>Mainstreaming campaigns also focus on community-based promotion, while still adhering to COVID-19 measures. Through this approach, we have reached 3.2 million people multiple times.</p>
<p><b>Integration modality:</b> Use of ongoing routine health (immunisation, child health), nutrition and education programme to integrate hygiene in order to make sure change is lasting and behaviours are reinforced to those accessing the services.</p>	<p>We integrated COVID-19 campaigns, such as combining hygiene into the existing immunisation programme (routine and COVID-19 vaccination), healthcare facilities, private sector programmes (workplace) and education programmes. For example, WaterAid Nepal's ongoing nationwide hygiene integration into the routine immunisation programme, merged COVID-19 preventive behaviours with the existing work.</p> <p>We have been supporting the government's <b>'Hygiene promotion through routine immunisation'</b> and when COVID-19 hit, we were able to quickly respond and integrate relevant key behaviours into the hygiene sessions, such as wearing a mask and maintaining physical distance. Additional materials (such as 650,000 visual reminder stickers for behaviours and 10,000 flip charts) were produced for health workers to use during hygiene sessions throughout the country. These materials were also being used during COVID-19 vaccinations.</p> <p>WaterAid South Africa developed a series of visual hygiene assets to broadcast using mobile trucks in COVID-19 vaccination clinics. Few other countries are supporting the national government to integrate hygiene into the COVID-19 vaccination campaigns in order to reinforce preventative behaviours while people are receiving vaccines.</p>

Details of each implementation modalities and actual response are reflected part of the innovation section on the next page.

## Our innovations in COVID-19 hygiene response

To share our innovation, learning and recommendations, we have broken down our hygiene response into the following key themes below:

- **Hygiene at national/sub-national scale** using non-contact methods. This includes hygiene promotion mostly using mass, digital and social media channels. Using influential personalities, such as celebrities, WASH ambassadors, influencers, community leaders, comedians, athletes and music artists in nationally/sub-nationally broadcasted mass/social media assets. Celebrities are also going to remote areas and 'miking' hygiene promotion, using loud-speakers and pictorials and languages that make the messages relevant to a diverse segment of the population to remind and reinforce behaviours.
- **COVID-19 sensitive community-based hygiene behaviour change campaigns.** Conducting face-to-face hygiene promotion in a safe environment using hygiene behaviour change package.
- **Hygiene integration into ongoing programmes.** Integrating hygiene promotion into health, immunisation, COVID-19 vaccination, workplace, schools and the private sector.
- **Hygiene behaviour change technological and product innovation.** Designing innovative handwashing facilities, behaviour change products and hygiene package materials.
- **Monitoring and evaluating** our hygiene programmes and sharing learning. Results from a multi-country MTRA evaluating response and collaboration and coordination at various levels – country, regional and global.
- **Partnerships, collaboration and sector coordination.** Working through partnerships, collaborating with local organisations and improving sector coordination at a global level through key platforms/networks.
- **Making hygiene responses sustainable** beyond the current pandemic. Responding to challenges and ensuring hygiene behaviours and promotion last beyond the pandemic. What went well, what did not go so well, and how to turn failures into success.



▲ Tigalana Fidah, a senior nursing officer, using a handwashing facility in a female-friendly sanitation block at Ndejje Health Centre IV, Makindye Ssabagabo Municipality, Wakiso district, Uganda.

### Hygiene at scale

#### Hygiene at national and sub-national scale using non-contact methods:

Given how COVID-19 spreads, we realised that our usual way of working – gathering people together to deliver group and face-to-face community-based behaviour change activities – might put people at risk. Instead, we have applied a 'do no harm' approach and promoted important COVID-19 sensitive key hygiene behaviours using mass media (such as TV, radio, FM, and social and digital platforms) and other non-contact methods (such as announcing promotion through loudspeakers and microphones, and mobile campaigns using vehicles).

We learned that the skills, experience and processes we normally use to develop community campaigns can be repurposed to create mass media assets, such as videos and radio drama adverts. The same processes still applies – forming national creative committees and teams with governments, creative agencies, artists, media and behaviour change specialists to develop exciting intervention packages.

## Mass media

We developed a series of progressive promotional assets. Initially, TV, social media and radio adverts were **awareness-based** – highlighting the symptoms of COVID-19, how it is transmitted, how to prevent catching and spreading the disease, and what should be done if infected. This was important as the disease itself and some of the behaviours were completely new to people.

**Awareness-focused assets includes (click to view):**

- [Science behind handwashing](#)
- [Comedians in Nepal outline behaviours](#)
- [eSwatini cartoon](#)

As time went on, our assets became increasingly emotive and engaging – linking key preventative behaviours with motives such as nurture, affiliation, status and pride – highlighting everyone's role in protecting themselves, their family and their communities. Promotional materials were tailored and made relevant to each national context, and where possible, we used insights from previous country campaigns. Additionally, in line with our commitments to equality and inclusion, the materials also included sign language and featured people with different disabilities, genders and ages.

**Examples of motivational assets include:**

- [WaterAid Ethiopia's motivational video](#)
- [WaterAid Nepal's motivational video](#)
- [WaterAid Pakistan's engaging TV jingle](#)
- [WaterAid's The Naughty Hand animation](#)

Building on our experience, we created a range of motivational assets to help avoid campaign saturation, reduce campaign fatigue and continuously reinforce the behaviours.

We developed emotive and trusted assets using celebrities, influencers, community leaders, comedians, athletes, musical artists, WASH ambassadors and local leaders in different sectors. They appeared in adverts (TV, radio drama/voices), social media posts, visual illustrations and billboards.

They also utilised their own channels to promote key hygiene behaviours and encourage these as the new social norm. Utilising well-known and influential individuals also helped with trust, especially as COVID-19 was a new disease and there was a lot of misinformation circulating. The majority of our assets were branded using various logos, such as government, WaterAid, campaign names, donors and other collaborators.

**Examples of influential individuals:**

- [WaterAid Zambia's The Power of 5](#)
- [WaterAid Bangladesh developed a fun puppet for kids](#)

In addition to television and social media assets, we have used radios, FMs and locally appropriate loudspeakers to reinforce behaviours.

▼ Visual illustration depicting a well-known football goalie and artist in Tanzania with the slogan 'Choose to protect your nation' and 'Choose to protect those you love' as part of the hygiene campaign promoting key behaviours.



► Health staff leading hygiene promotion sessions for patients attending Basa Health Centre in Rwanda.



## Radio and FMs

Campaigns were being run on local and national radio channels to promote key behaviours in local languages in many countries.

Radio/FM campaigns include various themes including skits, talk shows, panel discussions with experts and people with disabilities, jingles, public service announcements, dramas, call-in programmes and competitions. A benefit of radio and the call-in programmes is that it allowed for a two-way interaction and also reached remote rural areas. Individuals were able to express their opinions and ask questions.

Additionally, radio programming allowed for standardised audio script that could be aired multiple times to remind and reinforce key behaviours. Examples include:

- Rwanda [radio stars](#)
- Zambia [radio PSA](#)

## Non-contact methods

While mass media is an excellent tool to reach a large amount of people in a short period of time, we know that not everyone has access. With the aim to reach the most vulnerable and secluded populations, we employed a variety of mobile campaigns to connect with people in rural and remote areas.

Hygiene promotion highlighting the benefits of practising key behaviours aired on the radio and were taken to communities through 'miking' using loudspeakers and microphones.

Mobile trucks were equipped with illustrative billboards and driven through communities, equipped with recorded motivational audio script linking with key behaviours. Community resource volunteers visited households of women in vulnerable situations, people with disabilities, homeless populations and excluded communities, ensuring they had access to critical information and understood key preventative behaviours.



For more information and learning about the use of mass media focus intervention, read this [blog](#).

◀ Sandrine, playing the part of Agasaro in one of the Radio Ishingiro plays. This was utilised prior to COVID-19 in Rwanda and shared during the pandemic to play a role in promoting hygiene behaviours and preventing the spread.

**Key recommendations and learning from hygiene promotion using mass media and non-contact methods:**

**Higher reach/coverage and exposure is possible through mass focus hygiene intervention**

One off exposure is not enough. Higher reach with repeated frequency, using multiple assets is key to reinforce behaviours. Use of varied and progressive assets helps to reduce campaign fatigue.

Hygiene promotion through mass media-focussed delivery channels can reach higher numbers of people within short periods in repeated frequencies – and has been key during lockdowns and physical distancing. However, this can be a costly delivery channel, not inclusive, and long-term sustainability is yet to be monitored.

**Utilise multiple channels such as TV, FM radio and WASH drama series**

Using multiple channels/touchpoints was a useful approach, many people tuned in to listen and other partner agencies have since adopted some of these methods to use in their programmes.

**We found that different groups of people get information from various sources and touchpoints. Someone with a disability or a certain age group might prefer a channel that differs from the general population, so it is crucial to use multiple methods.**

**Reinforcing the same behaviours through multiple channels using different assets, characters, and visual/audio scripts.**

**Use nationally trusted celebrities, comedians and artists**

Use of influential people as change agents to promote behaviours had a wide reach and built trust. For example, in Ghana we used musicians with thousands of followers to promote life-saving hygiene promotion on social media. In Zambia, we used singers to initiate handwashing challenges. We also used trusted artists in Tanzania and comedians in Nepal to promote key behaviours.

**Use various methods and delivery channels that are inclusive/accessible**

We ensured visual adverts, audio scripts and content was inclusive and sensitive to the needs of the target population. For example, we ensured a video advert included a sign language interpreter and a range of role models, such people from different social classes and professions.

Additionally, while hygiene through mass media mobilisation helped to reach the wider populations within shorter timeframes, it was also important to use other non-contact methods, such as promoting hygiene behaviours to those in rural places with loud-speakers and community-based intervention.

**We learned that it would be helpful to have a set of inclusive assets – including sign language and braille – readily available to contextualise and disseminate during an emergency response.**

**Communication should be context-specific**

Communication and promotional content should be context-specific and reflect the dialogue of the people we work with and are aiming to reach. It is critical to use targeted communication and focus on what is relevant to the community.

This is the best way to reach the target population and help to combat ‘fake news’ and misinformation, especially with a new disease. Use context-relevant characters in assets, such as local and trusted people to promote behaviours.

**Learning example**

**Failure to success**

To encourage behaviour change, we tried several innovative ways to reach people throughout the pandemic with our hygiene intervention. At WaterAid Zambia, we used drones to promote five key hygiene behaviours in communities. This was an innovative non-contact way to reach communities in remote areas. However, this led to increased crowds in schools and communities, which was then likely to lead to increased transmission of COVID-19.

With this realisation, we had to stop using drones as a method of delivery, despite being a new and effective touchpoint.

Next, in order to intensify the promotional campaign, our team in Zambia leveraged the government-led, WaterAid-supported ‘Kutuba Campaign’. This campaign used mass media and community-based interventions with powerful, innovative assets, including ‘**Power of 5**’ to promote key COVID-19 prevention behaviours reaching 7.5 million people.

‘Power of 5’ has been really successful – it initially started off with five key athletes promoting key behaviours and then expanded to use five powerful woman, five inspirational national leaders and the **Deaf Society**.

**COVID-19 sensitive community-based hygiene campaigns**

While we continue to use the mass media-focused intervention, in our second phase of work, when lockdown restrictions eased, we worked with governments and other partners to include COVID-19 behaviours in community-based hygiene behaviour change campaigns. In the majority of the countries where we work, we leveraged our existing hygiene behaviour change campaigns to review and re-design the package to include COVID-19 behaviours. The same creative process was used to review and develop these additions to the package.

The campaign package included a training manual for facilitators, session plans, activities, games, emotive demonstration, storytelling, competitions, jingles/songs, scripts, rewards, takeaways, and cues and nudges to reinforce behaviours. For the sessions, we gathered people in open spaces, and encouraged mask wearing and physical distancing was maintained. Each person in the target population was exposed to key hygiene behaviours between 3 and 12 times.

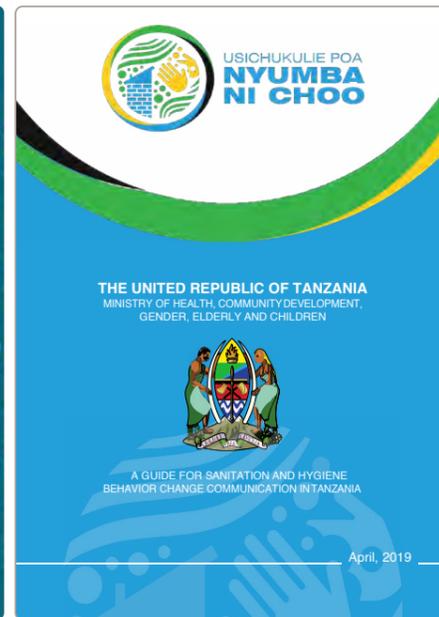
Many countries already had well-established and tested national behaviour change programmes and packages, so only needed COVID-19 behaviours and additional materials/takeaways to be included. However, in others we had to design and test new campaigns.

All community campaigns required training to ensure each hygiene promotion session was delivered in the same way, using the right materials. In most cases, frontline health staff, community-based hygiene promoters, and community volunteers led the hygiene promotion sessions, with supervision of WaterAid staff.

These sessions will continue to be delivered after WaterAid-funded emergency projects end, highlighting the sustainability of working through government structures and part of the ongoing hygiene behaviour change campaign.

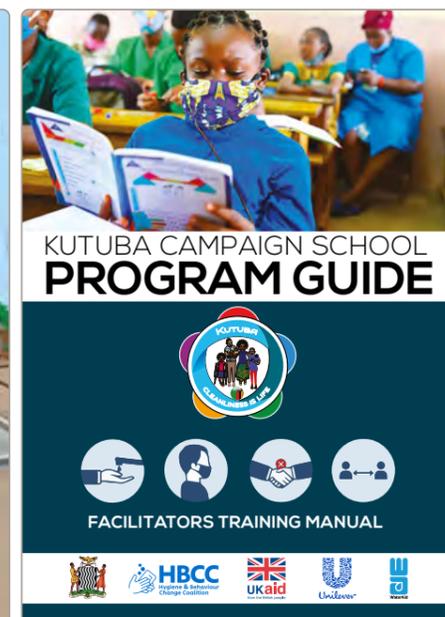
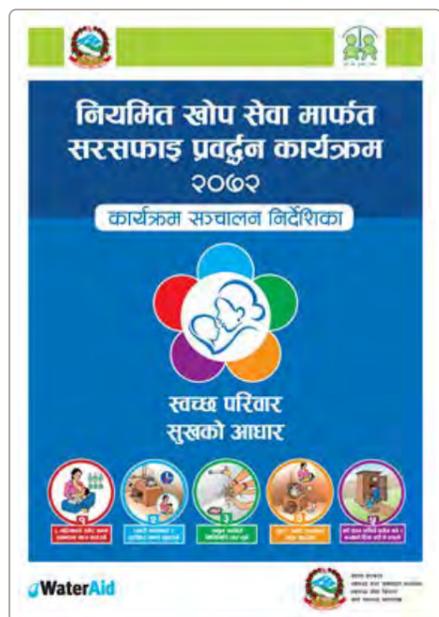
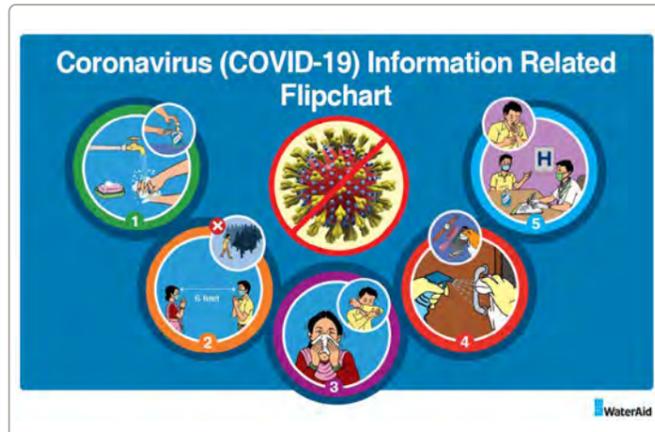


◀ Sor Socheat, Hospital Cleaner, in the delivery room at Battambang Referral Hospital, Sampov Loun Hospital, Cambodia.



## Examples of government-led WaterAid supported hygiene behaviour change campaigns

● Clockwise from top left: Kutuba calendar, Tanzania community guide, Ghana community guide, COVID-19 flip chart in Nepal, Zambia school guide, Bangladesh session guide for communities, and Nepal community session guide.



## Key recommendations and learning from community-based hygiene behaviour change campaigns

**Interpersonal communication and direct exposure with promotional activities motivates people to change behaviours**

Behaviour change intervention should focus on changing social desire/norms within the behavioural settings. Human beings are social creatures – we follow and care about what other people do. Behaviours need to be part of the societal norms. Inter-personal communication, participation in community events and in emotive activities, inspire people to follow new behaviours, form new habits and create social desire to sustain over time. Community-based intervention also allowed us to reach marginalised groups.

**Mass media followed by community-based hygiene campaign reaches a wider population and ensure behavioural outcomes**

We have experienced that the initial mass media-focused intervention followed by a community-based campaign has a greater reach, intensity and influences people to change behaviours. Community-based intervention helped to reinforce the behaviours in the context and offer opportunity to engage in promotional activities, while exposing people to the key behaviours. Such as people washing hands before attending a hygiene session, wearing a mask during the session and maintaining physical distance. This directly exposes people with the intended behaviours.

**Work with and through government institutions**

Leveraging existing government platforms to design and implement large scale hygiene response. Strengthening our relationship with government institutions to make the campaign acceptable amongst communities. Building government staff's capacity helped retain the capacity within the system to continuously promote and reinforce hygiene behaviours over time. Continuous mentoring, refresher trainings and technical support are key.

**Training and technology is important for fidelity**

Proper training to promotor, enumerators and frontline staff is critical to ensure fidelity of the campaign, for example consistency in the delivery of the package, as designed. Before and during COVID-19, we trained thousands of frontline workers as part of ongoing work to implement the hygiene intervention package as designed. The standardisation of the package materials and use of technology also maintained the fidelity of the campaign.

**Hygiene promotion together with cues/nudges to remind behaviours and provision of facilities (such as handwashing facilities, behavioural products) will ensure a level of behavioural adherence.**

Following our ToC and behaviour change insights, we have combined three levers for behaviour change together. We have motivated people through the promotion of hygiene through various touchpoints including mass media and community-based intervention. We have developed various cues/nudges to reinforce behaviours (such as visual stickers, branded mirrors with visual illustrations of the behaviours, visual cues to practise key behaviours, such as mask wearing and maintaining physical distancing). This was combined with the installation of handwashing facilities in public places to change the setting, and also encouraging households to build locally available/context-specific handwashing facilities.

## Examples of cues and nudges



▲ Ethiopia developed 'wheel of hygiene' for hygiene promoters to use in sessions as a fun way for people to visualise key COVID-19 prevention behaviours.



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▼ Clock and 'stand here' sticker from Zambia.



▼ WaterAid Pakistan developed fun photo frames for social media to encourage people to practise key behaviours.



◀ Students in Pakistan celebrate the importance of handwashing on Global Handwashing Day, 2020.

## Hygiene integration – health, immunisation, schools, workplaces and the private sector

The provision of WASH services, especially hygiene behaviour change, is fundamental to early childhood development, health and educational outcomes, immunisation uptake and reducing the spread of disease. With good hygiene, hospitalisations are reduced, adults can go to work, children can attend school and people live longer, healthier lives. By integrating hygiene into existing sectoral programmes, we will reach more people than with one-off activities, and benefits are maximised.

Where possible and feasible, we have integrated our hygiene behaviour change programme with areas such as child health, immunisation, cholera and nutrition. We have done this through healthcare facilities, schools and workplaces – including factories and private sector programmes.

Our response to COVID-19 has been no different, as the provision of safe water, sanitation and hygienic conditions is essential to protecting human health during infectious disease outbreaks and throughout the pandemic, we have integrated hygiene into these domains of work. As we continue to respond to this health crisis, we are also creating flexible funding that suits the needs on the ground.



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▲ People watch and listen to hygiene promotion behaviours while waiting for their COVID-19 vaccination, in South Africa.



### Hygiene into routine immunisation and health programmes

In many countries where we work, we have promoted hygiene and built handwashing facilities in healthcare facilities throughout the pandemic.

We have also:

- Leveraged our nationwide hygiene integration into a routine immunisation programme in Nepal to integrate COVID-19 sensitive behaviours and promote the hygiene programme.
- Provided handwashing facilities and personal protective equipment (PPE) to healthcare facilities.
- Provided training on COVID-19 prevention measures.
- Advocated for WASH and hygiene as the first line of defence against COVID-19 for communities, health workers and their patients at the 74th **World Health Assembly**.

Prior to COVID-19, we advocated for hygiene in healthcare facilities, with a focus on hand hygiene as this protects against healthcare-associated infections<sup>13</sup> and reduces the spread of antimicrobial resistance. COVID-19 has now reinforced the need for hand hygiene in this setting.

Through our active engagement with WHO on WASH in healthcare facilities, we shared our hygiene approach to 'Hand hygiene in healthcare facilities' as part of **COVID-19 and WASH FIT**<sup>14</sup> (facility improvement tool) webinar series.

## WASH in schools

We are providing handwashing facilities, visual cues and nudges, along with hygiene promotion training to teachers, to ensure that schools and early childcare centres can open and operate safely. Millions of children go back to **school** with nowhere to wash their hands, therefore it is critical to ensure WASH structures are in place.

We are building resilience through hygiene behaviour change campaigns and the capacity of Head Teachers through the training sessions. For example, in Uganda there are plans to roll this essential training out to 125 teachers. We are promoting hygiene in schools in South Africa, Rwanda, Mali, Nepal, Pakistan, Bangladesh, Zambia, Ethiopia and Mozambique, among others.

### Key outputs:

- Built hundreds of handwashing facilities in schools in many countries.
- Ten immediate WASH in schools **actions** for safe reopening **during the pandemic**.
- COVID-19 advocacy with back to school checklist **messaging**.
- Sustainable WASH services in **Mozambique schools**, with COVID-19 as an opportunity for paradigm shift.

## Hygiene in the workplace and through private sector work

COVID-19 had a devastating impact on supply chains, workplaces and workers globally. From disruption to goods and incomes, to impacts on mental health and global markets. To reopen safely and ensure workplaces are resilient, we are pushing for the introduction of WASH and hygiene behaviour change to strengthen supply chains and enable a safe return to work. Working with the private sector, we have contributed to the following key outputs:

- **Supported the development of COVID-19 Guidance:** Prioritising hygiene for workforce health and business resilience.
- Enabled **safe return to work** for global supply chain employees in the face of COVID-19.
- Developed hygiene behaviour change capacity building and WASH self-assessment tools for a **resilient supply chain**:
  - **WASH risk self-assessment tools;**
  - **Capacity building training package for hygiene behaviour change;**
  - Behaviour change illustrations for **offices, factories** and **field work**.
- Working together with private sectors, we implemented our hygiene response to COVID-19 in the workplace, mostly in factories and key workplaces in Bangladesh, Cambodia, India and other countries.
- We received funding from the private sector such as the Heineken Africa Foundation (HAF) and collaborated to promote hygiene in Ethiopia, Nigeria, Mozambique, South Africa and Rwanda. We worked jointly with the Foreign Commonwealth and Development Office (FCDO) and Unilever, funding part of the **Hygiene Behaviour Change Coalition** (HBCC) initiatives in six countries: Ethiopia, Ghana, Nepal, Pakistan, Tanzania and Zambia.

## Hygiene integration in COVID-19 vaccinations

There is often a belief that vaccines or medications are silver bullets in preventing people from getting diseases. While a successful vaccine roll-out and medicine distribution will be an important milestone to save millions of lives, it is imperative to note that the extent of vaccine efficacy and effectiveness is far from 100%, and not all diseases can be completely eradicated. Hygiene therefore remains incredibly important, with or without a vaccine.

While vaccine hesitancy is contributing to low uptake, vaccine optimism is contributing to low adherence of hygiene behaviours.<sup>15</sup> Funding for vaccines and medicine is essential to address the immediate need of these diseases. But future investment and programmes for COVID-19 prevention should be given clear priority on investing in hygiene, plus vaccines and should emphasise the importance of good hygiene behaviours.

COVID-19 vaccine rollout can be an additional entry point to reach people with hygiene behaviour change in the context of the pandemic. When behaviours are promoted alongside vaccines, this can ensure a comprehensive and sustainable approach to disease control. Using our existing hygiene behaviour change work, we have also integrated hygiene into COVID-19 vaccination programmes and are working with the Ministry of Health in many countries to continuously reinforce the key behaviours through the COVID-19 vaccination platforms.

A few examples of our work in this includes:

- WaterAid **South Africa** are partnering with the government and **UNICEF** to incorporate hygiene prevention behaviours and promotion into the government's COVID-19 vaccination roll-out programme. In this partnership, key assets have been developed to include in the vaccination programme. We are supporting an exciting community outreach campaign using large commercial vehicles with light-emitting diode (LED) panels that travel to designated vaccination sites and serve as a trusted source of information. Addressing people's concerns and playing videos in local languages, the truck

is assisted by nurses, health staff and volunteers who promote key hygiene behaviours, before, during and after vaccination.

- WaterAid **Mozambique** are part of the communications technical working group and the WASH cluster. We are working with the Ministry of Health to include key hygiene behaviours into the government's roll-out of the **COVID-19 vaccination** through the development of material with prevention insights, including a backdrop banner and rollups.

- WaterAid **Nepal** already had a strong relationship with the government and a successful programme integrating hygiene into routine immunisations at a national scale. This relationship allowed for quick involvement and technical support on incorporating hygiene behaviours into the COVID-19 vaccine roll-out. We developed additional materials such as flip charts with key hygiene behaviours, printed illustrations on the back of vaccination cards, and created visual stickers to hand out to people to remind and reinforce behaviours.



- ▲ Sticker with key hygiene behaviours that is handed out as a reminder after vaccination and hygiene promotion sessions.

## Our institutional recommendations for hygiene integration into vaccines

Influence national governments to embed hygiene (as part of the full WASH package) with routine immunisation clinics or settings, related budgets and guidelines.

Support national planning for a COVID-19 vaccine roll-out to include guidance on hygiene behaviour as everyone's responsibility. Support for the design of an inclusive hygiene package to roll-out at vaccine sites in an integrated manner, including at immunisation outreach clinics, schools, healthcare facilities and public settings where vaccine information is shared or delivered.

Influence national governments to embed hygiene across line ministries and departments as part of strengthening the systems needed to build resilient communities through long-term hygiene behaviour change.

Use global and/or regional platforms, such as HH4A to collectively advocate for the integration of hygiene with COVID-19 vaccine roll-out, into routine immunisation for long term sustainability and within national level HH4A Country Roadmap processes.

Partner with other large organisations, such as UNICEF, or local Civil Society Organisations (CSOs) to help synergise efforts.

## Key learnings from vaccine integration

<p><b>Hygiene is a best-buy investment for governments</b></p>	<p>Handwashing with soap remains one of the most cost-effective public health interventions and is key to building resilience. Together, with other key behaviours, it will help in preventing and reducing the spread of diseases.</p>
<p><b>Comprehensive approaches are needed to prevent diseases and contain outbreaks</b></p>	<p>Vaccines are not a silver bullet but are critical in addition to investing in hygiene and other preventative measures.</p>
<p><b>WASH is critical to ensure safe settings and has the potential to improve vaccine efficacy</b></p>	<p>Hygiene helps keep the vaccination environment safe and hygiene-focused WASH interventions for immunisation also helps to improve other child caring behaviours, such as exclusive breastfeeding and uptake of other health services.</p>
<p><b>Hygiene is fundamental for health and disease control</b></p>	<p>Investments in WASH and hygiene in healthcare facilities are crucial for disease control, protecting frontline workers, and contributing to a higher quality of care.</p>
<p><b>Integrating hygiene into vaccination programmes to increase vaccine uptake and strengthen health systems</b></p>	<p>Based on our pilot initiative, and now the nationwide scale up of hygiene into the vaccination programme, we can conclude that immunisation is a key entry point to integrate hygiene – helping improve behaviours as well as increasing vaccine uptake. Using existing immunisation systems and building frontline health staff's capacity to implement hygiene, together with immunisation, will ensure institutional mechanism and strengthen systems, including sectoral capacity. Investment in hand hygiene facilities in outreach clinics will also help ensure the quality of services.</p>

# Handwashing facilities

## Innovative handwashing facilities in public places and institutions

Having access to handwashing facilities with soap and water is a key factor in determining handwashing behaviour and a critical part of our response. It is important to ensure handwashing facilities are clean, functional, inclusive and sustainable, so people can continue to use them to protect themselves against COVID-19 and other transmittable diseases.

Prior to COVID-19, hand hygiene infrastructure in public places was not a major priority for government or private sector. However, shortly after the pandemic hit, the WHO released new recommendations<sup>16</sup> and guidelines<sup>17</sup> stipulating that hygiene facilities should be placed at the entrance to all public and private commercial buildings, major transport hubs, markets, shops, places of worship, healthcare facilities and schools.

We quickly responded by developing handwashing technological **guidelines** for public places and institutions, and in partnership with government and private sector, designed and installed 2,700 handwashing facilities in public places, including in churches, bus stations, airports, markets, healthcare facilities, schools and other key **public places**.



Handwashing facility installed in a school in Zambia.

When it comes to handwashing facilities, we know that simply providing infrastructure will not result in it being used. Handwashing is influenced by a range of social, physical and cognitive determinants. Research<sup>18</sup> shows hygiene programmes are more successful when they combine infrastructural improvement with 'soft' hygiene promotion that addresses a range of determinants, not just education about disease prevention.

While providing handwashing facilities and soap addresses just part of the determinants, we ensure these facilities are conveniently located, inclusive to the variety of users that make up the population and clean to increase handwashing rates. Behaviour change requires both infrastructure and creatively designed behaviour change intervention using people's motivations.

## Innovation in handwashing facility design

Due to the nature of the COVID-19 and the way in which it spreads, some public handwashing facilities pose a small risk of re-contamination. After cleaning hands and then touching the tap to turn it off, the tap might be dirty from when it was originally touched. To combat this, our teams have worked with partners to design hands-free, foot-operated handwashing facilities. One paddle dispenses soap and the other releases water, preventing cross-contamination.

Additionally, we wanted to ensure facilities were inclusive and suited the needs of all people including children, women, older people and people with disabilities. We developed facilities with taps that could be adjusted to different heights to suit the needs of those in wheelchairs or young children. In Zambia, specialist disability-friendly handwashing facilities were developed for people with disabilities, particularly wheelchair users and those unable to use their feet for the foot-operated handwashing facilities. The team worked directly with a DPO and incorporated their feedback into the design.

Mobile handwashing	Border points	Paddle-operated
<p><b>Handwashing on wheels</b> was designed by WaterAid <b>Bangladesh</b> to bring handwashing to everyday commuters in the city's most populated areas. This provided easy access to soap and water, and units are equipped with cues to trigger behaviour.</p> 	<p><b>Handwashing at the border</b> – WaterAid <b>East Africa</b> partnered with East African Community (EAC) and country government structures to provide handwashing facilities at busy border points to help curb the spread of COVID-19.</p> 	<p>Hands-free, <b>contactless handwashing stations</b> designed by WaterAid <b>Nepal</b> helped to prevent cross-contamination. These have been installed in more than 300 health centres, border areas and over 100 public locations in urban areas.</p> 
Inclusive handwashing facilities	Bus stops and airports	Schools and healthcare facilities
<p>WaterAid <b>Zambia</b> worked with a DPO to design an inclusive and accessible <b>handwashing facility</b>.</p> <p>WaterAid <b>Tanzania</b> worked with a person with disabilities to provide feedback on a handwashing facility design.</p> 	<p>WaterAid <b>Ethiopia</b> used learnings from our initial response to develop permanent handwashing facilities for bus stations. We handed this over to the management body of the bus station, which has a security guard to prevent theft and damage of the facility. WaterAid <b>Liberia</b> developed hands-free handwashing facilities at airports.</p> 	<p>WaterAid <b>Rwanda</b> developed a sustainable and inclusive group handwashing station for schools and healthcare facilities.</p> 

## Construction, maintenance and sustainability

In partnership with government, local private sector institutions and partners, we built 2,700 large-scale permanent and semi-permanent handwashing facilities in key public places as of August 2021. In addition to delivering handwashing facilities, we ensured the facilities were installed and handed over to the relevant committees or groups. Caretakers were assigned for daily operation, training was conducted for minor maintenance and repairs, and technical support was provided in the development of the operation and maintenance (O&M) plan.

Due to the nature of initial emergency response to COVID-19, the aim was to quickly instal handwashing facilities in key public places, so people could wash their hands. Therefore, facilities ranged from temporary, semi-permanent to permanent. Once we realised COVID-19 was going to last longer than an initial emergency response, we shifted our way of working.

We are now working to convert most into permanent facilities and ensure only durable, long-lasting facilities are designed and delivered. Robust O&M plans are critical to ensuring both soap and water are available, and facilities are properly managed. Facilities that were not being maintained have since been moved to different locations where they could be functional.

We are working with duty bearers to ensure long-term ownership. The results of the MTRA and overall learning are being incorporated to ensure sustainability.

## Recommendations for sustainability of handwashing facilities in public places

Ensure only permanent or semi-permanent handwashing facilities are built in all settings.

When building new designs, ensure you work with a DPO and conduct a **safety and accessibility audit**.

If possible, convert any temporary handwashing facilities previously built in the early stage of response into semi-permanent or permanent facilities.

Work with community leaders, municipalities, school leaders, healthcare facilities and governments to ensure that they take responsibility for the O&M of these facilities – and ensuring they always have adequate supply of water and soap.

Make sure we are not building handwashing facilities in places that don't have volunteers and/or institutions who can maintain them to ensure long term sustainability.

Ensure an O&M plan is in place for all public handwashing facilities (a compulsory requirement for any facilities).

Work with local fabricators to ensure spare parts are locally available and affordable.

Each facility should have visual cues/nudges to reinforce/encourage use and promote physical distancing.

Ensure continued longitudinal monitoring system is in place to make these facilities functional. Regular monitoring by the owner of the facilities and long term monitoring by WaterAid.

## Lesson learned

WaterAid Tanzania installed large-scale, permanent handwashing facilities in public places to provide essential infrastructure for people to wash hands with soap and water. However, a rapid assessment conducted shortly after showed that some facilities were not functioning, lacking maintenance plans and leading to failure. A quick response and early diagnosis then led to success. The team held discussions with respective public institutions and management committees, established O&M plans, and worked to ensure functionality. A follow-up assessment showed that 100% of facilities were fully functional with O&M plans in place.

# 4 Monitoring and evaluation

M&E is a key part of any hygiene behaviour change programme and should be an ongoing integral process. However, M&E approaches were changed and adapted during the pandemic due to a plethora of factors. Initially, it was assumed this would be a short-term response, therefore response action was prioritised over developing monitoring frameworks.

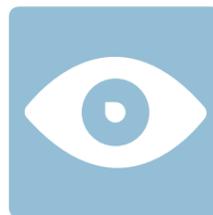
The use of mass media was a new touchpoint for our programmes, so we had to develop a way to monitor mass media behaviour change campaigns.

We have developed guidance for remote monitoring and to **monitor mass media** campaigns. Whilst estimating the reach and frequency is more complicated for TV and radio, we developed an approach that helped to define and measure the scale and intensity of mass media campaigns.

During a time-sensitive, emergency response project like COVID-19, it was not possible or practical to conduct a baseline assessment initially, as we would normally do in a traditional hygiene behaviour change programme. We therefore conducted a large-scale Mid-term rapid assessment (MTRA) to quickly assess the ongoing effect and outcomes of hygiene response in eight countries with WaterAid programmes.



▲ WaterAid Ghana held a sensitisation and advocacy training session with teachers in La Accra on WASH and human rights.



The aim was to estimate the prevalence of COVID-19 prevention behaviours (handwashing with soap, mask wearing, physical distancing and surface cleaning), exploring the relationships between key behaviours and hypothesised determinants (barriers, knowledge, motives and norms).

We assessed exposure to intervention activities and evaluated the most trusted and preferred delivery channels (touchpoints) to expose the target population with hygiene behaviour change interventions.

We also assessed the functionality and sustainability of built handwashing facilities, and sector coordination mechanism for response and WaterAid's value addition.

We are aware that the target population will have been exposed with multiple behaviours and interventions from various actors, not just WaterAid. Therefore, the assessment aims to better understand the current status and sense how things are changing over time within our intervention areas – mostly assessing the contribution rather than attribution of our work.

## Research questions

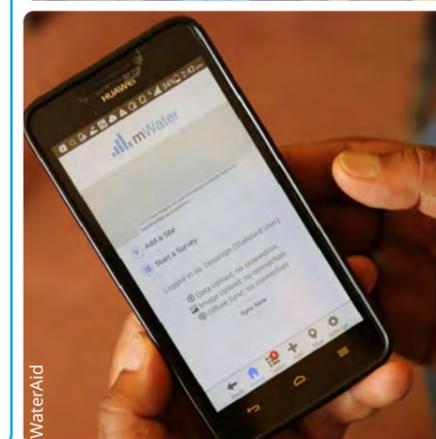
1. **Understanding:** What is the current level of understanding/knowledge regarding the behaviour linked with COVID-19?
2. **Practical application:** Are people currently practising key hygiene behaviours? And is it being reported (we recognise the limitation and self-reporting bias)?
3. **Social norms:** Do neighbours or colleagues practise these behaviours? Are these behaviours common in the community?
4. **Barriers:** What is the current practise in different socioeconomic situations? What factors or barriers limit people's ability to practise these behaviours at home, institutions and in public places? This could be related to their gender, levels of income, ethnicity, health status or other factors that need to be considered and understood.
5. **Motivation:** What factors may have caused people to change their behaviours?
6. **Touchpoints:** What are the key touchpoints and how do people prefer to receive hygiene response/interventions? Insights into authenticity, relevance, usefulness and contextualisation of the content for different target audiences.
7. **Facilities at household level:** Do they have access to facilities and behavioural products (such as handwashing facilities with soap and water, masks etc) at household level and has the access to services/products increase/decrease after COVID-19?
8. **Understanding:** What is your key understanding of people on the current hygiene promotion initiatives? Do they use assets, messages in terms of attraction, clarity and motivation to practise behaviours?
9. **Facilities in public places/institutions:** Are the installed handwashing facilities functional? Is water and soap available? Do they have O&M plans?
10. **Programme design and coordination:** What process and consideration are made while designing and implementing hygiene response? What are the existing coordination platforms?

## Methodology

The MTRA was a cross-sectional study using mostly quantitative data with limited qualitative methods. The data was collected during October and November 2020 in eight countries, with data collection taking up to two weeks to complete in each country.

We have standardised the tools centrally and trained in-country data collectors. Initial analysis was done by WaterAid UK to quickly extract the results and make the ongoing hygiene campaign evidence-based.

Subsequently, data was analysed by the Risk, Attitudes, Norms, and Self-regulation (RANAS) behaviour change group and London School of Hygiene and Tropical Medicine (LSHTM) to produce a global report and support the in-country report.



● Materials from the 'Did you wash your hands?' campaign.

**The MTRA used three key tools as part of the data collection:**

- 1. Rapid assessment survey/interviews using closed-ended questionnaire tools in 3,529 households.** The purpose of this method was to collect reported data from the sampled population through face-to-face interviews to answer questions 1 to 8 and assess how current interventions were contributing to people's hygiene behaviours.
- 2. Spot check assessment of public handwashing facilities using a standard checklist in 355 handwashing facilities.** The purpose of this was to assess the availability, functionality, safety and inclusivity of handwashing facilities with provision of soap and water including its O&M mechanism. This addressed research question 9. Only handwashing facilities that had been directly installed or supported through our COVID-19 response were included in the study. Where a considerable number of handwashing facilities had been installed, a sample of facilities were randomly selected.
- 3. Key informant interviews (KII) using both closed- and open-ended questions among 87 respondents.** This method was used to understand how hygiene behaviour change programmes are designed and implemented. It also helped to understand the sectoral coordination mechanism, as well as the system thinking of these interventions and WaterAid's value addition in the sector. KIIs were conducted with government staff from multiple ministries (WASH and Health) at various levels (national, sub-national and local level), including partners and media houses.

**Results**

A total of 3,529 people were interviewed, with a mix of men (49%) and women (51%) in eight countries. 18% of the population had a form of disability. Overall, 92% of people were exposed to the intervention, reporting having heard or seen preventative behaviours to protect against COVID-19. Knowledge was high on critical moments for handwashing with soap (82%), wearing a mask in public (79%) and physical distancing (71%). Knowledge was much lower regarding the disinfection of frequently touched surfaces (41%). Over 65% of people reported changing behaviours for all key behaviours as a result of the intervention.

Our sub-set analysis also showed that critical moments for handwashing, such as after defecation and before eating, were highly reported, but handwashing after touching frequently touched surfaces and after being outside the home were low. Focusing on the four key behaviours, we asked respondents to confirm whether they had seen others practising key behaviours. Results indicated that more than 50% of the population had seen others practising the key behaviours (social norms).

The MTRA revealed that there were key barriers for each behaviour. 35% reported a barrier for handwashing with soap as it was deemed as 'too expensive'. 33% reported barriers when wearing a mask, with 20% stating they found it 'difficult to breath'. 69% reported a barrier to physical distancing, with the most common reason being 'people do not maintain their distance from me' and that spaces were too crowded. Similar to handwashing with soap, the biggest barrier for surface cleaning was that 'disinfectants are too expensive'.

When disaggregating data, we found that the top three places where people get information varied on whether or not they had a disability. Persons with disabilities preferred newspapers, loudspeakers and non-governmental organisations (NGOs), while the general population preferred TV, radio and social media. Other than this, there were no significant differences in responses based on gender, disability and age. During our evaluation, we found that various motives to practise key preventative behaviours existed, including pride, nurture, affiliation, fear and cleanliness.

**Reported barriers to practising key hygiene behaviours**

Behaviour	Barriers faced	Possible solutions for our ongoing programmes
<b>Handwashing</b>	<ul style="list-style-type: none"> <li>● Forgetting to perform handwashing.</li> <li>● Soap is too expensive.</li> <li>● Soap is prioritised for other activities (such as being used for laundry and bathing).</li> </ul>	<ul style="list-style-type: none"> <li>● Make sure handwashing facilities are equipped with visually appealing cues and nudges, ensuring facilities in public places have soap.</li> <li>● Most households have soap, it is usually prioritised for other activities, so we need to work to change the social norms around soap use for handwashing and promote creative ways to use less water when washing hands (such as devices that can prevent water waste).</li> <li>● Influence governments and the private sector to address the affordability of products.</li> <li>● Strengthen supply chains, innovation around lower cost soap production and soap-minimising devices.</li> </ul>
<b>Wearing a mask</b>	<ul style="list-style-type: none"> <li>● Difficult to breath while wearing a mask.</li> <li>● Not being able to afford to buy a mask.</li> <li>● Don't know how to make a mask.</li> <li>● Material to make a mask is too expensive.</li> </ul>	<ul style="list-style-type: none"> <li>● Encourage proper mask wearing (use visual illustration to show the correct use) and show how wearing a mask does not impact breathing or oxygen intake.</li> <li>● Encourage local organisations to ensure affordable materials are available to make masks. Hold training sessions to local groups/cohorts on how to easily make mask.</li> <li>● Encourage the use of locally-available masks.</li> </ul>
<b>Physical distancing</b>	<ul style="list-style-type: none"> <li>● Other people do not maintain their distance.</li> <li>● Places are too crowded/too many people.</li> </ul>	<ul style="list-style-type: none"> <li>● Reinforce mask wearing in crowded areas where it is hard to maintain physical distancing.</li> <li>● Place stickers, chalk circles, or nudges in crowded areas to encourage physical distancing while queueing.</li> </ul>
<b>Surface cleaning</b>	<ul style="list-style-type: none"> <li>● Disinfectant is too expensive.</li> <li>● Disinfectant is not available.</li> </ul>	<ul style="list-style-type: none"> <li>● Identify high-touch surfaces and clean with soap and water.</li> <li>● Dilute commonly available disinfectants, like household bleach, to disinfect non-porous surface after cleaning.</li> <li>● Encourage handwashing with soap to prevent transmission.</li> </ul>
<b>Self-isolation</b>	<ul style="list-style-type: none"> <li>● Must go to work to make money.</li> </ul>	<ul style="list-style-type: none"> <li>● Encourage the national guidelines and standards set by the respective governments to be followed.</li> </ul>





● Loudspeakers and rickshaws raising the awareness of hygiene promotion in communities in Mozambique (above) and in Myanmar (right).



### Governments and partners highlighted WaterAid's value addition into the sector from COVID-19 including:

- Technical knowledge and innovation on hygiene behaviour change.
- Targeting specific geographic locations.
- Using celebrities, sports people and artists to ensure trust in the campaign.
- Constructing innovative handwashing facilities.
- Working and influencing government on inclusive approaches.
- Equity and inclusion; reaching out to areas facing marginalisation with WASH facilities.

### Our added value

Following an external evaluation of our **Hygiene Behaviour Change Coalition** programme response, interviewees considered WaterAid as an **effective actor in the COVID-19 response across many countries, from being good contributors on hygiene behaviour change programming, strong relationships with government and frontline agency coordination forums.**

### Conclusions and recommendations from MTRA

The intervention had a good reach and exposed large numbers of people with preventative behaviours to protect against COVID-19. The top three reported behaviours included traditional handwashing with soap, wearing a mask in public and maintaining physical distance. Cleaning frequently touched surfaces and self-isolating were both considered much lower in importance, despite being included as part of the promotion.

Future interventions should continue to focus on changing social norms using key motives such as affiliation, pride and nurture to drive behaviours, including the use of visual cues/nudges as reminder for those behaviours.

### Utilisation of MTRA findings and way forward

The assessment allowed us to gather and utilise point-in-time data to respond during the crisis efficiently and effectively. Data was analysed and disaggregated to make improvements and inform our response going forward. Project teams were able to access the analysed data immediately and instantly use the results. We used the insights to make our response progressive and based on data in all countries. Country-level reports have been produced and disseminated to government and key behaviour change actors.

### Recommendations and learning for conducting assessments

- Include indicators related to exposure, self-reported behaviours, determinants of these behaviours and preferred channels of delivery in the programming.
- Be specific. While handwashing with soap is key, we wanted to monitor specific moments related to COVID-19.
- Ask people why and when they changed their behaviours – this can be key information for programmatic decision makers.
- A standardised checklist will help quickly gather and analyse data. We developed a standardised checklist to monitor functionality and accessibility of handwashing facilities and will continue to use this repeatedly over time. The MTRA has been contextualised and is being used in other country programmes.
- Ensure data can be disaggregated by gender, disability and other socioeconomic factors.



▲ Dr Martin Koné, Health Director, washing his hands at the washbasin inside his consultation room, at Talo Health Centre, Municipality of Falo, Circle of Bla, Segou Region, Mali.

### Ongoing monitoring

Monitoring is important for the success of a hygiene behaviour change programme and to ensure handwashing facilities are functional. We hold monthly check-ins where programme managers and country teams provide updates and support requests. Countries used in-country data to support programmatic decisions. Additionally, based off our MTRA, we developed a standardised checklist and monitoring tool for handwashing facilities – which are being used across all the countries where we work for routine monitoring and to address any facility repairment needs.

Documenting and sharing learnings, both internally and externally, has helped to contribute to knowledge management and improved COVID-19 response. We have developed guidance and one-pagers based on needs that arise, such as 'dos & don'ts' for visual cues and nudges, and for **implementing an inclusive response**. We have also shared case studies on various themes, ranging from mass media and hygiene integration to working with government partners. As we continue to respond we will continue to monitor programmes and document outcomes.

◀ A handwashing demonstration using a new contactless handwashing station in Manjakandriana commune, Analamanga region, Madagascar.

# Partnerships, collaboration and sector coordination

Partnerships and collaboration have always been key to the success of our work. By working with local organisations and leaders in the community, we are well placed to identify groups who are vulnerable and adapt our approaches to cater to their needs and ensure context-specific responses. We collaborate and work with governments very closely in many countries – the branding and approval from governments for hygiene packages helps us to implement our programmes at scale.

Additionally, by collaborating and networking externally, we have been able to advance our mission and bring hygiene behaviour change to the front of policy, advocacy, research, private partnerships, business and to the wider WASH and development community. Furthermore, improving sector coordination during the COVID-19 response was one of our objectives.

## Examples of various partnerships and joint initiatives

Initiative/partnership	Description	Learning/outcome
<b>WaterAid's engagement, participation and collaboration through the WASH and Health clusters in countries</b>	Our country programmes have been actively involved in the in-country WASH and health clusters mostly led by government in partnership with the UN and other stakeholders.  We played a crucial technical role and have been active in sharing and leading on this work.	Cluster meetings were an effective way to establish sector and cross coordination, harmonisation, and to agree the on behaviours.
<b>'HH4A' initiative</b>	Global initiative led by WHO/UNICEF in partnership few key organisations, including WaterAid. This initiative served to implement global recommendations on hand hygiene to prevent and control COVID-19.  Through this initiative, we have been supporting few countries to develop costed county hand hygiene road maps.	There has been a major push to develop costed country hand hygiene roadmaps. WaterAid, in collaboration with WHO/UNICEF, are currently engaging more than seven countries to support the roadmap development and costing process.  This will be key for governments to plan and allocate funding and advocacy, making the case for investing in WASH.
<b>SuSanA (Sustainable Sanitation Alliance) and Behaviour Change Working Group</b>	Network and discussion forum for sanitation and behaviour change. Different technical experts lead various groups within the alliance, Behaviour Change Working Group co-led by WaterAid (Dr Om Prasad Gautam).	Led by WaterAid in collaboration with partners, conducted two thematic learning sessions on COVID-19 response and roles of behaviour change conducted. First during initial response to set-up target and second was a year later to update progress.

Initiative/partnership	Description	Learning/outcome
<b>Hygiene Hub</b>	Hygiene Hub is led by LSHTM with funding from Unilever and FCDO. This platform helps actors in LMICs rapidly share, design and adapt evidence-based hygiene interventions to combat COVID-19. We sit in the steering group and contribute resources, case-studies, challenges and learnings.	Our hygiene response to COVID-19 was shared through an interactive global map. More than six case studies from our hygiene response to COVID-19 was published. We also shared learnings from mass media, innovation in handwashing facilities and collaboration with government.
<b>FCDO-led COVID-19 behaviour change group</b>	This group meets every two weeks and is led by FCDO, with core technical members from different ministries in the UK and behaviour change experts from key stakeholders, including WaterAid ( <b>Dr Om Gautam</b> ). This group discusses technical issues, shared learning and inputs into guidance documents/papers.	Technical guidance documents and global shared learnings. Group hosted many global webinars to share resources and learnings.
<b>WASH4Work</b>	WASH4Work aims to mobilise businesses to address WASH and hygiene challenges in the workplace, in communities where companies operate, and across supply chains.	Our Programme Support Unit and strategic partnership team developed <b>guidance papers</b> and a capacity building package. We implemented and evaluated a hygiene intervention package, and supported the development of rapid assessment <b>tools</b> . Our capacity building webinar trained more than 27 organisations and WASH4Work provided these tools for many private sector organisations.
<b>Global Handwashing Partnership (GHP)</b>	GHP works to save children's lives and improve health by promoting handwashing with soap. GHP is a public-private partnership that coordinates Global Handwashing Day (GHD).	Held joint webinars, shared learnings and coordinated GHD. We contributed in a technical capacity at all key events, webinars and planning processes for GHD.
<b>Hygiene for Health Campaign</b>	WaterAid's global advocacy campaign to accelerate action and progress towards everyone's access to hygiene for improved health outcomes.	Through this campaign, WaterAid started positioning key policy and advocacy issues linked to hygiene and influencing donors, key stakeholders and Government for greater investment, coordination and policy environment for hygiene.

# Challenges and making hygiene responses sustainable

Since the beginning of our hygiene response to COVID-19, our emphasis has been on making the response sustainable over time. We have been documenting challenges, key learnings and recommendations to improve the outcomes and implementation of our work in the future.

## Challenges

Some challenges include:

- **Inadequate water supply and lack of hygiene products** are common problems faced in many areas where we work, so this was a driving factor in delivering handwashing facilities and promoting good hand hygiene. However, this is not a new issue, and COVID-19 simply highlighted the disparities many people face. We will continue to be creative and innovative in delivering handwashing facilities and demand governments fulfil their responsibility to **ensure everyone has access to water for domestic use** including for handwashing, personal hygiene, menstrual hygiene etc.
- The mass installation of handwashing facilities means an increase in wastewater, which highlighted the need for **proper sanitation and wastewater management**. Now where handwashing facilities are installed, they are either directly connected to the main sewer system or the wastewater is treated.
- **Limited funding** hindered any swift responses during the initial stages of the pandemic, but we were able to leverage our existing funding and subsequent donor funding to ramp-up campaigns. By quickly applying for grants and submitting proposals, we were able to gain the crucial funding needed.
- **Estimating a precise adequate reach was difficult** when it came to mass media users, as this was a new approach. We have developed a thorough process to estimate target population, document frequency of delivery and reach, and held a webinar to train our teams. This has been simplified to be more user friendly and accompanied with a 'How to Guide'. We will continue building tools and share learning with others in the sector.



▲ Chantu cleans the handwashing station at the Kampong Trolach Referral Hospital, Ka Ot Village, Pieny Commune, Kampong Trolach, Kampong Chhnang province, Cambodia. July 2020.

- Some countries had difficulties implementing comprehensive response programmes due to **political challenges**. COVID-19 was not seen as an issue by some leaders and elections resulted in large gatherings without physical distancing being enforced. For example, in Tanzania initially, our hygiene response focused on communicable disease prevention programme rather than COVID-19, as the government did not declare COVID-19's existence until July 2021. In some countries, such as Zambia, we have carried out significant work with the politicians to make their election COVID-19 sensitive.
- The **sustainability** of the overall hygiene behaviour change programme **using non-contact delivery methods** and the durability of the new handwashing facilities requires continued monitoring as we are still implementing our response.

## Lessons from working with politicians

Zambia had an election during the middle of the pandemic. **WaterAid Zambia** worked closely with the government to ensure the election campaign was COVID-19 sensitive and also lobbied different political parties to adhere to the principles.

Many political parties' manifestos included WASH and commitments to fight against COVID-19, while also supporting the hygiene response.

## WaterAid supported Electoral Commission of Zambia by:

- Inspecting polling stations to ensure **Standard Operating Procedures** were in place – this included handwashing and sanitation stations were available and accessible to all people, including those with a disability.
- Developing a **checklist** for COVID-sensitive elections.
- Providing **infection, prevention and control** materials – this included visual cues and nudges, soaps, sanitisers and masks.
- Leveraging ongoing behaviour change campaign 'Kutuba' and used **political leaders** to **promote key hygiene behaviours** during the election.

▼ Okyeame Kwame, a WASH Ambassador, interacting with community members on how to prevent the spread of COVID-19. Ghana 2020.



Despite these challenges, we are making huge efforts for our response to be sustainable. Now, as we move forward and transition from an initial rapid emergency response to long-term sustained behaviour change initiative, we have opportunities for new partnerships, increased funding, government commitments and a unique moment to make hygiene for all a priority.

As there is currently an unprecedented focus on hygiene, providing us with an opportunity to leverage multiple motives and change behaviours for an entire generation. Moving hygiene up on the political agenda and holding governments and institutions to account for the progressive realisation of the right to WASH, will help achieve development agendas, allow people to live healthier and longer lives, and aid in the prevention of future pandemics.

At WaterAid, we are leveraging this momentum and moving towards COVID-19 sensitive hygiene behaviour change programming and WASH intervention – focusing on the sustainability of our response.

## Sustainability

**Sustainability** is the heart of what we do, and we always strive to ensure that behaviours and services continue over time. We advocate for sustainable infrastructures and system, with a focus on implementing hygiene through the right institutional mechanisms.

This also includes building local capacity, developing skills of communities and governments, and holding service providers and governments accountable. Even in our initial hygiene emergency response to COVID-19, our aim was to ensure the results were long-lasting, sustainable and that we employed a system strengthening approach. This means working together to transform the national, regional and local systems needed for sustained and equitable hygiene behaviour change and WASH services.

Real hygiene behaviour change takes time and while data shows a high level of exposure to the intervention, we are working to ensure this translates to a long-term change in behaviour.

# 7 Overall learnings and recommendations to build resilience and pandemic preparedness

As we realised COVID-19 was going to be more than an emergency response, we updated our guidance to reflect changes in evidence and minimum standards.

We started promoting our previous hygiene behaviour change campaigns and focused behaviours (handwashing, food hygiene, clean toilets, safe use of water and menstrual hygiene management) while still promoting COVID-19 behaviours (critical handwashing times, use of masks and physical distancing) to ensure our campaigns were carried out safely. Additionally, we reflected on our response, what was working and what needed improvement.

## What did and did not work well?

What went well?	
<b>Rapid learning</b>	Using formative research from 17 countries, two regional state of hygiene studies and assessments, conducting rapid assessments on handwashing in South Asia, and a multi-country MTRA in eight countries. These rapid assessments helped to gather insight and allow for evidence to design an intervention and then at the midpoint to adapt and ensure a progressive response based on evidence.
<b>Partnerships</b>	Our existing close partnership with governments to design, implement and evaluate branded hygiene behaviour change was immensely important. Our ongoing 15 hygiene behaviour change campaigns in different countries offered a foundation to quickly start the COVID-19 response in partnership with governments. Working through existing structures and leveraging partnerships, especially those on the ground, allowed for a rapid response. Collaborating and coordinating between partners helped to strengthen not only our response, but the hygiene sector.
<b>Integration</b>	Integrating hygiene promotion into ongoing programmes such as routine immunisations, hygiene in education, hygiene in the workplace, ongoing government campaigns and COVID-19 vaccination. This allowed us to take opportunity of ongoing and trusted campaigns/structures and quickly reach people.
<b>Large scale hygiene campaign</b>	Working with governments, we implemented 15 hygiene campaigns which we will continue in the coming years while making them COVID-19 sensitive. Global HH4A initiatives and its partnership with local ministries will also open an opportunity to design and promote nationwide hygiene campaigns and enable us to reach people at-scale in other many countries.
<b>Local languages</b>	The use of local and native languages helped to reach those who might be more vulnerable and harder to reach due to who they are or where they live, which improved the trustworthiness of the campaign.

What went well? (continued)	
<b>Two-way systems</b>	Feedback from community was important, especially when fighting a new disease. Having a two-way system, such as call-in radio programmes or WhatsApp messages, allowed for people to ask questions, voice their concerns and provide feedback.
<b>Government leadership is key for scale implementation and ensuring long term financing</b>	2030 is just around the corner. Learning from the past, the sector needs to think and act big. Government leadership and ownership is key for scale implementation. Working together with governments, we need to ensure large scale hygiene programmes have enough financing. Massive sector coordination and political commitments will be key.

What could have been improved?	
<b>Procurement delays</b>	We are not a humanitarian organisation and only have some experience in emergency responses, so we didn't have a quick procurement process set up initially and many delays hindered our first responses – such as building public handwashing facilities.
<b>Innovative hygiene materials for emergency response across all programmes</b>	As few of the behaviours were new, so the existing hygiene package needed updating. Some country programmes quickly re-designed innovative hygiene assets, while others needed more support. This was due to country lockdowns and not being able to mobilise the expertise – also highlighting the uneven capacity in some countries. We are working to put resources together so that a suite of innovative, exciting hygiene assets can be readily available and easily contextualised.
<b>Better engagement with the health and education sector</b>	Countries where we have good functioning relationship with the government, it was quick, and easy to respond hygiene response/campaign as compared to countries where we have only coordination.
<b>Early monitoring and disaggregated indicators</b>	Short term response was prioritised over sustainability, which was reflected in the lack of monitoring and disaggregated indicators. This data collection was thought to have been an extra burden on countries, but the lack of data inhibited important information that could have been crucial to programme design.

## From failure to success and lessons learned

*'While we celebrate success, let's learn from failure and complete the task more intelligently.'*

Learning requires making the link between past actions, the effectiveness of those actions and future action to be taken to improve and strengthen outcomes.

When we first started responding to COVID-19 in March 2020, it was a very new disease with not much information available. Countries around the world were entering different phases of lockdown, businesses were closing, people were working from home and a general sense of the unknown spread globally. As leaders in WASH and hygiene behaviour change, we immediately stepped up to help fight the spread of COVID-19. Over the past 18 months, we have gained immense learnings through new evidence, research, case studies and of course, our failures.

### Key lessons learned include:

- **Perceived risk of failure should not stop innovation.** More can be learned from failure compared to success. Document the learnings and continue to improve.
- **Timely and supportive monitoring** of any innovative ideas and technology are vital to ensure sustainability and avoid long term failure.
- **Failing at an early stage can make future progress stronger.** Use the evidence to intervene and adapt the design or programme quickly.
- It is critical to **investigate small-scale failures** within our large-scale hygiene response to COVID-19 and to **document these learnings**.

Many countries are currently experiencing third/ fourth waves with cases and hospitalisations increasing. Findings from our response and MTRA are being incorporated into ongoing programming, and have been shared with other NGOs and governments to shape activities. For example in Zambia, the Red Cross came up with an adapted COVID-19 response plan based on the findings from the MTRA conducted by WaterAid – while the Zambia government used the results to develop sub-national response plans. In East Africa, we have been approached by other actors and asked to replicate handwashing technology as the model for scale up across various countries.

## Building resilience and pandemic preparedness

Over the past 18 months learnings, recommendations, resilience and pandemic preparedness have been key terms in our vocabulary. When reflecting on our work, the key parts that contributed to success included working closely with ministries responsible for WASH, including health and education, and the private sector. We influenced governments' COVID-19 programming by supporting the adaptation of materials and trained government staff. Furthermore, ongoing hygiene behaviour change campaigns at scale provided a way to make hygiene a national priority.

While there are still challenges around ensuring government agencies take on long-term responsibility for promotion of overall behaviour change programmes and handwashing facilities, donors and Government need to urgently increase non-restrictive funding in hygiene programmes as a critical element of pandemic response and preparedness. This will allow funds to be contextualised and organisations to respond to needs on the ground.

Achieving global hygiene for all requires substantial planning and investment. Costed strategies and plans will help long-term programming. For sustainability, governments must lead this process and take advantage of the political momentum and prioritisation gained during the pandemic.

## Final recommendations and learnings

### Be prepared with a proof of concept package

Countries showed they can implement effective hygiene behaviour change campaigns delivered through mass media during an emergency response, followed by community-based intervention.

We should retain the institutional learning and produce an emergency package (with streamlined BCD approach, menu of activities, templates, assets and a compendium of technologies) that can be adapted and deployed for a quicker response in a future crisis or emergency.

### Integrate hygiene in other sectors

Continue to prioritise and build on awareness of hygiene as a global priority to achieve multiple development agenda goals, including pandemic preparedness and preventing and responding to the public health emergencies. Push for hygiene to be prioritised in health, education, the workplace and public places – ensuring there are adequate budgets, capacity building and plans in place.

While governments recognise the importance of hygiene, it is key to positively influence behaviours in a more creative manner and understanding the importance of visual cues/ nudges, and delivering the campaign through existing government mechanisms.

### Handwashing facilities during emergencies

Have a standardised and inclusive handwashing facility design ready. Ensure supplier and procurement plans are in place to quickly fabricate and deliver handwashing facilities when needed. Safety and accessibility audits should be conducted during design and delivery. Making sure an O&M plan is in place with a long-term monitoring system.

### Sustainability of behaviours and handwashing facilities

Behaviours need to be reinforced over time and there should be an institutional mechanism and capacity to do so. Handwashing facilities need ongoing support – this includes post-project support (such as training) to management committees, long term monitoring, a handover plan and operation and maintenance plan. Funds should be allocated to support follow up transition of handwashing facilities.

### Equity and inclusion

Embed equality and inclusion as core principles from the beginning of a programme (as a minimum standard). Ensure we are gender responsive in our approach and acknowledge that pandemics and crises affect genders differently.

Make sure targeted and groups who are at risk of marginalisation are part of the design process to ensure it is contextualised and relevant. Use multiple touchpoints during delivery to reach remote populations and excluded groups.

### M&E to support effective programmes

A strong enabling environment is linked to robust monitoring. Good data is key for adapting programmes, advocating for adequate finance, incorporating into policy and strategy. Ensure key indicators are included from the beginning and strengthen monitoring and gathering evidence – MTRA is a good example of this.

### Behaviour change is key

Promotion efforts should be centred around exciting, engaging behaviour change activities and not solely based on information provision and education. Using principles of behaviour change to invoke surprise and emotion will help to facilitate new behaviours. Application of the BCD approach even in emergencies demonstrated good results.



## Where to focus in the future?

- **Science and evidence-based behaviour change intervention:** Hygiene behaviour change programmes should target disease sensitive behaviours that are essential to prevent transmission. We will continue focusing on multiple behaviours targeting different settings. We should not rush to implement knowledge-focused intervention even during emergencies, but rather be intentional in using theoretical frameworks such as BCD, clear ToC and generate evidence through assessments/formative research and implement behaviour change centric intervention.
- **Focus on peoples' emotions, motivation, change in behavioural settings and social norms:** Based on science, we have learned that any behaviour change intervention should have **three behaviour change levers** to achieve lasting change. Always use activities that are linked with peoples' motives/emotions, go beyond fear and use multiple motives. Changing behavioural settings is possible through the placement of behavioural products or facilities (such as handwashing facilities) with visual cues, nudges, reminders to reinforce behaviours. Where facilities are installed, O&M plan/actions, and long-term monitoring is key. Always focus on changing social norms within the behavioural settings.
- **Focus on higher exposure, intensity and maintaining fidelity:** One off exposure is not enough, higher reach with repeated frequency using multiple assets is key to reinforce behaviours, and also reduce campaign fatigue. As much as we are concerned about the campaign fidelity, if we are responding to pandemic like this and dealing with dynamic nature of the virus, the hygiene campaign package also needs to be progressive to avoid campaign saturation. This is why diversity in assets is important while targeting multiple target groups.
- **Focus on inclusivity and sustainability:** Be intentional to use an equality and inclusion framework from the start. Use existing large-scale institutionalised delivery modality, such as integrating hygiene into WASH, health, education, nutrition, neglected tropical diseases (NTD)

programmes, where possible. Mass media followed by community-based intervention has greater strength for sustainability. Consider groups that might be more likely to be marginalised during outbreaks.

- **Think big, act at scale and ensure long term financing:** Historically, many small-scale projects have been implemented and demonstrated a lot of learning in the sector, but now we need to think big, act big and move fast. It was evident throughout the pandemic that hygiene is crucial at all levels. Government leadership for scale implementation is key and scale implementation is only possible if government takes ownership/leadership. Government owned programmes have achieved national scale implementation and built capacity through the training of existing human resources. Part of the global HH4A initiative, countries are developing hand hygiene roadmaps but those need to be fully costed, financed, implemented at scale and should cover multiple hygiene behaviours during design and implementation.

▼ A child washes his hands with soap and new inclusive handwashing facilities in Tanzania on Global Handwashing Day, 2020.



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Front cover left image: Roger Kigenza (26, left) and Louise Mukeshimana (28, right), the community members washing their hands at one of the new handwashing facilities during the handover ceremony at Kinyinya Health Centre, Gasabo District, Kigali City. Rwanda. December 2020.

Front cover bottom image: Participants preparing the liquid soap, Kirtipur Municipality, Kathmandu, Nepal. September 2020.

Front cover right image: A man in Zambia shows off his mirror branded with key behaviours after a hygiene promotion session.

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