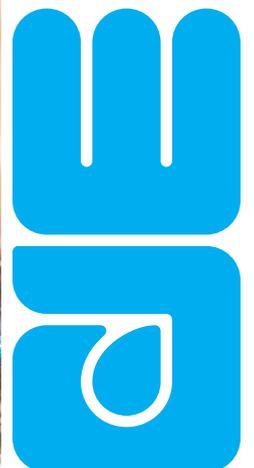




Framework

Hygiene behaviour change



WaterAid

Together, the documents below set out how we will achieve our vision of everyone, everywhere with clean water, sanitation and hygiene by 2030.

Global strategy

The frameworks define our position, approach and programme standards for all our areas of work: a) our cross-cutting principles – human rights, sustainability, equality and inclusion, and partnership; b) our core programme approaches – sector strengthening and empowerment, WASH in other sectors, and hygiene behaviour change; c) our thematic/geographic work – water, sanitation, hygiene, and urban WASH. The frameworks point to accompanying guidelines, toolkits and resources to provide more detail on how to apply the frameworks in practice.

Our role and programmatic approach

Quality programme standards and policies

Our frameworks are developed through a collaborative process, involving staff across the global organisation and external stakeholders. This ensures our position, approach and standards are based on experience and best practice, making our work more effective. They are periodically updated as our learning, and that of the wider sector, evolves.

Frameworks and delivery concepts

Our frameworks have been developed and approved through the Global Programmes Executive. The programme standards from all the frameworks are collated into the *Quality programme standards*.

- Guidelines
- Toolkits
- Resources

Hygiene behaviour change framework

Position

Good hygiene behaviours, supported by clean water and sanitation, are necessary to prevent the transmission of pathogens and diseases, keeping people healthy. With good hygiene and better health, children can go to school, adults can work, and people can live more dignified lives.

However, preventable diarrhoeal diseases, pneumonia, typhoid, soil-transmitted helminths (STHs), trachoma and other neglected tropical diseases are still prevalent in many countries where hygiene conditions and practices are poor. Only 19% of people across the world wash their hands with soap after defecating¹ and 35% of healthcare facilities have no water and soap for handwashing.² Diarrhoea remains the fourth leading cause of death among children under five globally, resulting in almost half a million deaths each year,³ and has lasting effects and irreversible impacts on children's nutritional status⁴ and development potential.

Sustaining good hygiene behaviours, such as handwashing with soap, is linked to a 32-48% reduction in the risk of diarrhoea,⁵ a 16-21% reduction in the risk of acute respiratory infections,⁶ and a substantial reduction in neonatal infections.⁷ Good food hygiene, household water treatment and safe disposal of child faeces prevent diseases, and improved hygiene practices in healthcare facilities can reduce healthcare-acquired infections and the associated mortality.

Hygiene behaviour change interventions are proven and cost effective. They have the potential to transform health, nutrition, education and economic development globally. Yet, hygiene has been neglected, putting people at risk of preventable diseases. Universal access to good hygiene must be prioritised at local, district and national levels – at home and in communities, schools, public places and healthcare settings. As outlined in our *Global Strategy 2015-20*,⁸ to achieve our vision of everyone, everywhere by 2030, hygiene behaviour change must be included in all WaterAid programmes.



● Madina, 11, a member of her school's hygiene club, washes her hands with soap at her new school toilet block, Mecanhelas district, Mozambique.

We use evidence-based, innovative and creative hygiene behaviour change interventions that improve people's health and dignity. We do this by motivating them to think and act differently, making positive changes to their environment (physical, social and biological) and influencing policy.



Approach

Changing people's behaviour is difficult and complex.⁹ But it is possible, with the right approach.

Hygiene promotion is too often focused on simply educating people about health, germs and disease, using messages, posters and leaflets. Such approaches rarely result in sustained behaviour change¹⁰ because they don't consider cultural, social, psychological and environmental factors, including people's motives and access to WASH.

There is mounting evidence that research-based interventions that address people's individual motives, use emotional triggers, take marketing approaches, make environmental changes and involve the whole community are much more successful in improving behaviours such as handwashing¹¹ and food hygiene.¹² Our programmatic approach enables us to bring about transformational change through policy, practice and advocacy activities based on critical analysis.

There are more than 100 theories to guide hygiene behaviour change approaches, from those based on cognitive, knowledge-based principles (educational model), behavioural economics and health psychology to theories based on social psychology, focusing on people's emotions and changes in behavioural settings.

The dominant behaviour change theories and approaches used in the water, sanitation and hygiene (WASH) and health sectors include the social norms approach, cognitive dissonance approach, health belief model, theory of planned behaviours, participatory community-based approaches (including SARAR, participatory rural appraisal [PRA], participatory hygiene and sanitation transformation [PHAST], community-led total sanitation [CLTS], community health clubs [CHD] and child-to-child [CtC]), marketing approaches, and recent approaches such as SaniFOAM, IBM-WASH, COM-B, the RANAS model and behaviour-centred design (BCD).

The diversity of approaches available reflects the complexity of human behaviour. Each approach has its own strengths and weaknesses. Many theoretical approaches focus on understanding what makes people change their behaviour, but few use evidence to design, implement and evaluate programmes.

At WaterAid, we initially (1981-95) focused on the provision of taps and toilets, but learned that although infrastructure enables good hygiene it doesn't sufficiently encourage people to change their behaviours. To generate more awareness, increase demand and promote the importance of key behaviours, we added knowledge improvement to our service provision (1995-2014). However, this still didn't result in lasting improved behaviours.

● Swala Kumari Singh, 44, holding a mirror and a fan illustrating key hygiene behaviours. Dhime, Jajarkot, Nepal.



Based on this experience, our hygiene approach now focuses on sustained behaviour change. We are moving away from the cognition model (teaching people to do things) to more creative and scientific approaches that address people's motivations, disturb their behavioural settings (environment), and make improved behaviours new social norms. This approach rewards people for adopting new habits, changing what is considered normal in communities.

Since 2015, we've aimed for a consistent approach to hygiene across all our country programmes, maximising our impact. We use what we learn to influence the wider sector to implement more innovative programming in communities and institutions (such as schools and healthcare facilities). We champion an evidence-based and context-specific approach that results in lasting positive changes.

Hygiene behaviour change is an essential component of our work and embedded in our water and sanitation programmes, policy and advocacy, capacity building, monitoring and evaluation, and organisational management. We design hygiene interventions through a creative process based on evidence from formative research. We continually build the technical capacity of our staff, partners and stakeholders, using our experience and research to design more effective interventions. We implement our hygiene work through sustainable institutional mechanisms using the latest approaches. We evaluate our behaviour change programmes to improve our work and we share this knowledge with others and use it to influence policy.

● **Djelika Coulibaly standing outside the women's latrine block in Bougoura Communal Health Centre, Segou region, Mali.**

We work together with partners in local, district and national governments, and sectors including WASH, health, education and nutrition. We help to promote sustained hygiene behaviour change at scale by building the capacity of local non-governmental organisations, community-based organisations, academic institutions, research-based institutions, the private sector, specialist groups such as women's groups and disability organisations, networks and civil society organisations. We support governments to develop and implement national hygiene policies and strategies, programme guidelines, and effective monitoring and evaluation systems. We research why hygiene is not prioritised and some improvements fail. And we advocate effective behaviour change approaches at all levels – global, regional, national, sub-national and community.



WaterAid/Basile Ouedraogo

Key principles

1. We take innovative approaches that appeal to people's emotions and motivations to achieve sustainable behaviour change

Knowledge-based hygiene interventions do not work. Traditional programmes focus on educating people about health, germs and disease. Such approaches rarely result in sustained behaviour change¹⁰ because they fail to account for the fundamental role of cultural and social norms,¹³ environmental constraints (such as access to WASH facilities and products) and human motives. Differences between what people know and what they do are well documented. People know they should wash their hands and what the health benefits are – but they still don't. For this reason, we take an innovative approach that considers which factors motivate people (such as nurture – the desire to care for children, disgust – the desire to avoid dirt and sources of infection, affiliation – the desire to fit in and belong socially, status – the desire to improve our social position, and comfort – the desire to make things easy) to change their behaviour, and we use reminders and nudges to reinforce behaviours and sustain positive habits.

● **Abdou Sogoba, 50, inside the toilet he built in his compound, Toukoro village, Segou region, Mali.**



WaterAid/Basile Ouedraogo

2. We use a creative process to design context-specific hygiene interventions based on evidence

Before designing an intervention, we conduct formative research to understand the context, target population, behavioural determinants (physical, social and biological), motivational factors (such as nurture, disgust, affiliation, status and comfort), touch points to reach people, social/cultural diversity, power relations, gender norms, and barriers to sustaining good behaviours. We also assess the institutional structure for delivering hygiene behaviour change interventions and the policy environment (the availability of policies, guidelines, frameworks and standards). We consider the diverse roles and experiences within the community and make sure we understand the different perspectives of women and girls, men and boys, children, older people, people with disabilities, people living with HIV and AIDS, ethnic and religious minorities, slum dwellers and people in remote locations.

Once we have the evidence we need, we lead the creative process to design the intervention package, working with a multi-disciplinary team. We gather insights and inspiration for the campaign, identify motivational activities to engage the target populations, and find ways to make the intervention innovative and surprising, addressing people's motivations and challenging barriers. We take an inclusive approach during design to make our work relevant and accessible to all members of the community. We design a range of promotional packages for different target populations in various settings (households, communities, schools, healthcare settings, public institutions and policy settings). And we make sure our work is socially and culturally appropriate, so that our intervention can achieve sustained behaviour change at scale.

Any intervention should address three levers for change:

- **Change the script in people's heads**

Address the key motives and emotions identified through research and assessment to introduce new behavioural rules and habits.

- **Create new social norms**

Promote a collective desire (such as to become the ideal family) based on good hygiene behaviours within the community. Use participatory activities like games, competitions, public pledging events and emotional demonstration activities to embed social practices and challenge cultural barriers.

- **Change environmental settings (physical, social and biological)**

Make sure the environment supports improvements to behaviours, ensuring behaviour change products are available in the right places (for example, positioning handwashing stations with soap and water close to toilets and in kitchens), and placing visual cues, nudges and reminders to reinforce behaviour.

When appropriate, we introduce social marketing approaches to provide essential items for hygienic practices, such as soap, menstrual pads and handwashing stations.

3. We target key hygiene behaviours

Although many hygiene behaviours are important, including too many in an intervention risks diluting the focus. Likewise, evidence shows that focusing on just one has a limited impact. We focus on a small selection of key hygiene behaviours under the single umbrella of hygiene promotion:

- **Handwashing with soap at critical moments** (such as after defecating or cleaning a child's bottom, before eating food or feeding children, and after touching dust, dirt or waste; or before and after touching patients and contact with medical waste and bodily fluids in healthcare settings)

- **Safe use (including cleanliness) and hygienic management of human excreta** (including children's faeces)

- **Safe domestic water management from source to the point of consumption** (including collection, transportation, storage, household water treatment, and consumption)

- **Food hygiene** (ensuring thorough cooking and re-heating, proper storage of cooked food, handwashing with soap before eating food or feeding children, and cleaning serving utensils just before serving food)

- **Menstrual hygiene** (focusing on improving awareness, challenging taboos, improving facilities, promoting the use of products and managing waste in household, community and institutional settings)

- **Other context-specific behaviours** (such as face washing in areas in where trachoma is endemic, and cleaning and waste management in institutional settings)

- **Julianna, 16, hangs up her cotton sanitary towels to dry after washing them. Part of a hygiene awareness project in Morondavo, Madagascar.**



WaterAid/Kate Holt

4. We carry out hygiene programmes in various settings using three key implementation modalities

Our hygiene interventions are mainly implemented in five key settings:

1. **Households and community settings** (rural, urban, slum, hard-to-reach, emergency)
2. **Healthcare settings** (local healthcare facilities, hospitals, care homes, health outreach clinics)
3. **Educational settings** (schools, informal education centres)
4. **Public spaces** (local markets, transport hubs, beaches, workplaces)
5. **Institutional settings** (changing the behaviours of government stakeholders and key decision-makers to support a positive regulatory environment for hygiene)

Our hygiene behaviour change programmes in these settings are implemented using three different modalities targeting key behaviours:

- **Mainstreaming/comprehensive modality:** integrating hygiene behaviour change into water supply and sanitation programmes to maximise the impact
- **Integration modality:** integrating hygiene behaviour change into health (child health, immunisation, management of childhood illness, healthcare services, disease prevention), nutrition and education to ensure sustainable delivery
- **Campaign modality:** initiating hygiene campaigns at scale (nationwide, district-wide, city-wide, region/province-wide) to reach a wider target population in a specific timeframe

These delivery mechanisms should expose more than 80% of the primary target population four to six times using different touchpoints, focusing on key behaviours.

5. We take a systems-strengthening approach to improve sustainability

To sustain hygiene behaviours, we consider: coordination and integration, strategic planning and formative research, functional institutional arrangements, accountable governance, effective delivery of services and behaviour change, policy environment, monitoring and evaluation systems and sustained financing.

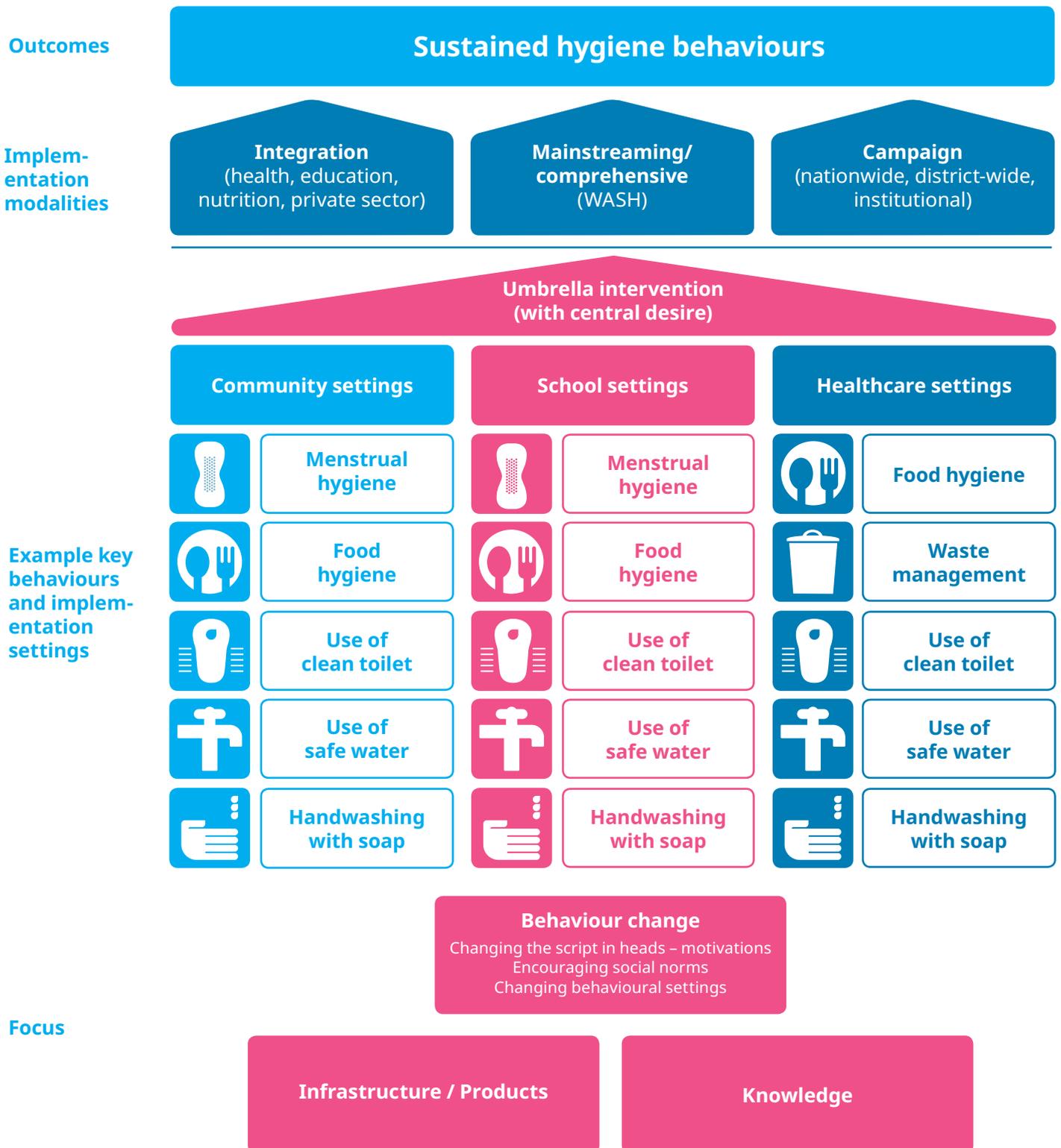
We support governments to increase their capacity to plan (district-wide/city-wide/municipality-wide), design, execute, and prioritise and allocate funding for hygiene behaviour change interventions. We support them to formulate standards, guidelines and policies. We encourage governments and the private sector to integrate hygiene into health, nutrition and education. And we help build or strengthen monitoring and evaluation systems to assess hygiene behaviours and measure the impact of interventions.

6. We work in partnership to maximise our impact

We work in partnership, sharing our knowledge and experience on hygiene behaviour change with key institutions, including:

- national, district and local governments in WASH, health, nutrition and education
- civil society organisations
- partners in women's organisations and disability organisations, to make sure behaviour change programmes are inclusive
- academic and research institutions to generate new knowledge and evaluate programmes
- the private sector and marketing partners, to jointly design more innovative, and therefore more sustainable, interventions

Key shifts and implementation modalities



- user committees/groups, front-line health workers, and volunteers, taking a participatory approach
- alliances, networks and global partners, helping to shape the agenda, share innovation and learning, harmonise approaches, and contribute to the sustainable development agenda

7. We carry out evidence-based advocacy to influence policies and financing

Our hygiene work embodies our approach of integrating our programme and influencing work to achieve sustained positive changes. And we call for governments to take responsibility for hygiene and hold themselves accountable. We advocate effective national policies, strategies, guidelines and standards.

Our country teams strategically engage with governments, researching and addressing the factors that hold back hygiene improvements. We engage with donors, governments and partners at global and national level to increase their prioritisation of hygiene and encourage them to allocate long-term resources (financial and human) to behaviour change interventions. We use evidence to demonstrate how much more effective innovative behaviour change campaigns can be than traditional approaches, and support sectoral monitoring and evaluation systems that show the impact. And we work across sectors to integrate hygiene into health, nutrition and education.

8. We strengthen monitoring systems and use evidence to improve our programmes

We use our planning, monitoring, evaluation and reporting (PMER) core procedures, processes and systems to regularly assess our work and improve our approaches. We define an appropriate set of indicators to measure, monitor and evaluate our programmes at baseline, during implementation and in follow-up.

We monitor our progress at project and programme levels, and at national and sub-national levels:

- At project and programme levels, we measure the outcomes of the hygiene intervention, such as actual behaviour change, through observation, spot checks (for example, recording the availability of handwashing facilities with soap and water in relevant locations), and self-reporting (for example, recording people's knowledge, reported behaviours and social norms). We monitor the number of people in the target population that have been sufficiently exposed to the hygiene intervention four to six times in a year. And we monitor our processes to understand which factors deliver sustained changes and which don't. We also assess the sustainability of the project or programme over time.
- At the national and sub-national levels, we assess system indicators, such as whether district-wide/city-wide plans have been developed, policy has changed and standards or guidelines have been developed, and whether our contribution has influenced forum discussions or sector monitoring. We also assess whether joint model initiatives have led to implementation at scale through different sectors.

- We use various methods and tools to monitor and measure outcomes and evaluate the effect of the behaviour change programme. We champion the development and implementation of baseline and monitoring data and minimise any knowledge gaps by conducting our own evidence-based research. We periodically evaluate our hygiene programmes to find out whether the intended outcomes have been achieved and sustained over time. We use evidence of actual behaviour change rather than relying solely on self-reporting, which can overstate change.
- Our research, evidence-based planning, reviews, reflections and revisions all contribute to more effective and sustainable interventions. We use simple, reliable and measurable indicators and approaches to record hygiene behaviours accurately and minimise bias.

9. Our hygiene promotion work is equitable and inclusive

Our hygiene behaviour change programmes take on different forms depending on the local context. However, all use the same principles. Our programmes are inclusive, participatory, non-discriminatory, relevant and accessible to all members of society. The safety of the target population, including children, women and people with disabilities, is vital. We and our partners are responsible for preventing anyone being abused or ill-treated through our work, and we hold ourselves accountable. Our child protection policy protects the rights of all children and young people, including those with disabilities or from religious or ethnic minorities, and regardless of gender, sexual orientation or status.

Everyone in the target population, especially the most vulnerable and disadvantaged individuals and groups, must be able to access the programme without discrimination. We listen to people's voices before designing the intervention (during formative research) and ensure women, men, people with disabilities, older people and children are represented in the creative process and during implementation.

Our hygiene interventions should empower women and marginalised people. They should avoid gender-based or any socially constructed stereotyping. We strive to ensure our resources are available in different forms for people with different abilities, and for those with visual and hearing impairments. We collaborate with disabled people's organisations to continually improve and build the capacity of specialist organisations to help design, implement and evaluate our hygiene programmes.

Gender-sensitive programming is critical because there are gender-defined roles and responsibilities for specific behaviours in many societies, such as women being expected to collect water and prepare meals. Menstrual hygiene management directly affects women and girls but is often surrounded by social stigma and taboo. We use female facilitators and learning spaces that are accessible for women. This provides an opportunity to empower women and increase their participation. We take care to avoid bringing about unintended consequences for gender roles, such as adding to women's roles and responsibilities, or encouraging gender-specific norms.

Our hygiene facilities are gender-separated, inclusive and child-friendly where appropriate. Handwashing facilities are inclusive, child-friendly and include a safe, clean space where women can manage their periods hygienically.

Applying the principles of behaviour-centred design in practice

In line with our global strategy 2015-20 and our programmatic approach, we aim for a consistent hygiene behaviour change approach, based on our key guiding principles, across our country programmes. This allows between-country comparisons and creates new opportunities for learning. We provide guidance to staff and partners on how to design, implement and evaluate a behaviour change intervention. We take a behaviour-centred design¹⁴ approach to guide our hygiene programme design and programming cycle. This uses an ABCDE model to put the approach into operation: A: Assess, B: Build, C: Create, D: Deliver, and E: Evaluate.

A: Assess

This step involves collecting and analysing scientific and local knowledge (secondary sources) to determine what is known, or unknown, about current and desired hygiene behaviours. It involves a literature review and one-day framing workshop with relevant stakeholders, including government. It looks at when and where certain behaviours are practised, what might change behaviours, and how the target audience might be affected. The knowledge gaps identified in this step help define the scope of the formative research (B). This step should take no more than one month.

B: Build

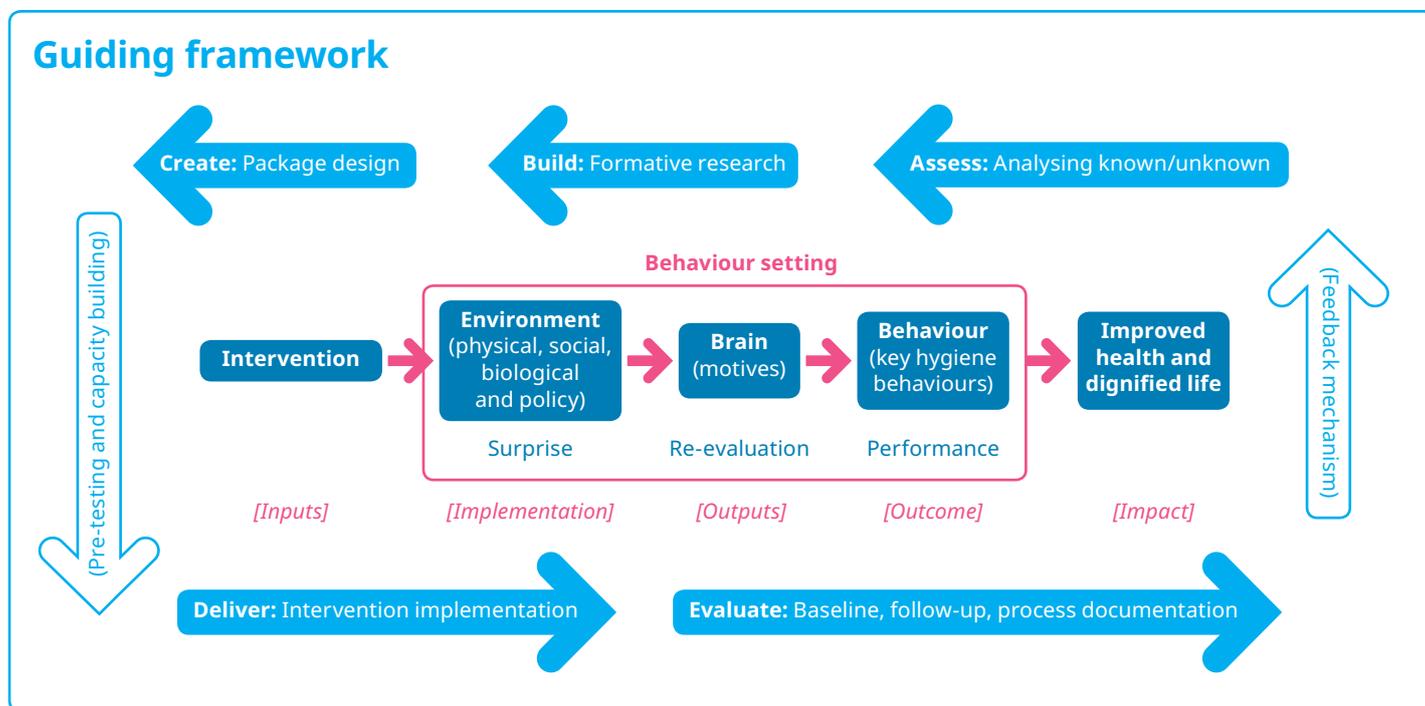
This step involves formative research. During this stage, we fill the identified knowledge gaps by gaining an understanding of the target population's behavioural determinants, motives, barriers, power relations, socio-cultural norms and touch points, and we define the key behaviours to change. This formative research should provide enough information and insight to design the intervention package. It should take no more than two months.



● A female health volunteer conducting a hygiene session at District Hospital Khalanga, Jajarkot, Nepal.

C: Create

This step involves designing a behaviour change intervention package based on insights from the formative research. The package should be context-specific, comprehensive, innovative and engaging. It requires working with a creative team or agency to brand the campaign and develop promotional materials, tools and activities that are surprising and engaging, including the three levers for behaviour change. This step also involves agreeing on the key performance indicators, duration of the campaign and intensity of the implementation; developing a clear theory of change and capacity building plan; and producing the package. It should take no more than three months.



D: Deliver

This step involves implementing the intervention package through a sustained delivery mechanism (touchpoints) so that the maximum proportion of the target population is exposed to the programme activities (four to six times in a year). The intervention should motivate people, change the environment to reinforce behaviours, and create new social norms related to the target behaviours. It should be delivered using a three-pronged approach: mainstreaming – together with water and sanitation services; integration – integrating hygiene into health, nutrition, education and the private sector; and campaign – implementing the programme nationally, district-wide and city-wide. This step involves building the capacity of partners, stakeholders and front-line hygiene promoters to implement the programme effectively. Ideally, it should take at least a year.

E: Evaluate

This step involves monitoring and evaluating the hygiene intervention. We assess whether the predicted environmental, psychological and behavioural changes occurred after the intervention. This involves looking at whether the desired changes have been achieved and understanding how actual behaviour has changed at project/programme level and how we influence at sub-national/national level. We conduct baseline, endline and process monitoring, and assess the reach of the intervention and its social effect. This should take no more than two to three months.

Strategic fit

Good hygiene practices are integral to the transformational change needed to achieve our vision of everyone, everywhere with clean water, sanitation and hygiene by 2030. Hygiene is one of the four strategic aims in our global strategy 2015-20. It is central to our work, maximising the benefits of access to clean water and sanitation and improving health, nutrition, education and livelihoods.* Our hygiene work feeds into our four strategic aims, as explained below:

Equality

Traditional approaches to hygiene fail to change the behaviours of the people most in need (including women and girls, children and people with disabilities) and entrench inequalities. Our approach addresses the key barriers for the whole community, focusing on the most marginalised people. Our work is inclusive, using a range of touchpoints and methods that follow equality and inclusion principles. We work with specialist partners to continually make our work more inclusive.

Sustainable services

Ensuring improved hygiene behaviours and sustaining them is a challenge. Our innovative, creative and evidence-based interventions, considering people's emotions, motivations and context, lead to lasting habits and new norms. To improve the sustainability of our hygiene interventions, we: improve sector coordination, build the capacity of partners, support strategic planning in district/city-wide projects, find new, sustainable ways to fund our work, support institutions, help develop policies and standards, make use of innovative technologies and promote knowledge sharing.

Hygiene

Improving people's hygiene practices is a key aim of our work, maximising the benefits of access to clean water and sanitation and improving health, nutrition, education and livelihoods. We design innovative, creative and evidence-based interventions based on people's emotions, motivations and context. We focus on changing key hygiene behaviours to maximise our impact. We build the capacity of our stakeholders, partners and staff to design and implement hygiene robust programming. Our strategic partnerships with governments, public institutions, academia, the private sector and civil society support sustainable hygiene improvements at scale.

Integration

Good hygiene behaviours are essential to many other development goals. However, hygiene is often neglected and remains one of the biggest challenges to sustainable development. Governments, development partners, civil society and the private sector all share the responsibility for improving hygiene. We position hygiene as key entry point at which to work with and engage partners in health, nutrition, education and the private sector, encouraging collaboration and cross-sector working. We advocate putting hygiene at the centre of development programmes to improve people's health, wellbeing and dignity.

* WaterAid staff can find out more about the strategic shifts we're making in our hygiene programmes and influencing work on our intranet page, KnowledgeNet.

Rationale

Hygiene behaviour change is a major challenge to sustainable development

Hygiene is one of the most cost-effective health and WASH interventions. Yet, it is neglected – in public health, health policy, nutrition, education, monitoring frameworks and even WASH sector interventions. Although poor hygiene behaviours are the leading cause of morbidity and mortality from chronic health conditions and injuries globally,¹⁵ only 3% of health funding goes to hygiene behaviour change. The World Health Organization estimates around 22% of WASH-related diseases are behaviour-related but only 1% of national WASH funding goes to hygiene promotion.¹⁶ Hygiene programmes are often short-term and an afterthought. They are insufficiently planned and fragmented, limiting their impact and weakening the case for investment. Governments have an obligation to protect human rights, and are therefore critical in ensuring the success of efforts to improve hygiene behaviour change long term.

- **We believe strong government leadership is needed to achieve sustainable hygiene behaviour change. Hygiene must be integrated into efforts towards other Sustainable Development Goals. We start by understanding what works and what doesn't. We support governments to develop appropriate policies, legal frameworks, guidelines, standards and hygiene promotion packages/tools, and strengthen their capacity to execute them effectively. We work with national, district and local governments, advocating the allocation of long-term resources (financial and human) to hygiene behaviour change.**

Knowledge-based hygiene promotion, focusing only on infrastructure, does not change behaviours

While water and sanitation infrastructure and raising awareness of hygiene provide the physical conditions and knowledge for good hygiene practices, such approaches rarely result in sustained behaviour change. Globally, 27% of households and 53% of schools have handwashing facilities with soap and water,¹⁷ but only 19% of people wash their hands with soap and water after defecating.¹⁸ Unless good hygiene behaviours are made new social norms, toilets will not be used, food and water will continue to be contaminated, and people's health and dignity will be compromised.

- **We use innovative, creative and evidence-based approaches to hygiene behaviour change, targeting people's emotional motivations (nurture, disgust, affiliation, status and comfort), making changes to their environments and creating new cultural norms. We use our own experience and that of the wider sector to find out what works and what doesn't, continually improving our effectiveness.**

Hygiene interventions not based on evidence have a limited effect

Using evidence of what motivates people to change their behaviours and what holds them back is essential. While there is much evidence of what does not work, there is less of what does work. In each context, people's needs and motivations change, along with barriers and social and cultural norms. Hygiene programmes need to be based on formative research to be sustainable. Recognising the key hygiene behaviours to address is necessary to focus our efforts and improve our effectiveness. Hygiene interventions should be context-specific, taking into account the political, social, cultural and physical environment.

- We use evidence from formative research to design an innovative and creative hygiene intervention package through a creative process. We target key hygiene behaviours specific to each context to increase our effectiveness. And we tackle broader blockages and share our knowledge and experience with governments and partners to make an even bigger impact.

Without attention to equality and inclusion, hygiene interventions fail to change the lives of the people most in need

Traditional hygiene interventions fail to benefit the poorest and most marginalised people – women and girls, children, older people, people with disabilities, people living with HIV and AIDS, ethnic and religious minorities, slum dwellers, and people in remote locations. These people are typically excluded from research, design and implementation. Governments and civil society organisations often lack the skills, capacity and, in some cases, motivation to engage with the poorest and most marginalised people and implement programmes that benefit them. Where national governments have little or no control over non-state service providers, best practices are rarely followed.

- Our hygiene programmes focus on improving the behaviours of the poorest and most marginalised people. Equality and inclusion are embedded across our work. We advocate inclusive and accessible hygiene programmes and facilities for all. We carry out research to understand the power relations within communities and households, and use this information to ensure our work benefits those most in need and does not inadvertently reinforce negative social norms and stereotypes.

The lack of coordination and clear roles and responsibilities between government, service providers and stakeholders is a problem

In many countries, there is not a single body with responsibility for improving hygiene. Though the role of hygiene in improving health, nutrition and education is clear, these sectors still need to integrate hygiene into their policies and programming. Hygiene is typically not centralised, so roles and responsibilities are confused and resources lacking. Where coordination is happening, different organisations are using different approaches, limiting the impact.

- We work with governments and other organisations to put hygiene at the centre of WASH, health, nutrition, education and women's empowerment. We advocate clear institutional roles and responsibilities and greater integration. We engage in national hygiene policy and strategy formulation and support its implementation at local level to ensure a more focused, coordinated approach. And we work with partners across sectors to provide evidence of effective collaboration.



● Ghulam Fareed, 68, in front of the washroom in his house, Patan Wala village, Punjab province, Pakistan.

Quality programme standards*

Risk critical standards

R6 In hygiene interventions we must focus on behaviour change, and expose the target population multiple times.

Minimum standards

- M3.1 We will research the determinants of hygiene behaviours and social norms, and use creative processes to develop context-relevant, attractive and engaging hygiene promotion packages.
- M3.2 We will focus on behaviour change, and target people in household, community and institutional settings.
- M3.3 We will expose target populations multiple times to different components of the behaviour change package.
- M3.4 We will prioritise the following key hygiene behaviours, as appropriate for the context:
- Handwashing with soap at critical moments
 - Safe use and management or disposal of human excreta (including child faeces) and cleanliness of sanitation facilities
 - Safe domestic water storage and management from source to the point of consumption
 - Food hygiene (especially in relation to weaning and children's food)
 - Menstrual hygiene management
 - Other context-specific hygiene behaviours (such as face washing, solid and liquid waste management and household cleanliness)
- M2.2 We will encourage and support the active and meaningful participation of people who are marginalised and excluded.

Full quality programme standards: strategy level

- S3.1 We will encourage, champion and support governments to develop and implement national hygiene policies, strategies and programmes, and will be an active partner in implementing and monitoring them.
- S3.2 We will use our activities in hygiene behaviour change as a route to integrate WASH work with health, nutrition, education and private sector priorities.
- S3.3 We will ensure integration of public hygiene programmes within national and local health, nutrition and education plans and institutions.
- S3.4 We will highlight the public health challenges of highly populated low-income communities and promote the business case for investing in hygiene behaviour change to governments and development partners.
- S2.2 We will recognise that with rights come responsibilities. We will ensure communities are able to manage their own services where appropriate, and to practise good hygiene behaviours.

* While each thematic area of our work has its own set of standards, you will need to take a holistic approach, meeting all relevant standards in your programme work. See *Quality programme standards*¹⁹ for the full list.

Full quality programme standards: programme level

- PG2.2 We will support communities to fulfil their responsibilities to help to manage services and practise good hygiene behaviours.
- PG3.1 We will use knowledge of behavioural determinants and social norms to design hygiene promotion packages appropriate for each context. This approach will include methods such as formative research and will draw on expertise from different disciplines to design interventions through creative processes.
- PG3.2 We will use innovative and creative approaches rather than standalone knowledge-based campaigns to ensure sustainable behaviour change.
- PG3.3 We will prioritise hygiene behaviour change equally alongside water and sanitation, in terms of resource allocation, internal and partner capacity, and monitoring and evaluation.
- PG3.4 Our advocacy and policy work will position hygiene as fundamental to sustaining the benefits of improved safe water and sanitation services, enhancing dignity and maintaining health.
- PG3.5 We will integrate hygiene behaviour change with water and sanitation programmes.
- PG3.6 We will work with governments to integrate hygiene behaviour change with health, nutrition and education programmes, or as a standalone behaviour change campaign at district or national scale.
- PG3.7 We will prioritise the following key hygiene behaviours, depending on context, under the umbrella of hygiene promotion:
- Handwashing with soap at critical moments
 - Safe management or disposal of human excreta (including child faeces) and cleanliness of sanitation facilities
 - Safe domestic water storage and management from source to the point of consumption
 - Food hygiene (especially in relation to weaning and children's food)
 - Menstrual hygiene management
 - Other context-specific hygiene behaviours (such as face washing, solid and liquid waste management and household cleanliness)
- PG3.8 We will integrate our work on solid waste management with existing local plans and services, or influence the development of solid waste management plans where they don't already exist.

Full quality programme standards: project level

- | | | | |
|-------|--|-------|---|
| PJ3.1 | We will target hygiene interventions at household, community and institutional settings, including schools, healthcare facilities, factories, camps and temporary settlements. | PJ3.5 | We will aim to expose target audiences many times to different components of the behaviour change package, to reinforce behaviours and ensure the changes are sustained. |
| PJ3.2 | We will promote inclusive group handwashing facilities with soap and water in schools and handwashing facilities with appropriate cleaning agents in healthcare facilities. | PJ3.6 | We will use accessible, fit-for-context, socially appropriate and user-friendly hygiene promotion tools, materials, methods, activities and products. All hygiene hardware options will be inclusive. |
| PJ3.3 | We will use creative methods to design our hygiene approach. We will deliver it through a package of innovative interventions using emotional drivers, social norms and changed settings aimed at sustained hygiene behaviour change, rather than educational approaches that focus on increasing knowledge. | PJ9.1 | We will measure key hygiene behaviour outcome indicators at baseline, during implementation and after implementation. |
| PJ3.4 | We will promote the provision of essential hygiene products, such as handwashing facilities with soap and water, water and food containers with lids, and emergency pads for menstrual hygiene management. | PJ9.2 | We will regularly monitor, assess and evaluate sustained service levels and changes in hygiene behaviour. |

Glossary

Baseline

An assessment carried out before hygiene programme implementation that provides information on key indicators, such as handwashing practices before eating among caregivers of children under five, or the availability of handwashing facilities with soap and water close to household toilets and their use. Information obtained by a baseline assessment sets a benchmark for subsequent evaluation and allows comparisons to be made with the results.

Behaviour-centred design (BCD)

An approach that brings together diverse theoretical and practical ideas from fields such as neuroscience, operations research, cognitive and evolutionary psychology, animal behaviour, and marketing into one unified model, and can accommodate the insights of most other approaches into its generic framework. It provides a framework for understanding the determinants of behaviours, as well as designing, implementing and evaluating the behaviour change intervention. The approach has five key steps: A=Assess, B=Build, C=Create, D=Deliver, and E=Evaluate. This is one of the most rigorously tested behaviour change approaches, with a growing number of randomised control trials and operational work quantifying the effect of interventions designed using this theory-driven process. BCD-designed interventions have been found to be effective in targeting a range of behaviours (for example, food¹² and hand hygiene,¹¹ sanitation, oral rehydration solution use,²⁰ nutrition,²¹ exercise, and HIV prevention) in a range of income settings.

Child-to-child (CtC)

A hygiene promotion approach based on the belief that children can be highly influential in improving the health of others, especially with regards to raising hygiene awareness in the family.

Community-led total sanitation (CLTS)

An approach using the promotion of sanitation to bring about a collective community decision to reject open defecation. Communities strive to achieve open defecation free (ODF) status. CLTS in its 'pure' form does not recommend or subsidise specific sanitation technologies.

Formative research

Research that occurs before a programme or intervention package is designed. It helps to identify determinants, environments, norms, barriers and motives around desired key hygiene behaviours and to understand the population at greater risk of WASH consequences, and is a basis for developing or designing effective interventions that encourage behaviour change. It follows a process and includes a set of tools that can be used in different research or programme settings.

Hygiene

WaterAid definition:

Behaviours that encourage the widespread adoption of good practices that keep people and their environment clean, enhance dignity, prevent the spread of diseases, reduce under-nutrition and maintain health.

World Health Organization (WHO) definition:

The conditions and practices that help to maintain health and prevent the spread of diseases.

Hygiene behaviour change

A systematic approach to encouraging the widespread adoption of good hygiene practices, to keep people and their environments clean, reduce stigma, prevent the spread of diseases, reduce undernutrition and maintain people's health, enhance their dignity and improve their status.

Participatory hygiene and sanitation transformation (PHAST)

A participatory methodology designed specifically for and frequently used in the WASH sector.

Self-esteem, associative strength, responsibility, action planning and resourcefulness (SARAR)

A methodology for community action planning. Other approaches such as PHAST are based on SARAR principles.

Social marketing

An approach that uses marketing principles to achieve social benefits, such as changes in attitudes and behaviours, which are deemed to be good for society.²² This approach also helps promote different technological options for sanitation and hygiene where people can make choices based on their desires and affordability.

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Please reference this publication as: WaterAid (2019). *Hygiene behaviour change framework*. Available at washmatters.wateraid.org/hygiene-behaviour-change-framework

How we work and arrange our knowledge

This framework forms part of a body of documents that define how we work and how we arrange our knowledge, as shown below. For WaterAid staff, this framework and related documents can be found on our intranet page, KnowledgeNet, which is structured in the same way.

Our strategic aims	Sustainable services	Integration	Equality	Hygiene
Who we seek to serve	The poorest and most marginalised people			
What we work on	Water	Sanitation	Hygiene	
Cross-cutting principles	Human rights	Sustainability	Equality and inclusion	Partnership
Where we work	Large cities and towns	Small towns and growth centres	Rural and remote districts	Global and regional
How we bring about change	Our role and programmatic approach			
	Systems strengthening and empowerment	WASH in other sectors	Hygiene behaviour change	
Project delivery concepts	Outline project delivery concepts			

Good hygiene behaviours, supported by clean water and sanitation, are necessary to keep people healthy. With good hygiene and better health, children can go to school, adults can work and people can live more dignified lives.

We use evidence-based, innovative and creative hygiene behaviour change interventions that improve people's health and dignity by motivating them to think and act differently, making positive changes to their environment (physical, social and biological) and influencing policy.

This framework defines our position, approach and programme standards for hygiene behaviour change.

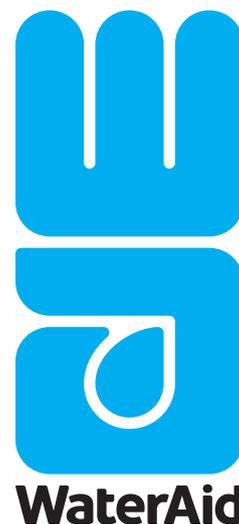


Clean water.
Decent toilets.
Good hygiene.



Front (top): Dr Martin Koné, 33, Health Director at Talo Health Centre, washes his hands with soap, Talo Health Centre, Falo municipality, Mali. WaterAid/ Guilhem Alandry. Front (bottom): Lucie, 11, Saiah, 13, and Ruffin, 14, wash their hands at school, Ankazobe district, Madagascar. WaterAid/Ernest Randriarimalala. Back: The WASH group in front of their girl-friendly toilets, Government Girls High School, Muzaffargarh district, Pakistan. WaterAid/Sibtain Haider.

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