

## Section 4 Case Studies

### 4.1 Nigerians for Pure Water

#### Instructions:

- Read the following case study. Note that all names and places are fictitious.
- Complete the series of questions pertaining to the case study

Nigerians for Pure Water (NPW) is a non-governmental organization that has been working in rural areas outside of Abuja, Nigeria for over five years. They are a grassroots organization working primarily in water, sanitation and hygiene in more than 20 local communities. The rural communities where NPW is working are underserved by the government and are primarily using seasonal rivers, ponds, and open wells to supply their drinking water. Latrines and sanitation infrastructure are uncommon.

NPW's approach begins with constructing and installing biosand filters in households with the greatest need, charging each household a small fee for the filter. Community Health Promoters are trained within each community to provide education on safe water, sanitation and hygiene practices as well as assist with any maintenance and operation needs of the biosand filter users. NPW is planning to follow-up with a sanitation program to construct latrines, since open defecation is a common practice, but has not yet received the funding for such a project.

NPW has seen an improvement in the health of biosand filter recipients, but realizes the need to support a comprehensive water and sanitation program. Olajide, the Program Director of NPW, has planned a visit to one of the villages to check on the progress made by the organization. The Community Health Promoter, Yele, has agreed to show Olajide around the community and visit with several families that have received biosand filters.

They arrive at Desola's house shortly before lunch and are invited to share some tea. The biosand filter is painted a bright blue color and prominently displayed in the corner of the kitchen. Olajide notices there are several, open containers near the filter that are used to store water.

Desola is anxious to demonstrate how the family drinks filtered water. Her son has just returned with a bucket of water from the nearby pond and Desola pours the bucket into the filter basin. She grabs an open container and places it underneath the outlet to collect the filtered water. She explains that the water is then stored in a different container (without a tap or spigot) before the family drinks the water. Her son is thirsty after fetching the water and takes a glass, dips it into the drinking water storage container, smiles, and drinks from the glass of water.

The kitchen is a busy room. Desola is cooking lunch for the day, chickens run in and out of the room, and a small goat is resting under the table. Yele asks Desola to talk about the filter and if it has helped the family at all. Desola is pleased to report that she has spent less money on medications in the past few months for her young children. She also says that her neighbors have been asking how they can get a biosand filter because they like the taste and appearance of the water.

After drinking tea, Yele and Olajide continue their visit in the community and are both pleased with the progress NPW has made so far. He realizes that there are some opportunities to improve the Community Health Promoter program. He will incorporate these changes into the next monthly training of the Community Health Promoters.

**Exercise – Project Plan**

As a large group, discuss how NPW plans to solve the water problems in the rural area around Abuja. Write your response below.

**Exercise – Role of Community Health Promoter**

In partners discuss, what is the role of the Community Health Promoters in the NPW project? What are some activities that they would be doing to fulfill their role?

**Exercise – Community Health Promoter Training**

Personal Reflection: If you were the Community Health Promoter, what type of training and tools would you want to perform your job? As a Coordinator, how would you prepare the Community Health Promoters to effectively complete their duties?

**Exercise – Future Plans**

In partners, discuss what NPW could do to improve their current water, sanitation and hygiene program. Based on Olajide's visit to the community, what would you change or add to the Community Health Promoter program?

**Exercise – Training**

As the Coordinator, how would you incorporate these changes into your training activities with the Community Health Promoters?

## 4.2 School Hygiene Promotion

### Instructions:

- Read the following case study. Note that all names and places are fictitious.
- Complete the series of questions pertaining to the case study

Fulana is working as a Community Health Promoter with Water for All, an international NGO working in Peru. To complete her duties, she spends two days a week working in her own village and two additional villages nearby. Fulana has been working with Water for All for more than a year and began her work through the primary schools in each of the villages. The elementary schools had received funding through Water for All to construct latrines for the students and promote hand washing.

Fulana held meetings with the school teachers to discuss ways to promote better hygiene and sanitation practices with the students. She learned that the teachers were overworked and didn't have enough time to focus on basic life skills with the children. The teachers reported that many students missed school on a regular basis due to illness and that many had short attention spans and lacked focus when they were present. Fulana also found out that many children didn't know why they were getting sick and just accepted diarrhea as a fact of life. As well, she noted that the drinking water source was an open, shallow well where children used a rope and bucket to fetch water.

Fulana also had a chance to talk with a few of the students. They didn't like being sick because it was embarrassing to have diarrhea and meant missing out on play time with their friends. The children also didn't like washing their hands because they had to fetch water from the well to do so. When they used soap, they preferred the brightly coloured and fragrant bars instead of the plain white powdered soap.

### Exercise – Designing the Right Message

Often, schools can be an ideal yet challenging setting for promoting sanitation and hygiene behaviours. Based on an understanding of the children's knowledge and motivations, what two or three key messages would you design to encourage better sanitation and hygiene practices?

**Exercise – Designing the Right Activities**

Brainstorm two or three activities that you could do to promote improved hygiene and sanitation practices with the children.

Fulana decided to distribute handwashing equipment - soap and wash basins to each of the classrooms to promote ownership of the materials. Since the schools did not have enough funds to employ an individual to clean and maintain the latrines, each classroom was assigned a maintenance task every week. Children were protective of the soap for their classroom, whereas previously, soap often went missing from the common area. Latrines were kept clean by the students, ensuring more use of the facilities.

**Exercise – Taking Care of Facilities**

How would you encourage maintenance and ownership of sanitation and hand washing facilities in a school setting?

## 4.3 Late Adopters

### Instructions:

- Read the following case study. Note that all names and places are fictitious.
- Complete the series of questions pertaining to the case study

Joseph is a Community Health Promoter in the village of Lakeview. He has been working for the past few months in his own community to bring about better hygiene practices such as handwashing and proper disposal of children's faeces. He visits each house in the village once a month. On the first visit, he introduces himself and tells people about the new behaviour he is promoting.

On the first visit to Sara's house, she is very positive about the ideas that Joseph has about safe hygiene practices to help improve the health of the family. She says that she understands that by washing her hands with soap at critical times (after defecating, before preparing food, and before eating) will result in a healthier family. Sara nods in agreement that she will begin to wash her hands at critical times.

On Joseph's second visit they create a handwashing station using materials from the house. He encourages Sara to use some soap from washing clothes for handwashing as well. On the third visit, Joseph notices that the handwashing station does not have water near it nor soap. It appears as if the facility is not being used at all. This seems to be the case in several households in the village. He's discouraged by the lack of participation by some of the villagers.

Joseph is having difficulty understanding why people do not want to adopt these hygiene practices. He has made several visits and tried to negotiate improved behaviour during each visit, but he is not seeing results in some of the households.

### Exercise – Identifying Barriers

What are some possible barriers to behaviour change in Sara's house?

**Exercise – Overcoming Barriers**

What are some ways to address the barriers that you identified?

**Exercise – Providing Support**

How would you as the Coordinator encourage your Community Health Promoters when they face challenges in the community? What are some activities you could do with them?



## 4.4 Hygiene Promotion in Burkina Faso

### Description of the program

Programme Saniya was carried out in Bobo-Dioulasso between August 1995 and July 1998. The program was implemented by the Ministry of Health of Burkina Faso with technical assistance from the London School of Hygiene and Tropical Medicine and funded by UNICEF. It aimed to promote a small number of safe hygiene practices, was based on the existing local motivation for hygiene, and used local channels of communication to reach the target groups.

### The target behavioural practices

The initial research showed that the incidence of diarrheal disease was more related to failure to dispose of children's excreta effectively, and failure to wash hands with soap after contact with excreta, than to water quality. So the program focused on changing these specific practices.

### The target groups

The primary groups targeted for the intervention were mothers, older sisters and maids, who are the principal care givers of young children in Burkina Faso. School aged children were also keen to participate, so a curriculum for primary schools was added to the program.

### Designing the message

The content of the messages reflected the findings of the research, which suggested that mothers desired hygiene, not for the sake of avoiding diarrhea, but for aesthetic and social reasons. Messages were thus built around the respect they might gain from being hygienic, and the improvements gained in quality of life when excreta were removed and could not be seen or smelt. Germ theory of disease did not figure in any of the messages addressed to the adults, although it did form a part of the hygiene curriculum for schools.

### Choosing effective communication methods

The program used focus group discussions and a small questionnaire to identify local channels of communication suitable for the specific target groups. Although two-thirds of mothers regularly listened to local radio, the program staff decided that face-to-face household visits would also be needed, because other people who cared for children had little exposure to any type of communication except word of mouth. Messages were also transmitted during a *djandjoba* (social event with music and dancing), which provided a good environment for transmitting information.

### Program implementation

The program was launched in August 1995 with a municipal ceremony, a mass clean-up of public spaces, and a phone-in on local radio. Subsequently six activities took place over three years of the program:

- Community volunteers conducted monthly household visits.
- Health staff were trained to add participatory discussions related to hygiene to the normal program of health centre talks.
- A theatre group created a play that was performed weekly.
- A set of twelve radio spots was broadcast on three local radio stations.
- Teachers were trained and a curriculum devised for six hygiene lessons in primary schools.
- Schools received a starter box of soap and buckets to encourage children to wash their hands.

### **Monitoring**

- Five project workers accompanied community volunteers in a rotating programme of home visits and reported on theatre activities.
- Health centres completed forms that recorded their activities.
- Volunteers listened to a specified sample of broadcasts from local radio stations.
- Primary schools inspectors made visits to monitor progress.

(World Bank, 2002)

## 4.5 The Life of a Hygiene Educator in Uganda

"I am John Robert, a hygiene educator from Ogwete Village in North East Uganda. In the morning I get up and clean my own compound. I look after my animals and give them water.

"When WaterAid's partner Wera Development Association (WEDA) came to this community, this village was identified as one that had a big sanitation problem. There were a lot of diseases and diarrhea. People could not wash and there was nowhere to clean utensils. The whole area was always dirty; the paths were very bushy with snakes. There were faeces along the side of the roads. No longer...

"WEDA offered to train hygiene educators to sensitize the community to good sanitation practices. The community nominated me to be one of the educators.

"I have an interest in this work; I like to live in a clean environment. Before WEDA came here I could see how the roads and households were dirty with no place to clean cooking utensils. I wanted to help change this.

"I was given a bicycle by WEDA which makes it easy for me to travel around the community. I visit 40 households a week.

"I use a cluster system to get people together so I can educate them about good sanitation. There are 10 households per cluster. Each cluster has a cluster head who I liaise with to arrange sanitation meetings. I work with them to organize community sanitation workshops where we promote hygiene and sanitation to community members.

"I convince stubborn people to build latrines. I come to their place and actually start to dig their pit. I start the pit and hope they feel shame to continue with it. Some people have completed their pits. I show people examples of homes with clean facilities. I show them how clean everything is.

"There are barriers to my work in this community. Mainly households run by men who drink. They do not listen to sensitization. Sometimes the old do not have the strength to construct pit latrines and drying racks in their compounds. Where this is the case I organize days where community members can help the elderly construct facilities in their compounds. WEDA and the community encourage these activities here and help to mobilize people.

"I am not happy that only 50% of households in this community have a latrine. I want it to be 100%. I think we will have 75% of households with a latrine by the time WEDA install a borehole here. I am going to work hard to make sure the remaining 25% without a latrine set them up or are involved in setting them up.

"We have enforced bylaws to keep the paths and communal areas clean. They have been a big success. We are trying to agree further bylaws and get them approved by the cluster heads and the district authorities. These will stipulate that each household should have a latrine and a drying rack for utensils.

"Since these changes have been made here my children are not getting sick. Before I would have to take them to hospital regularly to get medication. This was an 8 km walk there and back on foot.

"In the old days when sickness came we may not have had a cent in our pocket to pay for medication. We would have to borrow money from very many people.

"I would have to spend an average of £19 a month on medication. I do not need to borrow money any more but we are still paying back our debts from the old days.

(WaterAid, nd)



John Robert Anguira, Hygiene Educator, Ogwete village, Uganda.  
(Photo Credit: WaterAid/Caroline Irby)

## 4.6 School Sanitation and Health Education in India

*New loos at two rural Indian primaries are having unexpected results in health education*

It is 11am, and the students of Marachipatti elementary school are queuing up in their courtyard. Girls and boys in two neat crocodiles stand outside the school's white-painted latrine block. They disappear inside. There is some vigorous hand washing. One by one they then emerge into the sunlight before filing back to the classroom, which is decorated with pictures of the Hindu elephant god Ganesh, Indira Gandhi, the Buddha and the saintly Tamil poet Thiruvalluvar.

This is, of course, the loo break. On the face of it there is nothing remarkable here - until you remember that this is rural India where there are few facilities of any kind, let alone toilets. The lack of proper sanitation is one of many obstacles Indian children face in their struggle for an education. Other factors include too few books, teachers who fail to turn up and the requirement for children to work - like their parents - in the fields.

Until recently, Marachipatti primary didn't have a latrine - nearly 85% of Indian schools are in the same dismal situation. Instead, the pupils would dash across the road and squat down in the thorn bushes. It could be a scary experience: "Sometimes snakes would come and disturb us. I would run away as quickly as possible", one 10-year-old girl, Vasanthi, explained. "This wasn't much fun."

The lack of sanitation brought other problems too. Pupils frequently suffered from diarrhea. They also got hookworm. "In the past, as many as 10-15 children would be absent because of illness," the school's assistant head teacher Mr Krishnan recalls. This lamentable situation ended three years ago when the British charity WaterAid came up with an ingenious solution: it built a sanitation block for the school's 104 pupils - at the cost of £260 - complete with two Indian-style latrines and a girls' and boys' urinal. More importantly, it asked the five- to 10-year-old pupils to manage the block themselves.

The students organized themselves into different committee responsible for keeping the loos clean, fetching water from the hand-pump outside and ensuring all pupils washed their hands with soap. Other students on the "tidy committee" looked after the school's modest grounds.

In addition, WaterAid paid for a health educator to visit the school, which is in the lush southern state of Tamil Nadu, some 65km north of the temple town of Tiruchchirappalli. The scheme was extended to some 40 other local government schools, covering 8,000 pupils.

And it worked. "I tell the students to cut their nails, make sure their clothes are clean and to brush their teeth and comb their hair," Vasanthi, a member of the personal hygiene committee, explains.

The initiative brought startling results: pupils became healthier and suffered from fewer illnesses. "I haven't got hookworm any more," said Vinod, a 10-year-old latrine committee member.

But, crucially, the pupils of Marachipatti primary took the message of hygiene awareness back into their homes. WaterAid's local health workers discovered it was far quicker, and

more effective, to teach adults good hygiene practices via their children than to target them directly. "I told my mother and now she washes her hands with soap before cooking vegetables," Vasanthi pointed out.

The villagers of Marachipatti are poor. They live for the most part in mud houses thatched with coconut leaves, close to the lagoon-like Cauvery River. Nonetheless, several parents were encouraged to build their own latrines at the subsidized cost of Rs 850 (£12). With better sanitation, they found that they were spending less money on medicines. "I used to spend 1,000-2,000 rupees (£14-£28) a year on drugs," said Dhanam, a 30-year-old mother. "This figure has been considerably reduced. We don't get diarrhea so much."

In the nearby government school of Udayakulamputhur, a short drive past fields of green rice and picturesque oblongs of red chilies drying on the road, the pupils make use of another new WaterAid-funded latrine block. This one is painted red. The students here have also become ambassadors of hygiene promotion - though in some cases their efforts have not always gone down well with an obdurate older generation.

"I've told my grandfather and grandmother what to do but they still don't wash their hands," Isabella, aged 10, lamented. "My parents do what I tell them. But there is a lot of fighting between my father and grandfather over hand-washing."

The school's head teacher, Mr Mali, detects a new pride among the students and parents. "Even if they have to spend some money, they are happily spending. If a kid loses his tie they will replace it," he says.

(WaterAid, nd)

## 4.7 School Hygiene Promotion in Pakistan

Since November 2006, Agency for Technical Cooperation and Development (ACTED) has been working on a UNICEF funded program for Water and Sanitation and Health Promotion in Azad Jammu and Kashmir. The program aims to provide water, latrines, hand washing facilities and hygiene education to approximately 8000 children in 90 schools in the Neelum Valley by the end of July 2007.

For the hygiene promotion component of the project ACTED has been implementing a six phase program using PHAST and Child-to-Child (CTC) methodology, which provides a framework for the active participation of children in the trainings and for turning the children into active agents of change within their families and communities.

The hygiene promotion activities included:

- Analysis of problems regarding the hygiene facilities and practices
- Discussion of barriers (to help the children in finding ways of blocking the spread of diarrhea)
- Choosing improved hygiene behaviors
- Presentation of children to mothers about PHAST
- Field visits where children and mothers point out good and bad hygiene practices in their own community
- Hygiene competition with quizzes and debates
- Street theatre with skits about hygiene practices, games and drama competition.

The involvement of mothers and non-school going children has been an important aspect of the hygiene promotion activities, avoiding focusing exclusively on school students. What's more, UNICEF hygiene kits have been distributed to all children. The competitions and theatre have also been a great success, bringing together children, parents and teachers from different schools to share their knowledge about hygiene while having a great time. The theatre group "Eye View" has been responsible for hosting the street theatre together with ACTED hygiene promoters.

A Knowledge, Practices and Coverage (KPC) survey was conducted at the start of the program to determine the quality of the hygiene practices and identify specific needs in terms of hygiene education. The survey will be repeated at the end of the program to assess the impact of the hygiene promotion activities on the knowledge and practices of the beneficiaries.

And last, at the end of the program the water and sanitation facilities will be formally handed over to the Education Department to ensure sustainability in the long-term. At school level, School Environment Committees, consisting of 2 students and 2 teachers, have been formed and trained and will be responsible for maintaining the facilities and fostering continued proper hygiene practices.

(Reuters Foundation, 2007)

## 4.8 Health Education for Malaria Control in India

### Project Background

The National Institute of Malaria Research (NIMR) and Community Health Cell (CHC), Bangalore, jointly initiated the program. An inter-sectoral coordination committee was formed involving ten governmental and non-governmental organizations for smooth functioning. The district health committee headed by the District Commissioner approved the proposal of the *Kalajatha* program. NIMR and CHC, Departments of Health, Education, Child and Women's Welfare, Rural Development and *Panchayat* Raj, Tumkur Science Forum, local political and religious leaders actively participated in this program.

### Project Plan

Thirty local artists (15 males and 15 females) from different occupational backgrounds were selected. A local scriptwriter wrote 8 songs, two dramas and 4 *rupakas* (musical dramas). The scripts were based on various aspects of malaria namely signs and symptoms of sickness, treatment, health facilities, processes of transmission, role of anopheles mosquitoes and names of the malaria vectors, breeding grounds of mosquitoes especially the vectors, its control strategies focusing especially on larvivorous fish and environmental management.

Other control strategies like insecticide-treated nets, adopting measures for maintaining general hygiene, keeping cleanliness in and around houses, and the role of the community were also included in the script. These were then translated into skits using local dialects, musical styles and theatre traditions. In the beginning, the artists underwent orientation training on the entire processes. Two troupes consisting of 15 artists each were formed. Before the actual performances, they rehearsed the events in the evening for two weeks in a religious trust of *Kuppur Mutt*. Each troupe was equipped with a set of musical instruments and a performing wardrobe.

### The *Kalajatha* events

The *Kalajatha* events were performed in December 2001. One week before the events, wide publicity was given through the local village administration (*Gram Panchayat*) and the community consent was obtained from the village headmen or *Panchayat* presidents. The Minister-in-Charge of the district and the local elected legislative assembly members inaugurated the program. The events were performed in the evenings so that maximum number of people could witness. Every day, each troupe visited two villages and spent two hours in each village. Villagers voluntarily attended the programs. Local health officials and *Gram Panchayats* provided all the necessary logistics and hospitality. A valedictory function was held at the end, which was presided over by the Director of Health Services, Karnataka. Local media covered the events and helped in spreading the key messages.

(Ghosh, 2006)



## 4.9 Safe Water Supply and Latrines in Ethiopia

Robeshu lives with her husband, Gemechu Feyessa, and their eight children in the district of Mulo, about 70 km south of Addis Ababa. Mulo is home to about 40,000 people, almost all of whom are poor farmers eking out a living from the land, tending cattle and growing teff, the grain used to make the flat pancakes that are the foundation of Ethiopia's national dish, injera.

In September, the land is green, lush and fertile. Mulo's rolling green hills remind you sometimes of Wales, or perhaps Somerset. But looks can be deceiving. During the rainy season (mid-June to mid-September) over 1000 mm of rain falls, and this year has been especially wet, causing flooding and land erosion – more evidence, if any were needed, of a changing climate in a fragile landscape.

But outside the wet season, it's hot and dry. The land is parched, springs and streams dry up and people have to work harder and walk further just to fetch water. This job typically falls on women and children, diverting time from school, family life and more productive activities.

### Protecting water at the source

For almost half of all rural Ethiopians, the nearest source of water is 1 to 4 km away. But thanks to the Ethiopian Government's national water, sanitation and hygiene (WASH) programme, Robeshu's walk is shorter. "I can now collect 20 litres of water seven times a day for my family," she says. "It's a shorter journey than it used to be, as we have permanent source of water less than 20 minutes away from our house." Robeshu takes her water from a protected spring tank, where the water is pure and safe, and free from contamination by human or animal waste.

Ethiopia has one of the lowest levels of water and sanitation access in Africa. Most Ethiopians consume less than 15 litres of water a day from nearby rivers or unprotected springs. Water-borne disease is one of the country's biggest killers. In Mulo, the District Administration had only managed to construct ten water points in ten years. But through the national WASH program, 15 new water supply schemes - which have employed pumps, hand-dug wells and boreholes - have been delivered in the past year.

### Building better hygiene

The Local Government's renewed commitment to public health has also resulted in a wave of household latrine building, with 1,700 simple pit latrines constructed in Mulo during 2005/06. Explaining the effect this has had on his family, Robeshu's husband Gemechu says: "There is no more bad smell; no flies are coming to contaminate our food. We are able to save our cash which we used to spend on healthcare. My family is enjoying a clean environment and privacy."

The Mulo woreda council has worked closely with the local health bureau to bring about these achievements. Each kebele (a community of around 5,000) deploys two female health extension workers, part of whose job is to go from house to house spreading the message about the importance of hygiene and latrines.

"We make house calls three times a week," explains Fantaye, a health extension worker in Thero Boro kebele, Mulo district. "Sometimes we have to walk up to two hours, but we are not discouraged by this."

By encouraging community members to carry out some easy-to-follow actions, health extension workers have brought about a real change in behaviour. Now, most people in Mulo are happy to agree with Gemechu when he says, unequivocally: "No way of going back to open field defecation!"

(DFID, 2007)

## 4.10 Communities Take Ownership of Hygiene in Bangladesh

Meet six-year-old Shirin. She's washing her hands with soap and water. She knows it's important to wash her hands before eating and after using the latrine. She knows she must wear sandals when she uses the latrine. She knows poor hygiene can make her ill.

She knows all this thanks to Syeda Helena Akhter, a Community Hygiene Promoter (CHP). CHPs are helping to change behaviour in Bangladesh to slow the spread of waterborne diseases such as diarrhea and cholera. In 2004, 2.2 million cases of diarrhea were recorded in Bangladesh.



UNICEF, with £11.8 million funding from DFID, has been pioneering the approach of using CHPs to promote good hygiene in rural communities in Bangladesh since April 2000. Building a latrine isn't enough. When it comes to changing ways of life, the entire community must feel involved.

### How the community hygiene approach works

Shirin lives in Shabajpur, a rural village in the district of Brahmanbaria, east of the capital Dhaka. With her mother and other village women and girls she is attending a discussion with Syeda Helena Akhter.

August 2005 is monsoon season and outside it's pouring with rain. So 40 or so women are huddled in one room, intently listening to what Syeda Helena Akhter has to say. They cover why it's important to wash hands after cleaning a baby's bottom; why it's important to use soap and clean water; why food must be kept covered. She uses a wind-up toy chicken and little piles of sand on a white cloth to demonstrate how dirt can be spread around the village.

She shows that by washing hands in a white bowl, the dirt is visible. It's a case of seeing is believing. The women then point out on a map which houses in the village have latrines. Most have one of some sort but those that don't share their neighbours'. All of this boils down to one message: the link between poor sanitation and gastrointestinal diseases.

Shabajpur has been certified as having 100% sanitation. The 2005 National Sanitation Strategy defines this as: no open defecation, hygienic latrine available to all, use of hygienic latrine by all, proper maintenance of latrines for continual use, and improved hygienic practice.

The hope is that as the younger generation grows up these important lessons will stay with them and be passed on to their children so that water-borne diseases become a thing of the past. (DFID, nd)

## 4.11 From Smelly Yards to Happy Husbands

A health worker wanted to find out about how to motivate people to dispose of child stools safely. This is what she did:

The health worker and her team carried out four focus group discussions to ask about the disposal of child stools. Mothers explained that they did not like to see stools on the ground because they were ugly to look at and “they stop you breathing”. They said that they admired mothers who managed to keep their courtyards free of stools. But they said that it was hard to always keep an eye on the child so as to be able to clean up afterwards.

The team interviewed some mothers who managed to keep their yards stool free. “My mother-in-law gave me a potty for the child” said one woman, “I taught the child to use it so now the yard isn’t smelly anymore”.

The team asked for volunteers to participate in behaviour trials. Each mother was given a potty, and asked to teach the child to use it. After two weeks they were asked what they thought. Mothers said that it had been difficult at first but that the child got used to using the pot after about three days. Others said that the potty was convenient, others that their husbands had noticed that the yard was cleaner and free of smells. They all agreed that even if a plastic potty cost a bit, it was well worth buying one for the sake of living in a nice clean healthy environment.

The health worker decided to build her hygiene promotion strategy around the idea that a happy, healthy family use potties to have a smell-free yard.

(UNICEF, 1999)

## 4.12 References

DFID (nd). Bangladeshi communities take ownership of hygiene issues.  
Available at: [www.dfid.gov.uk/casestudies/files/asia/bangladesh-sanitation.asp](http://www.dfid.gov.uk/casestudies/files/asia/bangladesh-sanitation.asp)

DFID. (2007). No going back to life without latrines in Ethiopia.  
Available at: [www.dfid.gov.uk/casestudies/files/africa/ethiopia-water.asp](http://www.dfid.gov.uk/casestudies/files/africa/ethiopia-water.asp)

Ghosh, S.K., Patil, R.R., Tiwari, S. and A.P. Dash (2006). A community-based health education programme for bio-environmental control of malaria through folk theatre (*Kalajatha*) in rural India. *Malaria Journal* 2006, 5:123. Available at: [www.malariajournal.com/content/5/1/123](http://www.malariajournal.com/content/5/1/123)

Reuters Foundation AlertNet (2007). ACTED Pakistan: Hygiene Promotion in Azad Jammu & Kashmir. Available at: [www.alertnet.org/thenews/fromthefield/337869/118587600975.htm](http://www.alertnet.org/thenews/fromthefield/337869/118587600975.htm)

UNICEF (1999). Towards Better Programming: A Manual on Hygiene Promotion. Available at: [www.unicef.org/wes/files/hman.pdf](http://www.unicef.org/wes/files/hman.pdf)

WaterAid (nd). Hygiene Education Making a Difference. Available at: [www.wateraid.org/uk/what\\_we\\_do/how\\_we\\_work/integrated\\_projects/hygiene\\_education/784.asp](http://www.wateraid.org/uk/what_we_do/how_we_work/integrated_projects/hygiene_education/784.asp)

WaterAid (nd). A Day in the Life Of. Available at: [www.wateraid.org/uk/about\\_us/oasis/autumnwinter\\_07/5742.asp](http://www.wateraid.org/uk/about_us/oasis/autumnwinter_07/5742.asp)

World Bank (2002). Hygiene Promotion in Burkina Faso and Zimbabwe: New Approaches to Behaviour Change. Field Note 7, Water and Sanitation Program, Africa Region. August 2002. Available at: [www.gtz.de/ecosan/download/WSP-hygiene-promotionin-burkinafaso-zimbabwe.pdf](http://www.gtz.de/ecosan/download/WSP-hygiene-promotionin-burkinafaso-zimbabwe.pdf)