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USAID HYGIENE IMPROVEMENT PROJECT SUPPORT TO WAWI I: FINAL REPORT

2009

This publication was produced for review by the United States Agency for International Development by Orlando Hernandez and Lonna Shafritz of the Academy for Educational Development's Hygiene Improvement Project.

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Acronyms

ADP	Area Development Program
BC	Behavior Change
BCS	Behavior Change Specialist
CIIFAD	Cornell International Institute for Food, Agriculture and Development
CLTS	Community-Led Total Sanitation
CWSA	Central Water & Sanitation Association
GRWP	Ghana Rural Water Project
HIP	Hygiene Improvement Project
HKI	Helen Keller International
HP	Hygiene Promotion
HWTS	Household Water Treatment and Safe Storage
HWWS	Hand Washing with Soap
ITI	International Trachoma Initiative
M&E	Monitoring and Evaluation
NGO	Non-governmental Organization
POU	Point of Use
TA	Technical Assistance
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WAWI	West Africa Water Initiative
WV	World Vision

General Background

USAID provides technical assistance (TA) to the West Africa Water Initiative (WAWI) on cross-cutting issues. This support has continued over several years during the initial phase of WAWI, which ended in September 2008, and the new phase, which started October 09. USAID support has occurred through different mechanisms. Assistance during WAWI I included a behavior change component, specifically hygiene promotion activities. WAWI partners with field programs have implemented activities focused on practices at the household level that may reduce waterborne illnesses, such as diarrheal disease, trachoma, and Guinea worm. The technical assistance has been targeted at improving the quality and breadth of hygiene promotion implemented by WAWI partners.

During WAWI I, the program operated in three countries (Ghana, Mali, and Niger) and brought together different types of organizations, including:

- Government agencies implementing specific disease control programs (e.g., National Program Against Trachoma)
- International NGOs with project implementation responsibilities on the ground, such as World Vision, WaterAid, the Carter Center, Helen Keller International (HKI), and the International Trachoma Initiative
- Local NGOs working as subcontractors of some of these international NGOs, such as New Energy in Ghana
- Private organizations under contract to address specific technical issues (e.g., Winrock International and CIIFAD)
- Funding agencies or international development agencies, such as the Lion's Club and UNICEF, working as financial partners and with some coordination responsibilities on a country-by-country basis

The USAID-funded Hygiene Improvement Project (HIP) was given the task of providing technical assistance in behavior change (BC) and monitoring and evaluation (M&E) to partners implementing WAWI I. HIP's involvement with WAWI I had two distinct phases. The first was from January to December 2006, and the second from January 2007 to September 2008.

During the first phase, technical assistance was provided in both BC and M&E. A regional BC specialist operating out of Bamako, Mali, provided technical assistance to WAWI partners in all three countries. The purpose of the BC effort was to advocate behavior change activities among participating partners in each country and to form and/or strengthen a network of individuals working in BC among national partners and their capability to promote hygiene. The M&E technical assistance had a limited scope and was provided through HIP's M&E specialist based in Washington, DC, who traveled to West Africa as needed. The M&E specialist reviewed M&E data that WAWI partners collected in the participating countries to determine if they followed indicators defined for the partnership under a predecessor project funded by USAID, and if data procedures were equivalent, to make cross-country comparisons.

During the second phase, however, the focus of HIP's technical assistance was exclusively on BC. Three BC specialists were hired locally in each of the WAWI countries. They lived in Bamako (Mali), Tamale (Ghana), and Maradi (Niger), respectively, within or in proximity to the

geographic areas of interest for WAWI in all three of these countries. HIP partner ARD Inc. hired the specialists, and HIP was responsible for providing BC technical support. During this phase, the BC specialists were hired to:

- Strengthen hygiene programming capabilities among the WAWI partners in each country
- Assist partners in the development and application of behavioral analysis skills, across hygiene and sanitation domains, according to the WAWI partners' needs
- Help partners develop a common BC strategy in each country and improve the partner organizations' technical ability to implement the strategy through a community of practice approach to behavior change

The remainder of this report focuses on the technical assistance provided in behavior change during the second phase. The technical assistance provided in the area of monitoring and evaluation was very specific and intended to develop recommendations to implement common indicators. Results of the M&E technical assistance can be found in Annex 3.

Rationale of BC Technical Assistance

Operationally, the technical assistance provided to WAWI partners in the BC arena during the period covered by this report was focused on three objectives:

Objective 1: Develop institutional capacity among WAWI partners to define and implement hygiene promotion activities that affect waterborne diseases.

Objective 2: Increase the amount of funding made available by WAWI partners to implement hygiene promotion/behavior change activities.

Objective 3: Expand the breadth of BC activities implemented by WAWI partners to promote hygiene practices (e.g., content, new communication channels, geographic intervention areas).

Institutional Capacity Development

To help the BC specialists meet their objectives, HIP had a two-pronged approach for institutional capacity development. First, it implemented activities to develop the technical and project management expertise of the BC specialists to address hygiene promotion in the context of WAWI. The expectation was to develop the skills of the BC specialists so they in turn could develop the BC skills of WAWI partners' staff involved in hygiene promotion. Second, HIP targeted the staff of the WAWI partners directly with BC skills workshops on hygiene promotion.

Different approaches were used to develop the skills of the BC specialists. These included:

- Conducting an orientation workshop and work planning meeting in Bamako, Mali, in April 2007
- Identifying and supplying literature justifying the impact of hygiene on health outcomes; assisting them in compiling a literature review of hygiene promotion strategies—in hand washing, POU water treatment, and sanitation—in their respective countries

- Helping them develop presentations to disseminate the results of this review in different venues (e.g., training sessions, international conferences)
- Identifying training opportunities and funding for attending workshops in West Africa that could help expand their knowledge in sanitation
- Identifying and supplying examples of behavior change strategies in the hygiene sector that could be emulated and serve as the basis for developing their own
- Participating in the two practical workshops (see below) as co-facilitators

To develop the BC skills of the staff of WAWI partners, HIP designed and implemented two practical workshops in each of the WAWI countries to demonstrate and have participants experience behavior change skills. The first workshops, held in July 2007, introduced the topic of developing behavior change strategies, using hand washing with soap (HWWS) at critical times to prevent diarrheal disease as the example. Each partner developed work plans for BC activities. The second workshops, held during April and May 2008, had a dual focus: to train participants to be effective trainers able to negotiate behavior change at the household level and to develop the skills to initiate community-led total sanitation (CLTS) activities in villages. Teams developed and demonstrated training modules as a workshop output. The content of the second workshop responded to the training needs identified through a consultation conducted via survey among WAWI partners. In addition to skills development, these two workshops contributed to the strengthening of bonds and the development of new bridges among WAWI partners at the national level, helping the BC specialists gain credibility among attendees. The agendas for each of these workshops are presented in Annex 1.

As part of its capacity development activities, HIP also provided support to the BC specialists in the design of specific trainings for WAWI partners. As part of this exercise, HIP provided guidance on both the content and form of these workshops, including reviewing the lesson plans and materials to be used in the trainings. The trainings conducted by the BC specialists are listed in Table 1 below.

Through these capacity development activities, the BC specialists helped participants experience the value of hygiene promotion and behavior change in general, as well as formative and monitoring research. In addition, these trainings also focused on the three behaviors of interest to HIP: hand washing with soap at critical times; hygienic or safe disposal of human feces; and household water treatment and storage. They also helped the WAWI partners address BC issues for persistent and recurrent areas of interest—Guinea worm and trachoma eradication, water, sanitation, and hygiene (WASH) for vulnerable populations, and water supply system maintenance—and associated family hygiene practices. In the context of this work, the BC specialists either inserted sessions in ongoing training activities and workshops or conducted stand-alone workshops of longer duration.

Table 1 – Capacity Development Activities Implemented by BC Specialists

Topics	Location, Dates, and Beneficiary Organizations
Hygiene Promotion and BC Approaches	Ghana: Sept. 24-26, 2007; UNICEF partners; 34 participants Ghana: March 3-5, 2008; World Vision staff; 26 participants

	Ghana: March 3-5 & 12-14; World Vision; Ghana Rural Water Project staff Ghana: Jan. 21-25, 2008; Qualitative Methods for Baseline Research Integrated Water, Sanitation and Hygiene Project; UNICEF partners; 54 participants Ghana: March 2-3 and 12-14, 2008; Promoting Community and Household Level WASH Behavior Change; World Vision WASH officers; 56 participants in both workshops Niger: May 2008; Hygiene Promotion for Teachers; 15 participants Niger: April and June 2008; World Vision, WATSAN committees; 42 participants
Hand Washing with Soap at Critical Junctures	Mali: Sept. 18, 2007; Local journalists, Ségou; 6 participants Mali : May 8, 2008; Meat Producer Association (APROVI); 50 participants Mali: May 22-23, 2008; Child care institutions; 48 participants Mali: June 2008; Integration of Hygiene to Gender Workshop Niger: Feb. 27-29, 2008; Leaders of associations of handicapped persons supported by the Ministry of Population and Social Reform; 15 participants Niger: Feb. 2008; CREPA (Centre Régional pour l'Eau Potable et l'Assainissement) promoters and partners; 11 participants Niger: May 2008; Training of Trainers: Hand Washing with Soap for School Teachers; Sabongari School; 20 participants Niger: June 10-12, 2008; Hand Washing and Food Safety; 20 participants
Sanitation	Ghana: Sept. 24-26, 2007; Pilot CLTS activities; Extension Officers Northern Region from Ministry of Local Government, Rural Development and the Environment; 34 participants Ghana: Dec. 10-12, 2007; Rural Water and Sanitation Project in northern Ghana and Central Water & Sanitation Association (CWSA) field staff Ghana: June 2-7, 2008; CLTS; WaterAid Ghana partners; 8 participants Ghana: June 30-July 5, 2008; CLTS field facilitators; 4 participants Ghana: August 3-8, 2008; UNICEF partners; 65 participants Ghana: August 11-14, 2008; Introduction to PHAST Methodology; UNICEF partners; 25 participants Mali: April 15-17, 2008; 23 participants
POU	Mali: Dec. 4, 2007; Findings of study on the acceptance of chlorination as an

	HWTS technology; WAWI partners; 10 participants
BC Strategy for the Northern Region: Support for Guinea Worm Eradication	Ghana: Aug. 27-28, 2007; WAWI partners and other NGOs and government agencies Ghana: Jan. 21-25, 2008; Training of research field staff, Formative Research Study, Integrated Approach to Guinea Worm Eradication through Water Supply, Sanitation and Hygiene Ghana: June 19, 2008; BCC Strategy Development Workshop; World Vision Ghana, WaterAid Ghana, and UNICEF staff
Community Involvement in Maintenance of Water Supply Infrastructure and Household Hygiene Practices	Niger: April 20-27, 2008; World Vision WATSAN committees; 87 participants

To help WAWI partners apply skills developed through the different training activities, the BC specialists paid follow-up visits to participants in capacity development events. The BC specialists visited workshop participants at the sites where they worked and provided onsite technical support and mentoring, which helped workshop participants address difficulties they faced in applying acquired skills. Many of the capacity development activities occurred in Ghana, where there was the most systematic follow-up of trainees in the field. Details of these visits appear in Table 2 below.

Table 2 – Summary of Field Visits to Support BC Initiatives Adopted by WAWI Partners

Topics	Location, Dates, and Beneficiary Organizations
Ghana	Review of rapid WASH assessment conducted by World Vision in Tolon/Kumbungu ADP (Area Development Program), Savelugu/Nanton ADP, Cheshegu CWSA launch of hand washing with soap campaign in Karaga and Bunkpurugu districts Support to trainees replicating CLTS in Tolon-Kumbungu, Zangballinhini, East Gonja districts in northern Ghana to improve community mobilization approaches
Mali	Review of materials for celebration of National Handwashing Day September 2007
Niger	Co-facilitate hygiene promotion activities with World Vision's health officer benefiting seven villages located in Kornaka West District Implemented or supervised implementation of hygiene promotion activities on behalf of WAWI Secretariat for funds allocated to three government agencies listed below under Leveraging of Funds

To further support capacity development, the BC specialists, with assistance from HIP headquarters, produced or reviewed: 1) existing literature on behavioral determinants of hygiene practices, 2) research methodology and research reports of formative and M&E activities implemented by partners, 3) field worker training materials, 4) promotional strategies and materials produced by the WAWI partners, and 5) sections of proposals to request new funding. Of special relevance are the following documents, reviewed by HIP:

Association Malienne de Recherche 'Action pour le Développement' (AMRAD). Draft Evaluation Report of UNICEF Mali School Hygiene Program. January 2008.

ARD. Stevenson, Sulemana. WAWI Ghana Strategic Plan. February 2008.

Ghana Sustainable Change Project (GSCP). Behavior Change Strategy for Guinea Worm Eradication.

Malian Ministry of Health. Integrated National Handwashing Promotion Workplan. March 2008.

Malian Trachoma Prevention Programming. Script for televised play to prevent trachoma to celebrate Trachoma Day. October 2007.

Nigerien National Program for Prevention of Blindness. Sketch for trachoma prevention.

Nigerien School Health Bureau. Teacher Training Guidelines for Addressing Handwashing with Soap at Critical Junctures. March 2008.

Nigerien Schistosomiasis Control and Prevention Program. Formative research protocol.

New Energy. WAWI Ghana POU Promotion concept paper. March 2008.

Saaka, Sumaila. Review of available literature on hygiene practices in Ghana: handwashing, POU and water disinfection and sanitation. September 2007.

Saaka, Sumaila and L. Shafritz. Implementing point-of-use (POU) water quality interventions in the West Africa Water Initiative (WAWI) Ghana field sites: the behavioural change challenges and prospects. 35th WEDC Conference, Ghana. 2009.

UNICEF Ghana. CLTS Training Materials. 2007.

UNICEF Ghana. Integrated Approach to Guinea Worm Eradication through Water Supply, Sanitation and Hygiene. Formative Research Design. January 2008.

UNICEF Niger. Strategy for Improving Essential Family Practices.

WAWI Partners Mali. Integrated Action Plan. 2008.

World Vision Ghana. Baseline Study Household Questionnaire. April 2008.

World Vision Ghana. Feasibility Study for Savelugu Water Improvement Project. July 2008.

World Vision Ghana. Job Description for BCC Specialist. WAWI II Project.

World Vision Niger. Management of Water Points through Water Committees.

World Vision Niger. Materials for training field enumerators collecting data on household hygiene practices to design WAWI II.

World Vision Niger. Outline of behavior change activities to be implemented in WAWI II.

Leveraging of Funds

The behavior change specialists in the three participating countries used a whole spectrum of strategies to help the initiative in general, a specific partner, or their affiliates to leverage resources in support of behavior change activities.

In the most straightforward example, appropriate information about hand washing with soap at critical times was disseminated to journalists in Mali through workshops. The workshops were conducted with the intent of having journalists raise the issue of hand washing in a variety of media outlets. Through this mechanism, hand washing was brought to the attention of the general public at no cost to WAWI, reinforcing the same message disseminated through other media.

The BC specialists also advocated for funding on behalf of WAWI partners before donors affiliated with the partnership. In Mali, for example, the behavior change specialist helped HKI and the National Sanitation Directorate in the public sector secure funding for the implementation of outstanding school hygiene promotion activities.

Along the same lines, subsequent to a CLTS training workshop, the same specialist used the closing ceremony as an opportunity to have the District Assembly publicly commit $1,100 to support CLTS activities in one village. The funds were released accordingly and the intervention was implemented. Similarly, the training officer of the Regional Sanitation Bureau in Ségou, secured the assistance of the Malian BC specialist to identify funding sources within the public sector structure to implement training workshops for community health promoters to conduct hygiene promotion activities in the area under his jurisdiction.

In Niger, the behavior change specialist helped the Ministry of Health's School Health Bureau at Niamey, the Regional Directorate of Public Health at Maradi, and the Regional Directorate of Population and Social Reform also at Maradi, each write a proposal to WAWI's Secretariat to obtain a grant for behavior change activities. The funds were made available, and the WAWI Secretariat requested that the BC specialist help the recipients apply the funds. All activities were successfully conducted and reports submitted.

World Vision Niger decided to create a position for a behavior change specialist within the organization. The person hired works with the village educators in hygiene promotion. In addition, World Vision requested the BC specialists in Niger and Ghana participate in the

preparation of a grant request to be submitted to the Hilton Foundation for the implementation of BC activities in each country under the WAWI II Project. In the case of Ghana, the BC specialist drafted the section on behavior change and prepared the job description for the WAWI II BC coordinator. Thanks to the insistence of this specialist, a line item for BC activities is now part of the WAWI II budget.

Expanding the Breadth of BC Activities

In the past WAWI partners relied primarily on health promoters and schools to convey hygiene messages. The BC specialists were asked to look for new channels to help communicate these messages to new audiences or to reiterate the messages to similar audiences. Repetition and saturation in message transmission was the goal. In the case of Mali, a deliberate attempt was made to look for new channels to communicate messages pertaining to hand washing with soap. The new channels included rural radio stations, women's groups, and traditional story tellers (e.g., griots). There was also a concerted effort in Mali to bring together the issues of gender and hygiene. For example, a workshop addressing gender-related topics would also cover hygiene content, particularly hand washing.

Targeting the hygiene needs of specific audiences also helped alert the general public about hygiene issues. In another example from Mali, hand washing messages were targeted at child care centers, thus the importance of hand washing was conveyed to caretakers that work with a vulnerable population. Both in Mali and in Niger, workshops were organized to inform organizations about the importance of paying attention to the sanitation needs of the handicapped, yet another vulnerable population. The activities were mindful that sanitation solutions need to be appropriate for certain population groups, such as the handicapped, and not only to the general public. The following table lists the capacity development activities implemented in this regard.

Table 3 – WASH Needs of Handicapped and Vulnerable Populations

WASH for Vulnerable/Disabled Populations	Ghana: May 17-18; WAWI partners Mali: June 18-20, July 4, and Aug. 28-30, 2008; 60 participants Niger: Feb. 27-29, 2008; Ministry of Health and Ministry of Population and Social Reform; 20 participants

Household water treatment and storage was not a hygiene promotion issue typically incorporated into WAWI BC activities. However, USAID conducted formative research to identify determinants of household water treatment and storage practices both in Ghana and Mali, and the BC specialists were involved in getting WAWI partners acquainted with the results of these findings. It was hoped that this information sharing would lead partners to become interested in yet another hygiene issue of crucial importance in diarrheal disease prevention, particularly since they focus on water supply. Access to water is crucial, but maintaining the quality of water as it gets handled before human consumption is equally important.

In recognition of the beneficial role the private sector can play in hygiene promotion, the BC specialist in Mali pursued activities and venues to incorporate private sector participation as part

of his involvement in developing the Malian National Hand Washing Initiative. Participation and involvement of the private sector in hand washing promotion efforts will only help to strengthen activities and support their sustainability.

Results

Results regarding the quality of BC activities implemented by WAWI partners based on comments made by partner staff (see details in Tables 4 and 5 below) can be summarized as follows:

- The behavioral analysis approach introduced by the BC specialists with HIP's guidance was, at the end of the period under consideration, being used as a conceptual model by both WAWI partner organizations and collaborators to plan and refocus their hygiene promotional efforts. Examples of this change came from partners such as World Vision/Ghana, UNICEF, and New Energy.

- Many partners have a better understanding of how to plan, develop, implement, and evaluate workable behavior change strategies around water, sanitation, and hygiene promotion as a complement to hardware provision.

- As a result, WAWI partner organizations and their collaborators now think strategically about the role of behavior change in helping them to reach HIP's WAWI Objective—increase the amount of funding made available by WAWI partners to implement hygiene promotion/behavior change activities and to ensure sustainability.

- The partnership appears to have a greater appreciation for the need of formative research to guide the development, implementation, and evaluation of BC interventions.

The CLTS training has had an impact in Ghana; the approach is being implemented in different villages in the Northern Region. A similar impact has been observed in Niger, yet this occurred subsequent to HIP's involvement. The BC specialist in Niger left his position and moved to UNICEF where CLTS has flourished. UNICEF will in fact implement a workshop to train various organizations in CLTS, and WAWI partners are likely to be invited. With UNICEF funding, CLTS will be piloted in three sites.

Table 4 – Summary of Results Based on Comments Offered by Partners for All Sites (Feedback from March 2008* and at the end of 2008 after HIP's involvement)**

Topics	All Three Countries
Brought WAWI Partners Together to Work on BC Activities	"The partners have been brought closer together in the past year" – WV/Ghana "The government organizations all participated as part of WAWI in the International Water Fair (Sideau)" – Water Ministry/Mali

Topics	All Three Countries
Increased Perceived Value of BC and/or BCC among WAWI Partners and their Implementing Agencies	"By incorporating BC into the strategy/activities and budget, we expect a change and better performance in the new project" – WV/Ghana. "People were not using the toilets they have. Visited communities after doing negotiation and now we see them doing the things they said they would." – WV/Ghana "Negotiation is now a common practice all our communities." – New Energy/Ghana Negotiation successfully used to increase water "adductions" in Segou – Govt. water agency/Mali MOH and UNICEF applying negotiation in Mali
Learned the Difference between Knowledge and Behavior	"Previously we assumed a lot of things, like if people are educated on something, they would do it." – WV/Ghana
Expanding Intervention Areas and Definitions	Due to BC specialist work, WV/Ghana added sanitation and hygiene to its work, originally focused on water. "Sanitation is not just latrines" – UNICEF/Ghana
Focusing on New Target Audiences	"Targeting the foot soldiers/the agents of change to reach the actual targets. This has paid off; we are now building latrines without a subsidy." – UNICEF/Ghana Training of women's groups and associations to reach the community (BCS suggestion) – MOH/Mali
Systems Approach Increased	"We are now looking at specific behavior clusters, e.g., how water is being used from point of fetching to point of use." – UNICEF/Ghana Requests from many partners for workshops to include BC – WV, WaterAid, HKI, and UNICEF/MOH – Mali.

*Based on interviews with WAWI partners about the influence of BC specialists and BC on their activities
** Feedback from BC specialists from their discussions with partners, based on work plans developed during workshops in Ghana and Mali in March/April 2008

Table 5 – Summary of Results by Country and Partner

Specific Partners by Country	Mali	Ghana	Niger
World Vision	- Coordinator in Bla has noticed obvious changes in behavior: the women who carry water home wash their hands with soap before touching the water. - Has requested TA for a	- Approved WV's WAWI II Plan; has budget for seven BC/hygiene promotion positions in different ADPs as well as one central BC coordinator. - Implemented negotiation	- Will recruit eight BC/hygiene promotion people to support the four bases of Marci, Zinder, Tillabery, and Tera. The terms of reference developed. They will be

	series of trainings in BC/hygiene promotion (HP) for their field agents.	and small doable change approaches and seen changes in communities over previous approach. -Held two workshops training district partners in the ADPs. - "BC trainings have had an impact on our work." - Due to BC specialist input, WV is adding sanitation and hygiene to its work, originally focused on water.	coordinated by M. Almoustapha Garba (part of the Niger Rural Water Project), a current staff member, based in Maradi, who participated actively in both workshops and other activities with the BCS. -Negotiation is included in the 2009 action plan. -16 WATSAN committees are operational, following training in collaboration with Water Ministry. -"Better results from final evaluation due to BC activities supported by HIP in previous six months" (April 2008).
UNICEF	- Funding of MOH program on HWWS has resulted in general availability of washing equipment and soap in all of the country; was not the case before the intervention supported by WAWI BC.	- Plans to add a BC/HP specialist	- Plans to apply CLTS in 2009, following a regional workshop on CLTS in Bamako in Nov. 2008. - Aide et Action, partner, has used negotiation successfully; villages in Zinder (Dungass and Yaouri) have developed WASH plans; hygiene clubs have been established and community and school-based activities are taking place.
WaterAid	-Planned a training on CLTS and negotiation for its field implementers in Jan. 2009.		
HKI	-Trained trainers and school masters on hygiene education in Segou (finances for Mopti and Gao not received). - Trained radio announcers in Segou on hygiene and production of messages. Helped them do a better job of targeting. -Inclusion of hand washing as an important part of face washing for trachoma.		

International Trachoma Initiative (ITI)			- Received positive feedback from others by phone about the video sketches aired on private and public TV on trachoma.
Govt. water agency	Successfully added water "adductions" in Millennium project villages in Segou, using negotiation approach.	- Have expanded target audiences—formed school health committees; campaign has been effective. - "Workshops have changed how things are done." -Promotion of HWWS in three communities in conjunction with UNICEF.	
Govt. health	- Successful information days of HWWS for orphans, kindergartens, etc. in Bamako. - Successful information days for traditional communicators, press, and women's associations in Bamako and Koulikouro. - High demand for HW posters.		
Govt. education		-Training of district level school-based hygiene promoters and district school coordinators on hand washing and sanitation.	- School environment is now regularly clean (Maradi) - Food vendors at schools are examined by medical staff and the food is tested; only if they pass, are they authorized to sell at the schools. - Butchers have hand washing facilities and NOW wash their hands with soap before cutting meat.
Other govt.	Participatory Governance Programme – planned to implement CLTS, but awaiting new project financing.		- Change in behavior noted in families in areas where the leaders of handicapped associations were trained on the following behaviors: HWWS during critical moments, hygiene around water points.
New Energy		- Implemented successful CLTS ignition in a community in Karaga, in collaboration with WaterAid (two staff who were trained	

		during 3/08 workshop). - "BC was included in POU proposal, an outcome of the trainings."	

Lessons Learned

- Getting previously reticent WAWI partners to commit resources to BC activities required first identifying opportunities to advocate for hygiene promotion, empowering the partners to conduct hygiene promotion on their own via multi-prong capacity development activities, and having BC advocates gaining technical credibility.

- Credibility may be developed by supporting BC activities that the partners are interested in implementing, even if it implies not focusing at first on HIP-supported behavioral practices that are known to have an impact on diarrheal disease prevention. Guinea worm and trachoma prevention are initiatives traditionally supported by WAWI partners. Identifying ways in which hand washing may be linked to face washing (already part of the fight against trachoma), for example, has made hand washing easier to incorporate into hygiene promotion. By the same token, first addressing community involvement in the maintenance of water points, an important concern for a major WAWI partner, helped to subsequently introduce hygiene promotion. Seeking collaboration opportunities and remaining flexible in the areas that receive support, even if not necessarily the main expected focus of hygiene promotion to prevent diarrheal disease, develops trust and facilitates relationships that may later permit modification of the BC agenda.

- Flexibility is also important in deciding which partners to work through to get to a larger constituency. In the case of Ghana, working through UNICEF allowed access to UNICEF partners in order to meet the objective of institutional capacity development. Direct initial contact with UNICEF partners may have been perceived as abrupt and derailing for the partners involved. Piggy-backing new hygiene promotion efforts onto similar activities with partners already in the lead of BC paid off, even with a large international organization such as UNICEF.

- The presence of the BC specialists in the project areas where WAWI partners operate such as Tamale in Ghana or Maradi in Niger permitted frequent contact with implementation partners. Physical presence on the ground helps create bridges that would otherwise not emerge when TA is provided from a distance or at the regional level.

- The directives concerning program focus from USAID changed over time, and in the latter months an emphasis was placed on fund leveraging. This new focus was conveyed to the BC specialists and incorporated into the work plan and monthly reporting. Both measures led to activities in this regard that were easily captured in the monthly reports.

- Support for BC activities from the donor community cannot and should not be short term, even if the disbursements occur in tranches. It is preferable that funds for BC activities used for both TA and hiring local BC specialists be channeled through one implementing agency.

Annex 1: Objectives, Outputs, and Agendas of Workshops Designed by HIP

WAWI Behavior Change Strategy Workshop
July 3-19, 2007
Objectives, Outputs, Agenda

Objectives
At the end of the workshop, the participants will:

1. Understand/be able to explain to others the behavior change issues faced by WAWI partners in their hygiene and sanitation activities.
2. Know the basic concepts of behavior change theory in health promotion and be able to distinguish between behavior, behavior change, and behavior change strategy.
3. Have applied a behavior change process to develop a WAWI-partner consensus on key elements of a behavior change strategy, using hand washing as the model:
    a. Completed some behavioral analysis charts (using model of page 26 of L. Cogswell's EHP report[1]) for key audiences (households, schools, etc.)
    b. Reviewed research
    c. Collected (briefly) field data
    d. Interpreted research and data
    e. Provided suggestions for how to modify field research tools/methodology (provided)
    f. Developed, based on extrapolating results and lessons learned from above activities, a list of possible interventions for different audiences in different behavioral areas—communication, advocacy, supplies, etc. (using model of page 28 of L. Cogswell EHP report)
4. Have provided input on their preferences for, opportunities for, and restrictions against possible measures to increase partner opportunities to bond and increase instances for technical communication as a result of activities initiated as a result of this workshop.
5. Have prepared a list of what activities they plan to implement during the remainder of 2007 using the model hand washing strategy and/or how they plan to develop strategies and implement activities on other hygiene and sanitation topics with assistance from HIP:
    a. Specified which activities can be done with current resources
    b. Developed some basic indicators to monitor activities

Expected Outputs
1. Model WAWI behavior change strategy for hand washing—including behavioral analysis tables and tables of suggested interventions for various key audiences.
2. Suggestions for revisions of field research tools/methodologies.
3. Participant preferences and opportunities for ongoing collaboration.
4. List of activities to implement and/or other strategies to develop with HIP assistance for remainder of 2007.

[1] Cogswell, Lynne. (2004) Strengthening Hygiene Promotion in the West Africa Water Initiative (WAWI) Partnership in Ghana, Mali and Niger: Assessing the Capacity of WAWI Partners to Promote Hygiene. EHP USAID.

AGENDA

Day 1

Time	Activity	Who
08:00–08:30 am	Registration	
08:30–09:00 am	• Welcome/opening • Review of meeting objectives and agenda • Hand washing as model	WAWI/Official BC Consultant BC Consultant
9:00–9:15 am	**Reception**	
9:15–9:45 am	• Intro/icebreaker • Expectations (participants) • Ground rules • Selection of eye and ear	LS/BCC BC C BC C BC C
9:45–11:30 pm	• Partner presentations on challenges related to behavior (5 min/institution) • Questions • Discussion	Participants
11:30–12:30 pm	• Behavior is key • What is behavior?	LS
12:30–1:30 pm	**Lunch Break**	
1:30 – 2:15 pm	• Discussion – how can a behavior focus help WAWI partner's activities?	Mixed groups –by target audience
2:15–2:45 pm	• Sharing of group ideas	
2:45–3:30 pm	• Introduction to Behavior Change Theories and Templates we will be using	BC Consultant
3:30–3:45 pm	**Coffee Break**	
3:45–4:00 pm 4:00–4:30 pm	• What do we know? • What do we need to find out? How? • Q'aire and methodology) • Plans for next day	BC Consultant LS
4:30–5 pm	• Evaluation of the day • Eye and ear report • Selection of eye and ear for next day	
5:00 pm	• Discussion of day	Co-facilitators

Day 2

Time	Activity	Responsible
08:30–8:45 am	Review of previous day and today's agenda	2 volunteers & co-facilitators
08:45–09:15 am	• Presentation of barriers and enabling factors from lit review	BC Consultant
9:15–10 am	• Review of process and tools for data collection • What to look for	LS
10–10:15 am	**Coffee Break**	
10:15 am –2:30 pm	• Field research	
2:30–3:30 pm	**Lunch Break**	
3:30–4:15 pm	• Group discussion/preparation of key findings	Mixed groups
4:15–4:45 pm	• Sharing of results from groups – overall discussion	
4:45–5:15 pm	• Evaluation of the day • Eye and ear report • Selection of new eye and ear	
5:15 pm	• Discussion of day and plans for next day	Co-facilitators
	Coffee	

Day 3

Time	Activity	Responsible
08:30–8:45 am	• Review of previous day and today's agenda	2 volunteers & Co-facilitators
08:45–09:15 am	• Feedback on tools, process; how to revise	LS/BC C
9:15–10 am	• Complete behavioral analysis grid	Mixed groups
10–10:15 am	**Coffee Break**	
10:15–11:15 am	• Complete behavioral analysis grid (continued)	Mixed groups
11:15 am– 12:00 pm	• Sharing of intervention grids and discussion	10 min/group plus discussion
12–12:30 pm	• Revisions/modifications	Mixed groups
12:30–1:30 pm	**Lunch Break**	
1:30–3:30 pm	• Developing intervention grids	Mixed groups
3:30–4:15 pm	• Sharing of intervention grids and discussion	10 min/group plus discussion
4:15–4:30 pm	**Coffee Break**	
4:30–4:45 pm	• Evaluation of the day • Eye and ear report • Selection of eye and ear for next day	
4:45 pm	• Discussion of day and plans for next day • Hand out short questionnaire on information needs for completion	Co-facilitators

Day 4

Time	Activity	Responsible
08:30–8:45 am	• Review of previous day and today's agenda	2 volunteers & Co-facilitators
8:45–9:15 am	• Discussion of information needs and collection of questionnaires	LS/BC Specialist
9:15–10 am	• Finalize intervention grids	Mixed groups
10–10:15 am	**Coffee Break**	
10:15–11 am	• Presentation of major changes and discussion	
11 am–12:30 pm	• Review partner work plans to determine: o which activities partners can improve by using HW BC strategy o what BC strategies for other topics would help partners implement activities	Partner groups
12:30–1:30 pm	**Lunch Break**	
1:30–2:30 pm	• Developing basic indicators to monitor activities	Partner groups
2:30–3:45 pm	• Presentation on 1-2 activities with indicators by partner	5 min per partner
3:45–4 pm	Coffee Break	
4–4:30 pm	• Final evaluation of the workshop	
4:30–5pm	• Eye and ear report • Discussion	
5 pm–	• Closure	

Facilitating Change Workshop
March 24–April 17, 2008
Objectives and Agenda

Who?
This workshop was developed by HIP and implemented by ARD/WAWI in order to build capacity in effective participatory training of fieldworkers in WASH. The workshop was designed to be as practical as possible.

The participants are experienced trainers of fieldworkers from the WAWI partner organizations in each country, as well as experienced trainers of relevant Ministry staff.

They are asked to bring a skill-building training activity that they have conducted or are planning to conduct in hand washing, POU, or disposing of feces, including all relevant material. On the first day, following a training demonstration by the workshop facilitators and feedback from the group, a facilitator(s) from each organization will conduct a demonstration session of about 15 minutes with the other workshop participants acting as the training participants.
Facilitators

- Lonna Shafritz is the workshop designer and co-facilitator. In 2007 she worked with WAWI partners in each country to develop behavior change strategies, using hand washing as an example.
- The BC specialist (Birama Diallo in Mali, Adamou Matti Dan Malam in Niger, and Sumaila Seidu Saaka in Ghana) will co-facilitate.
- In each country, a training specialist will also help facilitate.

Why?
Each organization's fieldworkers must motivate the communities. To improve their impact they need to learn techniques to improve behavior. It was agreed upon by the WAWI partners in each country that an effective way to address this would be for the staff that trains the fieldworkers to learn and practice how to train them to do this more effectively.

So What?
After this three-day workshop, participants will have conducted a skills-building training activity, received feedback from the other participants, and provided feedback to other participants on their trainings. These trainings will be based on a training design or lesson plan they will have developed, which will help them organize and execute their trainings to more effectively enable fieldworkers to encourage the community to practice better hygiene and sanitation behaviors. They will therefore have a series of activities that they can use in their work.

What? What For? (Objectives)
By the end of these three days, you will have:

- Demonstrated training facilitation skills
- Practiced counseling/negotiation skills related to individual/household level behavior change, using sanitation as an example

- Described how fieldworkers can apply problem-solving skills to promote community/collective behavior change, using CLTS (community-led total sanitation) as an example
- Developed key elements of a curriculum and/or a lesson plan for a specific activity to train fieldworkers how to negotiate individual/household level behavior change in sanitation and/or how to promote community-level behavior change through CLTS.

How? The focus of the training will be on community and household/individual level behavior change approaches, using sanitation as the model.

Workshop General Agenda Outline

1. Day 1
    - Welcome/overview
    - Objectives/expectations/ground rules
    - Facilitators will present training activity and receive feedback from group
    - Introduction to effective training: checklist and principles
    - Self-evaluation
    - Lunch
    - WAWI partners present training activities; feedback
    - Daily evaluation

2. Day 2
    - Presentation of key findings, barriers, and facilitating factors for sanitation from literature review (BC consultant)
    - Community-led total sanitation—theory and approach
    - Lunch
    - Negotiation skills related to sanitation
        - Demonstration
        - Identifying small doable actions, potential barriers, and how to deal with them
        - Role play
        - Feedback
    - Review of format for curriculum/lesson plan
    - Daily evaluation

3. Day 3
    - Teams will develop a workshop design and/or lesson plan for a specific training activity, focusing on practical applications and learning by doing
    - Lunch
    - Each organization will conduct their skill-building training session, receive feedback from other participants
    - Final evaluation

Methods/Learning Activities

- Lecture
- Video

- Small group discussion
- Role play
- Demonstration
- Checklist
- Reporting from small groups
- Skits
- Review learning materials

How? (How to measure learning?)

- Observation
- Checklist
- Self evaluation
- Peer feedback

Day One

Time	Topic-Activity	Present/ Demonstrate	Exercise	Handout/Material
8-8:30	Registration			**Facilitator's Manual – (just for facilitators)**
8:30-8:45	Welcome			
8:45-9:00	Overview: Objectives-Agenda			**1. Objectives/Agenda**
9:00-9:30	Introductions/icebreaker		2. Flipchart instructions	
9:30-9:45	Expectations/Fears		3. Flipchart	
9:45-10:30	Ground Rules/Logistics		4. Flipchart	
10:30-10:45	Training activity –example 1	**5. Example 1**		
10:45-11	Oral feedback/ suggestions		6. Flipchart	
11-11:15	Coffee break			**Post Experiential Learning Cycle on Walls**
11:15 – 11:45	Effective Training – o how to assess o provide feedback		7. Complete checklist	**7. Checklists – four per person**
11:45-12:00	Self evaluation		8. Complete two copies; keep 1; hand in one copy	8. Checklist
12-1	Training activity –example two & feedback	**9. Example 2**	9. Fill in checklist	
1-2	Lunch			
2-4:00	Training demonstrations by four teams: 30 minutes per group (15 min training; 15 min feedback)	10. Demon-strations		10. Checklists—five per person
4-4:15	Coffee break			**Distribute Participant Manual**
4:15 -4:45	Discussion/questions		11. Flipchart	
4:45 - ?	Daily Evaluation			**12. Evaluation form** checklist

Day Two

Time	Topic-Activity	Presentation	Exercise	Handout/material
8:30-9:00	Report of Day 1			
9-10	Key findings, barriers, and facilitating factors on sanitation and discussion	**21. Presentation (BC Specialist)**		21. Copies—2 multi-slides
10-10:15	Coffee break			
10:15-11:15 or 11:45	2-3 more training demos and feedback			Checklists – six per person
11:15 (or 11:45)-1	Community-led total sanitation (CLTS) – theory and approach	**22. Presentation (Lonna)& video**		22. Video, Flow chart (Peru)
1-2	Lunch			
	Negotiation skills related to sanitation			
2-2:30	Demonstration	**23. SCRIPT**		
2:30-3:15	• Selecting small doable actions • Identifying potential barriers and approaches		24. Groups of 3	24. In reference guide
3:15-3:30	Coffee break			
3:30-4	Role playing		25. Groups of 3	25. In reference guide
4:00-4:15	Feedback		26. flipchart	
4:15-4:30	Review of format for curriculum/ lesson plan	**27. Lonna**	27. flipchart	27. In reference guide
4:30-4:45	Discussion/questions Select training session to prepare/present for Day 3		28. flipchart for sign up	
4:45 -?	Daily evaluation			**29. Form**
	HOMEWORK: Plan what materials are needed for your training session tomorrow and bring them			

Day Three

Time	Topic-Activity	Presentation	Exercise	Handout/Material
8:30-9	Report of Day 2		31. flipchart	
9-10	Develop a workshop design/lesson plan for your training activity, focusing on practical applications and learning by doing		32. use template	32. Copy of forms
10-10:15	Coffee break			
10:15-11:15	Finalize the workshop design/lesson plan; practice the lesson		32. cont'd	
11:15 -1:15	4 teams do their skills-building training session (15 min with 15 min feedback)		33. each team	33. Checklist – 9 copies to provide feedback
1:15-2:15	Lunch			
2:15-4:15	4 more teams do their training session		34. other teams	34. Checklists
4:15-4:30	Coffee break			
4:30-4:45	Self evaluation			35.Checklists–3
4:45-5	Final evaluation			36. Final eval
5 -?	Closing			

Annex 2: Full List of TA Activities Implemented by BC Specialists

Comprehensive List of Behavior Change Activities
Implemented by HIP and BC Specialists
2/07 through 8/08

	Mali	**Niger**	**Ghana**
Activities			
Cross-country /multi-partner	Hiring of Behavior Change Specialists – Feb./March 07		
	Orientation and Work Planning – Bamako – April 07		
	Workshop on BC Strategy (Hand Washing) and Activity Plans – July 07		
	Literature Reviews, BC Materials Collection, and Partner Matrices		
	TA provided from HIP to BCS and from BCS to WAWI Partners; Work Plans; Reports – ongoing		
	Workshop on Facilitating Change – Training on Negotiation and CLTS – March-April 08		
	Interviews with WAWI partners about influence of BCS and BC on their activities		
Specific partners by country, during HIP involvement	**Mali**	**Niger**	**Ghana**
World Vision		-Helped develop module and conduct training workshop on hygiene, sanitation, and management of water points for 16 WATSAN committees in Kornaka West ADP (08) (Resulted in bridging relationships between 2 separate bodies within WV) -Helped train data collectors for evaluation (6/08) - Provided input on evaluation questionnaire (6/08)	-TA on BC intervention (8/07) - Conducted field visits and reviewed data collected in 3 villages using a WASH assessment tool, in order to help plan upcoming HP work (5/08) -Provided input into proposal for Phase 2 to ensure that BC activities are included and budgeted (6/08) - HIP suggested indicators included in WV proposal for WAWI II - Helped draft and revise job description for new vacancy in BC
UNICEF		-Technical assistance on strategy and messages related to	-TA on Guinea worm (07) - Helped train 34 on sanitation (09/07)

	Mali	**Niger**	**Ghana**
		cholera outbreak (8/07) - Worked with UNICEF/Maradi to develop communication approach for hygiene and sanitation behaviors of new project (Essential Family Practices)	- Input on TOR for baseline study (9/07) - Reviewed TOR for formative research; added hygiene indicators used by HIP (12/07) - Developed materials on sanitation and conducting training (12/07) - Participated in UNICEF preparations for International Handwashing Day; developed a detailed plan (7/08). Finalized proposal (08/08) -Supported 3 CLTS workshops implemented by UNICEF and WaterAid Tasks: • Contributed to the designing of the structure and curriculum for the workshop • Facilitated session on theory and practice of CLTS • Facilitated field work practice • Contributed to most sessions • Designed final evaluation form for the workshop (8/08) - Prepared for BC workshop for 25 participants from 5 new districts for UNICEF field implementing partners (mostly government) on I-WASH project (8/08)
WaterAid			- Helped prepare presentation for POU proposals for WAWI II - Help prepare training guide and conduct workshop on CLTS to be implemented in N. Ghana (6-7/08) -Supported 2 CLTS workshops implemented by UNICEF and WaterAid (8/08)
ITI		-Helped ITI review/revise script for TV/radio on trachoma; it aired eventually - Helped ITI prepare WEDC presentation	NA in Tamale
HKI	Support to National Trachoma Day – with govt. water agency.		NA

	Mali	**Niger**	**Ghana**
	• Developed sketch that linked importance of washing hands to face washing to prevent trachoma (10-11/07)		
Govt. water agency	Support to National Handwashing Day preparations and activity (07 and 08): - trained radio journalists in Segou - got significant free airtime	Collaborated on national strategy for WASH with consultants to include BC (6/08)	Contact with Ghana's Community Water and Sanitation Agency at national level to explore how to support its activities in the northern region (12/07)
Govt. health		- Helped get funding and conduct training workshop on BC in food hygiene and importance of hand washing at critical moments – 20 trained in Maradi region. - Worked with the PNLCC (Niger's Blindness Prevention Program) to secure funding for BC activities related to trachoma	
Govt. education		-Helped get funding and conduct training workshop on BC in school health related to hand washing – 20 trained - Teachers passing on info to students in schools	
Other govt.		-Helped get funding and conduct training workshops on BC/hygiene promotion for 15 leaders of disabled associations	

	Mali	Niger	Ghana
		- Worked with program on bilharzia and helminths to secure funding for BC activities	
New Energy			Discussed new USAID activity it is planning with Adventist Development and Relief Agency International (at invitation of project manager) (8/08)
WAWI-wide or country-level activities	Organized presentation of results of study on POU for partners (12/07)	BC specialist resigns – 6/08	Helped prepare and attended WAWI partners meeting in Tamale in 5/07
	Series of events and workshops (for food handlers, day care and preschool, and journalists) on hand washing (6/08)		Encouraged WAWI partners to include line item for BC in budgets (11/07)
	Presentations on importance of providing water and sanitation services targeted to vulnerable populations (8/08)		Submitted paper on POU to WEDC for conference; accepted and presented in Accra, (4/08)
			Worked on developing a BC strategy for Guinea worm eradication to be implemented by WAWI in collaboration with Ghana Sustainable Change Project (GSCP) (6/08) Participated in BCC workshop on Guinea worm organized by GSCP (8/08)
			BC specialist seriously injured and stopped work early (9/08)

Annex 3: Summary of Findings and Recommendations Regarding M&E Indicators

Use of Common M&E Indicators across WAWI Partners and Countries

Major Findings and Recommendations
July 2006

Introduction
This report summarizes major findings of the visits made by the HIP M&E Specialist to WAWI countries from March through June 2006. It also presents recommendations for the short and long term. It discusses the M&E systems that are in place, data collection efforts, the type of data, the frequency of data collection, etc. that are associated with each one of the set of indicators that USAID developed for the WAWI initiative.

Findings

Partner Specific M&E Systems in Place
WAWI's partners have different strategies to monitor and evaluate the impact of their interventions. They correspond to institutional M&E philosophies and approaches and are influenced by the interest of the different donors participating in the funding of activities implemented by the partnership. World Vision, for example, is putting in place its approach called Learning through Evaluation for Accountability and Planning (LEAP). This approach is highly participatory and, as in the past, it includes transformational development indicators that assess the quality of life changes occurring as a result of project implementation. Some of them focus on changes in behaviors, including hygiene behaviors. World Vision's M&E system is in place in areas where WAWI activities are implemented as well as in areas where it is not. This is particularly true in the case of Ghana.

WaterAid, on the other hand, has defined an evaluation system referred to as the Logical Planning Monitoring and Evaluation System. It is organized along a chain of events including inputs, activities, outputs, outcomes, effects, and impact. The impact measures include indicators on access and hygiene practices such as hand washing after defecation and before eating, households practicing "water hygiene," and using latrines. A software program has been developed to allow WaterAid partners and subcontractors to report on progress.

Winrock has also set up a sophisticated system to track both areas cultivated with irrigation technologies the organization has introduced and promoted as well as yields. It uses the later information to project revenue increases for farmers. This information, however, is limited to the pilot areas where irrigation technologies are used. These indicators are presented in Tables 4 and 5 below in this report.

The International Trachoma Institute and the Carter Center collaborated on implementing an M&E system to determine trachoma prevalence and hygiene practices, especially face washing, among children under 10 years of age. Information is collected to determine highly endemic

trachoma prevalence areas and target their interventions to communities located in these areas. Different operation research activities have been implemented by the International Trachoma Institute to determine the impact of massive antibiotic distribution, latrine construction, and hygiene promotion on trachoma prevalence. In Niger, UNICEF has clearly established a road map to meet MDGs in that country, and has conceptualized a system to track achievements. There are specific suggestions in the trachoma coalition pointing to the need for precision and recommending the use of cluster random sampling (CRS) instead of Trachoma Rapid Assessment (TRA), or Assurance Sampling Trachoma Rapid Assessment (ASTRA), a modification of Lot Quality Assurance Sampling.[2]

Each government has a specific ministry tracking system to determine the number of Guinea worm cases treated. They also have set up systems to track the construction of infrastructure, both water systems and household sanitation facilities. This information is used to estimate coverage and plan and coordinate future investments. This is true in all three WAWI countries.

Some of the Results Observed to Date

Quantitative Information

Following are examples of available quantitative monitoring and evaluation data. Five data tables are offered here as examples to reflect on the different programmatic emphases of the WAWI partners. The first one comes from the trachoma group, which includes the pertinent government agency in each country, the International Trachoma Institute, the Carter Center, the Lions Club, and HKI. This example is presented first because it offers information across countries and also information addressing both hardware and software issues according to the Hygiene Improvement Framework classification. Table 2 comes also from the fight against trachoma and it reflects the way that the trachoma partners keep track of the number of trachoma cases treated. Table 3 gives an example from Mali pertaining to hardware to show how government agencies integrate information at the national level, which is provided by different partners. Tables 4 and 5 demonstrate how investments in water for irrigation are being tracked by partners. This data show how water used for agriculture reflects the other dimension of water use besides health that is important in the WAWI partnership.

Water to Fight Waterborne Diseases: An Example from the Trachoma Group

Some of the better organized and integrated data are provided by the partners working on trachoma. Those data can often be found in the Annual Proceedings of the Carter Center. Table 1 below compares results for years, which are for the most part 2004 and 2005, unless otherwise indicated in the footnotes. For example, some of the data may have been collected in 2003 and not made public until 2004. It is organized along the SAFE Strategy indicators used by the Carter Center and its trachoma partners. The information accrues data for water points and latrines across partners. Only indicators similar to those suggested by the Tiers I Indicators are listed. These are subsumed under the letters F and E of SAFE, associated with prevention. They are organized according to the SAFE Strategy to make the point that institutions respond to their programmatic interest when choosing indicators; topics are addressed further down in this report.

[2] Ngondi, Jeremiah. Trachoma Prevalence Surveys. In Summary Proceedings. Seventh Annual Trachoma Control Program Review. Collaborating to Bring SAFE Together. The Carter Center. March 2006.

The table compiles information provided by the Carter Center proceedings and is complemented with data provided in the personal interviews during this trip.

Worth noting results include the following:

- In the reporting period, a total of 33,558 latrines were constructed throughout the three countries of interest;
- There was practically a four-fold increase of latrine construction in Mali;
- There was a drop in the prevalence of active trachoma from 35% to 2% also in Mali over a three-year period after massive distribution of antibiotics, as well as the reported drop from 63% to 23% in one district in Niger;
- Although resulting from one single study done only once in one site in Niger, latrine use among children is low, which means that they may not satisfy the needs of this age group that may continue to practice open defecation.

There are other aspects of the table that are important and which will be addressed in other parts of this report. One of them is that the cells are filled for all data points pertaining to the number of latrines constructed, which shows the importance that this aspect of the SAFE Strategy represents for the trachoma group, donors, and implementers involved. The other important point is that there are many empty cells. This can be explained two ways:

- Data may not be available or if they are, the data are not reported systematically from year to year in public reports
- One single partner or one group of partners working together on an issue such as the trachoma group do not have the full picture. There are different pieces of the puzzle and that data need to be pulled together to fill in the blanks on a regular basis.

Table 1 – 2004 and 2005 Results of the Surgery, Antibiotics, Face Cleansing, and Environmental Change (SAFE) Strategy Implemented in West Africa to Fight Trachoma—Indicators Closer to Tiers I Indicators

Pertinent SAFE Strategy Components + Impact	Selected SAFE Strategy Indicators as Closer to Tiers 1 Indicators Per Component	Ghana		Mali		Niger	
		'04	'05	'04	'05/'06	'03/'04	'05
Geographic Focus	(Highly endemic trachoma) villages targeted		823		548	4438	4512
Face Cleansing	New water points (boreholes and hand dug wells)	1102	834		647[3]	10	
	Repaired water points (boreholes and hand dug wells)			81	108		
	# of women trained in soap manufacturing					213	365
	% of children 1-9 years in targeted villages with clean faces				69[4]	80	88
Environmental Change	# of household latrines built	1813	3828	3327	12199	5335	7056
	Blocks of latrines built in public places, including schools			2	135[5]		
	% of households having usable latrines after three years of constructing them					76[6]	
	% of households reporting members always using latrine by type of member: men women children % of households with latrines disposing of child feces in latrine					 93[7] 92 55 52	
Health Impact	% of children < 5 years 6 months-9 years old with active trachoma	5[8]		35	2[9]	63	23[10]

[3] This number is different from that kept by the Division de l'Hydraulique, which reflects 734 new water points throughout the country as well as 52 water points rehabilitated that same year. See below.

[4] Averages kids detected with clean face through trachoma prevalence study conducted in Koulikoro Region in Mali covering the following districts: Banamba, Fana, Kangaba, Koulkoro, Ouelessebougou. Percentages per district range from 29% to 94%. Lowest percentage was found in Fana and the highest in Ouelessebougou.

[5] These numbers reflect the data provided by UNICEF for 2006.

[6] Moussa, Sadi. Assessment of Household Latrine Use and Sustainability in Doutchi Rural District, Republic of Niger. Summary Proceedings. 6th Annual Trachoma Control Program Review. The Carter Center. April 2005.

[7] All of the data pertaining to use of latrines reported in this cell were collected by one single study conducted in 2003.

[8] Yayemain, Daniel. Trachoma Prevalence survey in 12 Districts of Northern and Upper West Regions in Ghana. Summary Proceedings. 6th Annual Trachoma Control Program Review. The Carter Center. April 2005.

[9] Pertains to data from prevalence studies implemented in the following districts of the Koulikoro Region in Mali three years apart instead of two: Oue, Koul, Kan, Ban, Fana, Dioi and Kati.

[10] Personal interview with Mr. Mohamed Samna, ITI country representative in Niger. Data pertain to one district where a one year massive antibiotic distribution program had been implemented.

Tracking Number of Trachoma Cases Treated

Table 2 contains information about the number of trachoma cases treated for two years in the three WAWI countries. As can be seen, this information is quite complex as it takes into account the type of clinical services provided. Needless to say, the SAFE Strategy adopted by the trachoma partners also includes the massive distribution of antibiotics to treat trachoma at certain stages of development. Consequently, treatment implies both clinical services as well as antibiotic distribution. The increasing number of cases treated from year to year reflects the program expansion into new villages and/or regions as well as increased institutional capacity to serve the ill.

Table 2 – Number of Trachoma Cases Treated by Country and Comparison Year

Number of Persons Treated by Type of Treatment	Ghana		Mali		Niger	
	’04	’05	’04	’05	’04	’05
Surgeries for trichiasis	951	1146	2758	5872	5286	6500
1% Tetracycline eye ointment	15,101	12,697	N/A	75,000	48,886	60,781
Azythromycin	292,560	740,884	2,688,061	3,575,000	1,915,456	2,429,500

Information on the number of identified and treated cases of Guinea worm are also available.

Tracking Infrastructure Investments Example from Mali

The following table offers a breakdown of water points constructed and rehabilitated according to the official figures maintained by the National Hydraulic Division in Mali for 2005. As indicated in one of the footnotes of the previous table, these data do not coincide with the data collected and reported by the trachoma partners working in Mali. As a result, it merits reconciliation. The differences may lie in the definitions and what is counted.

Table 3 - Summary of Water Points Constructed/Rehabilitated in Mali in ’05 Based on Figures Made Available by the National Hydraulic Division

Regions	Rehabilitated boreholes	Equipped boreholes	Non-equipped boreholes	Wells	Fountains/ Standpipes	PMH Rehab	Cesspools	Total
Bamako		1			18		200	219
Gao		13	7	6		3		29
Kayes		130	23					153
Kidal		3						3
Koulikoro		7	20					27
Mopti	38							38
Segou		125						125

Sikasso		139	27					166
Tomboctou	11	6		9				26
Total	49	424	77	15	18	3	200	786

Water Used for Irrigation

Tables 4 and 5 present results tracked for the irrigation project implemented by Winrock in Ghana. Table 4 presents details about average yields per type of crop across all pilot plots. Table 5 presents a summary of results.

Table 4 shows clearly the different technical information that an implementing agency collects to determine if the cultivation techniques are appropriate to obtain the type of yields that are being observed. It also shows the level of detail that must be maintained per crop on the different plots to be precise about outcome data such as yields. These yields refer to pilot plots. The demands on data collection that may be placed on a given agency to provide an accurate picture of yields on an annual basis would be very heavy, even when samples are chosen among participating farmers.

Table 4 – Assessment of Average Yield of Vegetables Cultivated 2003-2006 [11]

Vegetable	Spacing		Maturity (days)	Harvest time (days)	Yields (tons)		
	W/in rows (cms)	Between rows (cms)			'03/'04	'04/'05	'05/'06
Tomatoes	40	60	120-125	45	11	13	12
Okra	45	60	75-90	90	7	14	14
Sweet Pepper	35	60	45-60	60	9	12	13
Hot Pepper	45	60	90-95	90	4	14	15
Cabbage	35	60	80-90	60	12	16	14
Onions	15	15	80-90	10	15	12	13
Cucumber	40	60	35-45	21	10	18	16
Carrots	3	5	80-90	60	16	13	10
Lettuce	15	30	35-45	10	18	14	16
Local leaf vegetables	20	20	25-45	10	18	17	18

Table 5 summarizes program outputs and outcomes as it includes the number of communities where the project has been implemented, the number of participating farmers by gender, the number of pilot plots and area under pilot cultivation, the technologies used, and the estimated income based on yields. Needless to say, not all production is sold on the market. Furthermore, anecdotally program implementers indicated that farmers do practice the same irrigation

[11] Taken from Abugah, R. M.D., Patrice Beaujault, Elise deRiel. Winrock/WAWI Ghana. Annual Report. June 2005 to June 2006.

techniques in the dry season in other non-pilot plots where they apply the teachings of the program.

Table 5 – Trends of Dry Season Cultivation under WAWI/Winrock Program in Ghana 2003-2006[12]

Indicators		Years		
		'03-'04	**'04-'05**	**'05-'06**
# of districts involved		5	5	5
# of communities involved		8	20	25
# of farmers	Male	19	152	264
	Female	22	75	163
# of hectares under cultivation		.97	7.23	16.3
# of treadle pumps		4	10	19
# of drip kits		8	12	28
Average income per pilot site US$		$164 (4 pilot sites)	$243 (5 pilot sites)	$197 (7 pilot sites)

The table indicates that the program has been working in the same districts but expanding coverage within the districts as the number of villages where activities are implemented grow from one year to the next. In addition, there are considerable increases in the number of participating farmers and as a result in the area under cultivation as well as in the technologies used to irrigate that area.

Qualitative Information

World Vision keeps track of the distribution of Water and Sanitation Committee by gender. That information is available in their quarterly and annual reports. Because this researcher was able to get only one annual report for one year, it is difficult to make a table using such data. However, there is additional information pertaining to the operation of these committees which is qualitative.

Quotes from reports that address the role of women in such committees follow. For example, regarding the involvement of women in water and sanitation committees, the WaterAid Mali '04 evaluation came to the following conclusion:

> Women are part of most WATSAN committees, water user associations and standpipe attendants, some in decision-making roles and positions of authority. They express that their views are considered and that their voices are heard. Their life conditions have also improved. They say that the project has helped them attain these gains. In all the projects visited, there were women in the town's initial discussion group and they were able to express their opinions. There is, however, a long way to go because in most cases; the major decisions are still taken by men, especially in traditional authority settings. Also established gender roles do not allow animators to think out of the box and give women what are considered (in Mali) as men's roles. For instance, no women masons have been selected or trained (p. 34).

[12] Ibid.

The same report added:

> In Nafadgi, all 11 standpipe attendants are women and so is its president. Many of these ladies first attended a six-month literacy course (implemented by the same NGO under a different donor) and can now handle the standpipe accounts. The role of gender in project sustainability has been demonstrated in this case (p. 34).

To conclude:

> Care must be taken, however, so as not to mistake gender bias for gender mainstream, as was the case in Dialakoroba where women are left with the responsibility of contributing for pump repairs in cases of breakdown (p. 34).

The recent World Vision mid-term evaluation examined the role of women in Water and Sanitation Committees. In the case of Niger, the evaluation team visited eight committees, and it concluded that women may be relegated to secondary roles and the expected number of women may be limited to one instead of two, which is the number of female committee members in the project document. As a result, the perspective of women may be ill represented. Anecdotal evidence suggests that men may believe that female involvement in water and sanitation committees may affect repairs of broken down pipes as women are not necessarily involved in mechanical repairs. The mid-term evaluation report regarding gender issues states that:

> Women's involvement in the installation and later in the operation of water points is essential. It would seem that when women play responsibility roles and that the water point is responsive to community needs in terms of water that women end up the best managers.

Regarding the involvement of **women in entrepreneurial activities**, the WaterAid Mali 2004 Evaluation concluded saying:

> Women have also formed groups for income generating activities like soap making. They have also instituted a micro-credit fund to enable them to buy covered buckets for hygienic water transport in both Korofina South and Nafadgi.

There is anecdotal evidence to suggest that women are involved as fountain keepers and involved in the production of soap. Soap production was an activity that attracted women in projects implemented by WaterAid near Bamako and implemented by other agencies in Bla, 320 kilometers away. As indicated in Table 1, the Carter Center collects information on the number of women trained in soap production.

Gaps with Respect to Tiers 1 Indicators

The wealth of systems in place leads to differences not only in approaches, but also indicators, definitions, methodologies to collect the information as well as measurement periods. There may also be different levels of implementation of a particular M&E system within one agency across countries. Between agencies there may be differences in focus.

Differences in Approaches and Definitions

In the case of access, for example, all agencies count how many boreholes, protected wells, and standpipes have been constructed. This information is used to estimate the percentage of the population living in areas serviced that has access to protected water sources. However, different parameters are used to estimate that coverage. In Mali, for example, the government assumes that a water point serves 400 residents. The number of water points is multiplied by 400 to get the number of people covered, and population figures in given communities are used to estimate percent of the population that is covered. In Ghana, however, the government assumes that one hand dug well provides water for 150 residents, and a borehole and standpipe for 300. In the case of Ghana, the number of wells is multiplied by 150, and the number of boreholes and standpipes is multiplied by 300. The figures are added and compared to community population estimates. WaterAid has a more complex system since it has information in terms of the distance of households to water points and the amount of water that families have access to. So, distance to water sources and quantity of water available are tracked.

Another example of the different approaches used pertains to the membership of men and women in water and sanitation committees. No household data collection effort includes questions about the participation of respondents in such committees. However, data on the composition of the committees by gender is kept in programmatic records.

Differences in Data Collection Periods

The periods of data collection, particularly when it comes to prevalence and household measures vary. ITI in Ghana has collected a rolling baseline on trachoma prevalence as it expands their intervention areas. The baseline data collection has occurred between 1999 and 2004. There has been a second measurement in some districts in 2002 and they plan to conduct yet another measurement in some districts in 2007. This seemed to be the country where different waves of measurement have occurred or are planned. No such exercise seems to have occurred elsewhere, even though there are large data collection efforts on trachoma prevalence implemented by ITI in collaboration with the government in Mali. But the data have been collected only once. Programs in each country may have their own evolution and the data collection may be associated with such evolution. Funds may be required to make the data collection more systematic across countries and at regular intervals. Yet, the research activities seem to be operational research endeavors that help make programmatic corrections and adjustments more than monitoring and evaluation activities per se trying to determine if objectives of these programs are being met.

On the other hand, while World Vision tracks Transformational Development Indicators every five years, WaterAid proposes to collect information at the household level that may be similar to that included in the Tiers 1 Indicators every three years.

On the same issue of timing, face washing data are collected via the trachoma prevalence studies in the different countries. However, in Ghana the Carter Center collects information on face washing monthly via a system that selects 10 cases in randomly selected communities from the pool of highly endemic trachoma communities detected through the larger prevalence studies.

Differences in Focus

The activities implemented by World Vision and WaterAid cut across water and sanitation, including both hardware and software. The connection between water and sanitation and

diarrheal diseases is more obvious in documents and discussions with WaterAid than with World Vision.

Regarding trachoma, ITI, the Carter Foundation, Helen Keller International, to some extent Lions Club, appropriate government agencies, and occasionally the BBC Trust and the London School of Tropical Medicine and Hygiene, have come together in the fight against the disease both in Mali and Niger. Such collaboration between ITI and the Carter Center is also strong in Ghana.

Another area of specialization is irrigation. The component focuses on increasing agricultural production and revenues. These activities are handled solely by Winrock International and are implemented only in Mali.

Interventions and the role played by implementing agencies are dynamic. The institution that had an intervention targeting schools one day, may be focusing the next day on efforts to train health providers in the treatment of trachoma. There may be a call to action from the partnership that can influence the work of the different partners. For example, in a recent meeting in Mali to launch behavior change activities held in July 2006, partners called for Winrock to expand its role and address hygiene issues related to potentially contaminated water being used to water plants. Expansion of focal areas will not mean that the initial area of focus will disappear.

The programmatic areas of concern lead to different objectives, which in turn may lead to different indicators. Face washing, for example, is of interest to the WAWI partners working on trachoma in Mali and in Ghana. It seems that World Vision picked up face washing in one household study conducted recently in Mali. Expansion of agricultural area cultivated plus yields is of course the focus of activities implemented by Winrock. Hand washing at critical times is part of the focus of WaterAid, which recently adopted impact indicators, but data on these do not seem to be collected or suggested as information that needs to be collected elsewhere. WAWI partners pick and choose indicators based on their concerns and needs, as should be the case. This implies that no such data can be accrued across partners in one country or across countries. It may accruable only across programmatic areas and only if and when data collection efforts are done at regular intervals in the participating countries.

There are specific Tiers I Indicators that seem to be ignored by most partners across countries or for which data were not readily available or included in the reports shared by partners visited. These are:

- Percentage of households in target communities that use an improved hygienic toilet (one exception to the rule would be data collected in one instance by the Carter Center in Niger)
- Percentage of children <36 (or 60) months whose feces were disposed of safely
- Percent of pumps installed for human water consumption that did not operate for more than 10 days
- Percent increase of women in entrepreneurial activities

There are other indicators that are not collected regularly by any partner or even the secretariat, but which can be easily obtained. Interviews with managers or individuals with BC/KM responsibilities within the organizations will be sufficient to collect data to track these indicators.

These are the indicators associated with the fourth of the WAWI partnership goals, Foster a New Model of Partnership:

- Work plans are created, adopted by the respective country teams, and annually updated
- Number of international or national policies, strategies, programs, and projects that are advanced through WAWI involvement or leadership
- Number of WAWI knowledge management products produced for dissemination to in-country practitioners or influential sector players

Coordination and Sharing

Regardless of the country and agency, there was little knowledge of the USAID indicators for WAWI among informants. The World Vision workshop implemented in Niger in 2005 discussed these indicators, but did not seem to leave a lasting effect. The indicators protocol did not seem to exist in French even though users of such protocol in Niger and Mali are mainly French speakers. The language barriers plus personnel turnover may be partially responsible for this general lack of awareness of the indicators. During this trip, Mme. Rahma Traore from ARD translated the indicators protocol into French.

There is no mechanism in place to review data collection efforts across partners and sites to try to harmonize indicators and instruments.

Little M&E data is shared across partners and countries. There are quarterly reports prepared by the different agencies that contain information on data that are tracked regularly. There are also research reports of specific data collection efforts that may occur less frequently, such as the trachoma prevalence studies implemented in Mali and in Ghana or the household surveys conducted in Mali by World Vision in 2005. These reports are normally not shared across partners within countries. There was no evidence that there was regular sharing across countries, even within the same agency. The relationship between the Carter Center staff in Mali and Ghana, for example, seemed informal and whatever data sharing about what is tracked and what progress is being made in each country program did not seem systematic. The M&E information seems to flow better between the periphery and the center than between WAWI partners at the periphery. Partners did not seem aware of the M&E systems that their collaborators have put in place or are using at the country level.

It is hard to know if the regional meetings systematically bring to the discussion table results of the M&E efforts implemented by the different agencies across countries. The World Vision mid-term evaluation, however, brought together implementing partners in each country and throughout the region to hear the findings, conclusions, and recommendations of the World Vision evaluation team. But this seems to be more the exception than the rule.

Recommendations

Two alternatives appear to be the next logical steps in order to adopt a set of criteria that meet the needs of WAWI. The objective in adopting WAWI-wide criteria is to cover the four major objectives of WAWI while also providing at least one criterion that allows all partners to be included. It is further recognized that financial and staff resources are not available to carry out data collection requiring time consuming efforts such as household surveys.

Alternative 1
Continue with the present ad hoc approach

Alternative 2

- Drop those criteria that require a household survey
- Accept those that only require at most once a year data collection from communities by field agents or survey team
- Modify criteria to closest fit of most partners
- Get commitment from all partners to the new approach
- Have donors require the use of criteria in new contracts
- Make secretariat the repository of data collection

EXISTING INDICATOR	ACTION	NEW OR REVISED INDICATOR	DATA SOURCE
1. a. % increase in population with access to safe water source (MDG) b. % of target population with access to safe water	Drop "b"		Well construction records
2. a. Increase in population with access to improved sanitation (MDG) b. % of households in target communities that use an improved hygienic toilet	Drop "b"		Latrine construction records
3. % of caretakers and food preparers washing hands properly with a cleansing agent (soap, ash, sand) and at appropriate times	Revise	% of target audience that performs hygiene practices as promoted % of children with clean faces upon inspection % of caretakers and food preparer washing hands with cleansing agent	Requires once a year survey by field agents or study team
4. % of children < 36 (or 60) months whose feces were disposed of safely	Drop		
5. % of children 1-10 who wash their face properly with a cleansing agent (soap, ash, or sand) at least once a day (24	Drop, see # 3 above		Requires once a year survey by field agents or study team

hours recall)			
6. % of children < 36 (or 60) months with diarrhea in the last two weeks	Drop		
7. # of cases of waterborne and water-related diseases (Guinea worm, trachoma, diarrheal diseases)	Modify	Percentage reduction in cases of Guinea worm and trachoma	Data collected by Carter Center and ITI in collaboration with government agencies
8. % of schools with basic sanitation for boys and girls, which include appropriate hand washing facilities			Construction records
9. % of women/men that participate in water/sanitation/hygiene promotion and management committee			Requires once a year survey by field agents or study team
10. % of sites where the pump did not operate for a maximum of 10 days per year			Requires once a year survey by field agents or study team
11. % increase in positive well drilling			Drilling records
12. % of water system recurrent costs recovered from user fees	Modify	Percent of water management committees with sufficient resources in reserve for ongoing maintenance	Requires once a year survey by field agents or study team
13. % increase of women in entrepreneurial activities	Modify	Number of women benefiting from entrepreneurial activities promoted by project	Requires once a year survey by field agents or study team
14. % increase in yields from use of micro-irrigation technology	Modify	Number of hectares under cultivation in dry season using promoted irrigation technologies	Seasonal surveys by field agents
15. Work plans are created, adopted by the respective country teams, and annually			Records to be collected by secretariat

updated			
16. # of international or national policies, strategies, programs, and projects that are advanced through WAWI involvement or leadership			Records to be collected by secretariat

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