



USAID
FROM THE AMERICAN PEOPLE

HIP HYGIENE IMPROVEMENT
PROJECT

TESTING SMALL DOABLE ACTIONS TO IMPROVE HYGIENE PRACTICES IN THE CARE OF PEOPLE LIVING WITH HIV/AIDS

December 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by the USAID Hygiene Improvement Project through Plan International-Uganda and the Academy for Educational Development.

The USAID Hygiene Improvement Project (HIP) is a six-year (2004-2010) project funded by the USAID Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition, led by the Academy for Educational Development (contract # GHS-I-00-04-00024-00) in partnership with ARD Inc., the IRC International Water and Sanitation Centre, and the Manoff Group. HIP aims to reduce diarrheal disease prevalence through the promotion of key hygiene improvement practices, such as hand washing with soap, safe disposal of feces, and safe storage and treatment of drinking water at the household level.

Contact Information:

USAID Hygiene Improvement Project
Academy for Educational Development
1825 Connecticut Avenue, NW
Washington, DC 20009-5721
Tel. 202-884-8000; Fax: 202-884-8454
hip@aed.org - www.hip.watsan.net

Submitted to:

Merri Weinger
Office of Health, Infectious Diseases and Nutrition
Bureau for Global Health
U.S. Agency for International Development
Washington, DC 20523

Final Report prepared by:

Xavier Nsabagasani

Technical Advisors:

Lucy Korukiiko
Elizabeth Younger
Brendon Barnes

Review Team:

Medias Gihembo
Agnes Kayego
Jacob Mutazindwa
Scovia Nabbanja

CONTENTS

List of Acronyms	4
Executive Summary	5
CHAPTER ONE: INTRODUCTION AND BACKGROUND	11
1.1 Methodology.....	11
1.2 The TIPS Phases.....	12
1.3 The Small Doable Actions Implemented.....	13
CHAPTER TWO: OBSERVATIONS AND CONCLUSIONS	16
2.1 Characteristics of the Patients.....	16
2.1.1 Bedridden Patients-Kampala (Urban Setting).....	16
2.1.2 Bedridden Patients-Kamuli (Rural Setting).....	17
2.1.3 Mobile Patients-Kampala	17
2.1.4 Mobile Patients-Kamuli.....	17
2.2 Findings on the Implementation of the Doable Actions.....	18
2.2.1 Hand Washing-Kampala.....	18
2.2.2 Safe Water-Kampala.....	20
2.2.2.1 Water Storage-Kampala.....	20
2.2.3 Feces Management-Kampala.....	21
2.2.4 Menstruation.....	23
2.3 Hand Washing-Kamuli.....	23
2.4.1 Safe Water-Kamuli.....	24
2.4.1.2 Water Storage-Kamuli.....	25
2.4.2 Feces Management-Kamuli.....	26
2.5 Menstruation-Kamuli.....	27
2.6 Emerging Issues from the Implementation of the TIPS.....	28
2.7 Conclusions and Recommendations.....	31
2.7.1 Hand Washing.....	31
2.7.2 Feces Management.....	31
2.7.3 Safe Water Use.....	32
2.7.4 Menstrual Blood.....	32
APPENDIX 1: LIST OF TIPS MATERIALS.....	33
APPENDIX 2: TIPS TOOLS.....	34

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CBHC	Community-Based Health Care
FGD	Focus Group Discussion
HBC	Home-Based Care
HIP	Hygiene Improvement Project
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
JCRC	Joint Clinical Research Centre
KCC	Kampala City Council
PLWHA	People Living with HIV/AIDS
PSI	Population Services International
TASO	The AIDS Support Organization
TIPS	Trials of Improved Practices
WASH	Wash, Sanitation, and Hygiene

Executive Summary

Previous focus group discussions (FGDs) and in-depth interviews (IDIs) conducted in selected areas in Uganda (Kampala and Kamuli) with people living with HIV/AIDS (PLWHA), their caregivers in the home, and home-based care (HBC) providers identified many high-risk water, sanitation, and hygiene (WASH) behaviors that increase the risk of patients contracting diarrhea. The FGDs and IDIs also indicated that many of the households could not implement the “ideal” behaviors that would reduce the risk of contracting diarrhea, so during the FGDs and IDIs, alternative “small doable actions” that would continue to improve the health outcomes were identified. This report outlines Trials of Improved Practices (TIPS) conducted by Plan Uganda and the USAID Hygiene Improvement Project (HIP) to pilot these small doable actions and make recommendations for the wide scale up.

Methodology

The TIPS participants were selected by the institutions that worked with the team during the FGD and IDI phase of the study. These respondents were a part of the households of bedridden and mobile PLWHA in diverse living situations with varying health concerns. The team implemented the TIPS in three consecutive visits, each with their own specific purpose. The first visit was done in order to identify the household’s current WASH practices as well as related gaps at the family level. The team recorded this information by filling out a questionnaire and taking extensive/detailed observation notes at this time. The second visit was used to check if the family had been practicing the recommended small doable actions that the team suggested after the first visit. After the third and final visit, the research team was able to conclude whether the suggested doable action was feasible or not. Also at this time, it was decided if the family would continue performing the action, or if another alternative would be more suitable. Overall, there were 25 families who participated in the TIPS: 12 in Kampala (urban) and 13 in Kamuli (rural).

TIPS Results

Hand Washing

Use of soap or ash in hand washing was largely successful in Kampala where eight families were recommended for the action and all eight of them ended up practicing it regularly. In Kamuli, use of ash when washing hands was most feasible as soap was found to be too expensive for most of

the families. In Kamuli, 13 families were advised to use soap or ash and 12 of them used ash on a regular basis. Tippy taps were more easily adopted in Kamuli than Kampala. In Kamuli, ash containers were instituted alongside the tippy taps for all who used them. In Kampala, due to the lack of space, families found difficulties in putting up tippy taps inside and outside of the houses. Only 3 of the 12 families who were visited had agreed to set tippy taps near their latrines. In Kamuli, hand washing near the bedridden patient was fairly successful. Two of the three families where this action was recommended had agreed and succeeded in implementing it. The health of the patient in the third family improved significantly and the hand-washing facility near the patient was removed. On the other hand, the outdoor hand-washing facility (a tippy tap with soap or ash) near the latrine was favorable. Most of the families in Kamuli largely implemented the tippy taps as was recommended. Only one person had not yet implemented the tippy tap by the third visit, but he was in the process of setting one up.

Safe Water

Recommended safe water practices were successfully implemented. In Kamuli, 5 out of 13 families during the initial visit were treating water either using WaterGuard (3 families) or boiling it (2 families). For the remaining eight families who were not treating their water, boiling was recommended to six families who succeeded in implementing it. One household of the remaining two eventually ended up using chemicals to treat water as recommended. The other household, by the third visit, had not resolved the issue of boiling water because he did not have a container to keep the boiled water in, and another household did not boil water because she did not have a sauce pan to boil it in.

The recommendation for storing water in jerry cans as narrow-neck containers with covers was successfully adopted in both rural and urban settings. In Kampala, only six families were storing water in narrow-neck containers: four families with white jerry cans provided by The AIDS Support Organization (TASO)/Population Services International (PSI)¹, one family with a kettle for boiling water, and one family with a narrow-neck pot. The TASO/PSI jerry cans were not

¹ These are special white jerry cans with a cover and spigot to release water. The cover is only removed when they are either cleaning the jerry can or adding more water. Water from the jerry can is served using a spigot. This is done to keep the container closed all the time in order to minimize contamination. So far these jerry cans have been as part of the package for the people who are HIV positive to help them improve on clean water consumption and were being supplied by the Joint Clinical Research Centre (JCRC), TASO, and PSI.

included in the figures of the initial visit because using jerry cans with taps (spigots) was not among the recommended doable actions. Nevertheless, the team encouraged these families to continue using these particular jerry cans. Storing water in jerry cans was recommended to five families who agreed and succeeded in implementing the doable action. In Kamuli, aside from the three families with TASO-provided jerry cans, no other families were using narrow-neck containers to store water. Storage of water in jerry cans was recommended to 10 families, but only seven had succeeded in implementing the action by the third visit. Two families had purchased the jerry cans by the third visit and one was still unable to purchase the jerry can by that time.

Feces Management

Although using a bed pan was recommended to all of the bedridden patients, the conditions and severity of the sicknesses dictated the kind of action to be taken. One of the bedridden patients in Kamuli preferred a bucket he was already using over the suggestion of a cut jerry can. He insisted the bucket was fine and that the family members did not have problems cleaning it. On the contrary, a patient in Kampala agreed to replace the bucket he was using with the cut jerry can because the patient and the family members thought it would be more comfortable and easier to manage. Unfortunately, the condition of the patient worsened and use of the cut jerry can was no longer relevant. A bedridden patient in Kamuli was too weak to use a bucket or a cut jerry can and his elderly mother who was nursing him could not easily lift him to the items. He therefore continued to defecate in the beddings. The sample to which the cut jerry can was recommended was too small a number and hence there is no representative evidence to think that this is a viable (or not viable) action.

Similarly, use of gloves and mackintosh (large plastic sheets) for improving feces management has remained difficult to implement as they were not easy to acquire due to financial limitations. One of the families in Kampala later on acquired a mackintosh when their patient became too sick. Given that the mackintosh was difficult to acquire and the fact that there was a small sample size, it is not viable to recommend use of mackintosh for feces management for very weak, bedridden patients. A bigger sample size would be needed in order to have a representative conclusion on the use of mackintosh.

Menstrual Blood

Recommendations for menstrual blood management were difficult to provide due to the fact that none of the women participating in the TIPS had their menstrual periods coincide with the team's visits and secondly, because most of the bedridden women were not having their periods at all. However, it was noted that one of the women in Kampala reported using dirty pieces of cloth to pad herself. She was advised to always clean the rags and wash them thoroughly before use.

Conclusions and Recommendations

Hand Washing

Hand washing remains very critical in the campaign aimed at improving hygiene practices among families of HIV-positive patients. Although most people acknowledge the importance of hand washing, the conditions in which they are operating and the facilities available to enable them to wash hands at critical times remain a big challenge. In this study, tippy taps are more feasible for the rural communities such as those of Kamuli. Therefore, rural communities should be familiarized with how to set up tippy taps and subsequently how to maintain and use them to wash hands. In urban settings such as Kampala, more mobile hand-washing stations (which can be placed near the door entrance where they are visible) should be promoted. In the rural areas, children were found to play a key role in maintaining the tippy taps. It is therefore crucial to engage the children in the initial discussions about setting up tippy taps. Support from community-based care providers would increase uptake of hand washing among the patients and their family members.

Hand-washing stations near the bedridden patients are feasible in both rural and urban conditions. However more sensitization on the importance of the hand washing stations near the bed both the ridden and mobile patients' would add value in improving the hand-washing practices at the critical times.

Use of soap and ash for hand washing are also feasible and sustainable once people know their importance. Ash is most feasible in rural communities where the price of soap may be barrier. Therefore both soap and ash should be promoted together in both rural and urban areas so that people can choose the most affordable option.

Feces Management

Use of a cut jerry can is suitable in some situations where patients agree with this practice. Other viable options to handle feces for the bedridden patients are buckets (large and the small Nomi), which were already being used. The choice will depend on the individual's preferences and the bottom line should be the appropriate disposal of the feces after using these facilities. It is difficult to draw a conclusive recommendation on the use of mackintosh due to the limited sample size of the families to whom it was recommended. Nevertheless it was observed that use of mackintosh was constraining for the poor families and for this reason, it should only be promoted to families who could afford it. Other options, such as the placing banana leaves covered with a piece of cloth under the hips of very bedridden patients can be promoted as alternatives to a mackintosh where families cannot afford them. Any cloth that is used should be washed regularly using gloves.

Safe Water

When well-informed, communities would take up the jerry can as a safe water storage facility. More emphasis should also be put on getting covers for the containers. Jerry cans are particularly good because they have narrow necks which do not allow much room for contamination. Boiling of water remains difficult for both the rural and urban areas. It would be more cost-effective if there were more sensitization about the use of chemicals to treat the water and at same time, ensuring that there is steady supply of these chemicals in the local shops. The commonly used chemicals were AquaSafe and WaterGuard.

More sensitization is needed to emphasize that all the water (whether from the tap or borehole) should be treated before drinking. At the same time, everybody in the house (not only the sick) should make sure the water that they are drinking is treated first.

Menstrual Blood

The issue of menstrual blood was a challenge as our small samples could not allow for a representative sample of the respondents who were menstruating during the project period. Nevertheless, one mobile female patient was found to have menstrual periods and was using rags as pads which were not being cleaned and dried properly. She would usually wash them at night, dry them under the bed, and would sometimes use them even before they had dried completely. Her child (who was under the age of 18) was handling the bloody rags without gloves, especially

when the patient was bedridden. It was thus recommended that the family buy gloves for use by the female child caretaker in case the mother became bedridden again. The woman was advised to use pegs to hang the rags and wait for them to sufficiently dry. By the third visit, the woman had acquired the pegs and promised to buy gloves so that in case she got her period again when she was bedridden, her daughter could continue to clean her without risking infection. Menstrual blood-focused TIPS with large sample sizes should be conducted to allow for representative conclusions and recommendations about practices related to menstruation among HIV- positive women.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

The TIPS implemented under this study were derived through a formative review process using focus group discussions and in-depth interviews with community-based care providers, HIV-positive clients, and caregivers in the home (substantially from the first phase assessment). During the first phase, key problems and high-risk practices were identified and summarized into a matrix of “small doable actions” (Section 1.3), after thorough discussions between the consultant, Plan Uganda, and the Hygiene Improvement Project (HIP). The TIPS were meant to pilot-test these small doable actions and make recommendations for the wide scale up. Although there were many problems and possible small doable actions identified in the assessment, it was agreed that the TIPS would focus on testing a few key doable actions. This report will present the process of TIPS implementation and their immediate outcomes. It will cover the methodology, findings, conclusion, and recommendations.

1.1 Methodology

Before the TIPS were implemented, the research team completed a 4-day training. Although the initial training was planned to last three days, an extra day was added to enable the team to fully internalize the tools and concretize agreement on the process. After the training, the tools were tested for one day and were later modified where need arose. During the discussions of the TIPS implementation manual, it was agreed that the materials needed to demonstrate the small doable actions should be purchased and used during the family visits. A list of the materials used is provided in Appendix 1 of this document.

A TIPS implementation manual was developed, which defined the process carried out during the TIPS, the instruments used, and the kinds of participants that were to be targeted. The types of families that participated in the study included:

- In-home caregiver of HIV-positive but bedridden person
- Person that is still mobile, but ill
- Household with latrine
- Household without latrine
- Family without a tippy tap
- Family with a bedridden woman in her reproductive age

In the selection of the participants, the research team worked closely with the community-based care providers from the institutions that were involved with the review phase.

1.2 The TIPS Phases

The TIPS phases were comprised of three visits. The first visit was a screening phase that included identifying the WASH practices at the time of the visit. During this visit, a structured questionnaire was used to identify the key hygiene practices and related gaps at the family level. The main areas covered included hand washing, safe water use, feces management, and menstrual blood. The details of the interview guide can be viewed in the attached tool (Appendix 2:1.1 Section A). After identification of the gaps, a summary sheet (Appendix 2:1.1 Section B) of identified problems was filled in and this was used as a basis of negotiation. The doable actions proposed to the families were guided by the negotiation guidelines in the implementation manual (Appendix 2:1.1 Section C). After the initial screening of each family, the research team met with the supervisor to decide on which doable actions would be the priorities. These doable actions would be those related to how to improve WASH practices of the patient (in particular) and other family members (in general) as defined in the manual. When it was felt that there were other important hygiene practices found missing in the home, they would be proposed. Although it was proposed that one doable action would be implemented by at least three families, some of the doable actions were tried by more than three families. For instance, in Kamuli, it was found that many families did not have places to wash their hands. As a result, tippy taps were recommended for almost all of the homes visited. After negotiation of the proposed doable actions, an agreement was reached and the researchers informed the family that they would be coming back in one week's time.

The second visit included checking on the family to see whether the agreements made during the first visit were being fulfilled. The instrument used during the second visit can be found in Appendix 2: 1.2. The discussion also included whether there was anything that failed, any challenges that arose, and how these challenges were addressed. Some of the challenges were addressed by finding other alternatives to replace those doable actions that never worked out.

The third visit was a follow up of the first and second visits. It was meant to conclude whether a doable action was feasible or not and whether the family was willing to sustain the doable action or not. The instrument used during the third visit can be found in Appendix 2: 1.3.

Sample Size

Overall, there were 25 families (12 in Kampala and 13 in Kamuli) who participated in the TIPS.

1.3 The Small Doable Actions Implemented

The following matrix summarizes the hygiene problems identified in each of the focal areas and the doable actions that were recommended.

Table 1: List of High-Risk WASH Problems and the Recommended Small Doable Actions

WASH PROBLEM	POSSIBLE SMALL DOABLE ACTION
A. HAND WASHING	
Caregivers do not wash hands with soap <u>before</u> giving food and medicine to the patient.	<ul style="list-style-type: none"> Place a hand-washing station (soap, water vessel/basin or tippy tap) near the bedridden patient so that caregivers can wash their hands. Encourage the caregiver to use a cleanser (soap or ash) when washing hands and use running water to rinse.
Bedridden patient does not wash hands after defecating because there is no soap and water available.	<ul style="list-style-type: none"> Place a hand-washing station (soap; water vessel/basin or tippy tap) near the bedridden patient so that he/she can wash their hands. Teach the bedridden patient how to wash hands with soap <u>thoroughly after defecating</u>.
Mobile patient does not wash hands after defecating because there is no hand-washing facility available.	<ul style="list-style-type: none"> Establish hand-washing station (water vessel/basin or tippy tap; soap or ash). In the rural area, the hand washing facility should be placed near the latrine. In the urban area, the design and placement of the hand-washing facility will depend on the preference of the family (inside house, near latrine, etc.).
Soap is rarely used when washing hands after defecating. People only use soap to remove visible dirt and bad smell.	<ul style="list-style-type: none"> Use soap or ash and running water to rinse when washing hands after defecating. <p>Possible Suggestions:</p> <ul style="list-style-type: none"> Obtain soap and cut into smaller pieces. Leave a small chunk at hand-washing station. If no soap is available, use ash.
B. SAFE WATER	
Water is not treated before consumption.	<ul style="list-style-type: none"> Treat water with WaterGuard/AquaSafe/PUR or boil it.
Water is stored in wide-neck containers without lids.	<ul style="list-style-type: none"> Use narrow-neck container (jerry can or narrow-neck clay pot) to store water. Put a lid on the storage container.
Containers to transport/store water are dirty.	<ul style="list-style-type: none"> Wash inside and outside of containers at least once a week with soap or detergent.

C. SANITATION/FECES MANAGEMENT	
Some people throw feces in the neighborhood close to the house or near neighbor's entrance area (in crowded slums).	<ul style="list-style-type: none"> • Families without a latrine should throw the feces in the public latrine or negotiate with a neighbor to get permission to throw the feces in the neighbor's latrine. • If latrine access is not possible, bury feces (if possible).
Some patients do not use latrines because they are not patient-friendly. Weak patients cannot easily use them because there are no support structures to assist the patients in squatting/standing back up.	<ul style="list-style-type: none"> • Install rope, pole, and/or handle in the latrine for supporting weak patient to squat or stand on their own more easily. • Build a removable seat to use over the hole of the latrine. • Provide walking sticks or crutches to get to the latrine and to use for leverage when squatting/standing.
Bedridden patient soils the bed and the excrement remains in the sheet until someone removes it.	<ul style="list-style-type: none"> • Use nappies made from old clothes and rags to absorb the feces. • Use plastic parts made from plastic "delivery sheet" material to cover nappies to contain the feces and urine. • Use potty or bed pan for collection of feces for the bedridden patients. <p>Two possible options for the bed pans:</p> <ul style="list-style-type: none"> • A middle size jerry can turned on its side with a hole cut in the middle can be put under the patient when they need to defecate or urinate; • A stool with a hole in the middle, with a place underneath the hole for a container to be placed to catch the feces. <ul style="list-style-type: none"> • Put ash/sand/leaves in the bed pan before defecating (to minimize feces sticking to container) and sprinkle ash/sand on top of feces to minimize smell. • Place within reach of patient (for patient's use if caregiver is not nearby): <ul style="list-style-type: none"> • Water/rags/tissue close to clean him/herself; • Container to put the soiled material in. • Place a mackintosh (plastic sheet) covered with a piece of cloth between the mattress and the patient. Have more than one piece of cloth and mackintosh within easy reach of patient (so he/she can exchange soiled material with clean material if caregiver is not nearby).
Caregivers do not protect hands when handling patient's feces.	<ul style="list-style-type: none"> • Caregivers use gloves or plastic sheet material to protect hands when handling the patient's feces.
Caregivers dry soiled linen in the sun and then place it back under the patient without washing it.	<ul style="list-style-type: none"> • The soiled linen should be washed with soap or any other detergent and dried in the sun before reusing.

D. MANAGEMENT OF MENSTRUAL BLOOD	
Bedridden women during their menstrual period do not have access to appropriate materials to absorb the blood.	<ul style="list-style-type: none"> • Menstruating women should be provided with materials such as pads, cotton, rags, and other locally available materials (for instance banana fibers) to absorb the blood. • Caregivers can pad the patients who are not able to pad themselves.
Bedridden women during their menstrual period do not have access to material to clean themselves.	<ul style="list-style-type: none"> • Place water and rags next to the bed for the patients to clean blood from their bodies. • Place a container next to the bed where the soiled cleaning materials can be put until they can be washed or later thrown into the latrine.
Caregivers touch the menstrual blood without any kind of protection on their hands.	<ul style="list-style-type: none"> • Caregivers protect their hands by covering them with gloves/plastic material when handling menstrual blood. • Caregivers cover their hands with gloves/plastic material when washing rags used to absorb blood. Dry the rags under the sun before reuse.

CHAPTER TWO: OBSERVATIONS AND CONCLUSIONS

2.1 Characteristics of the Patients

There were two broad groups of patients (the bedridden and the mobile) so the following information is separated according to these groups. Despite these broad categorizations, there were still individual variations within these groups and hence the success of trials also varied between households. The data is divided between the variations of urban and rural areas.

2.1.1 Bedridden Patients-Kampala (Urban Setting)

In Kampala, three out of the 12 patients were bedridden. Two of the bedridden patients were females and only one was male. The male patient was being cared for by his sister and her husband, and the two caregivers had also developed full-blown AIDS. This meant that in addition to taking care of the patient, they had to look after themselves. The sister of the bedridden patient was a volunteer with Nsambya Home Care and her husband was a retired police officer who got a small retirement benefit to look after the family. The household stayed in a large house with many children, some of whom were the sick patient's children. Paying of school fees for the children was a big challenge and the family if they could afford to continue sending them to school. The patient had lost sight by the first visit and his condition had worsened by the second visit, not being able to hear or speak. He was also soiling his beddings without alerting the caregivers.

The other bedridden patient in Kampala was an old lady (over 80 years-old) who was being taken care of by her daughter who was HIV-positive. Her daughter had an 18 year-old child and the child was in school, although the family had problems getting school fees. The family had some small piece of land nearby where they grew some food for their survival. They also had small rental rooms where they earned an extra bit of income. The family shared their latrine with their tenants and had problems keeping it clean.

The third bedridden patient in Kampala was a lady in Acholi quarters who had been abandoned by her friends and was living alone in a small, one-room wooden house. She was surviving at the mercy of the neighbors' children and a community-based volunteer from Reach Out Mbuya. She sometimes went for days without food. By the time the team visited her, she was defecating in the basin (which was left for days) making the whole room malodorous. The patient had no means of

survival because she was very weak. She told the research team that she had been diagnosed with TB. Her room was very dirty and even her beddings had not been washed in a long time.

2.1.2 Bedridden Patients-Kamuli (Rural Setting)

In Kamuli, there were three bedridden patients, two males and one 12 year-old female. By the second visit, the female's health had noticeably improved and she was able to attend school. One of the two males was a retired civil servant who was crippled as a result of the sickness and could not move from his bed; he could, however, hear and speak. He basically knew what he wanted and could still direct his caregivers as to what to do for him. His wife and daughters served as his caregivers. The other bedridden male in Kamuli who was in his thirties was very sick. He could neither talk nor turn himself in bed. He was being cared for by his mother who was also very old and weak, and had trouble lifting him up. He would defecate in the bed without warning. His very old mother was extremely stressed because she was the only one caring for her son. She had a difficult time cleaning his beddings and had trouble purchasing basic materials such as gloves, bedsheets, and food because financial problems. She was traumatized by already losing three of her children to HIV/AIDS. Her son was sleeping in pathetic conditions on the bare floor, and was covered with a very dirty blanket which had not been cleaned for a long time, and the room he was sleeping in had a terrible stench.

2.1.3 Mobile Patients-Kampala

In Kampala, there were nine mobile patients, seven females and two males. Of the two men, one was happily married with his wife and the two of them were on ARVs. Four of the women had lost their husbands. The remaining three women were single mothers, two of whom had separated from their husbands and were renting their own houses. One of the women had separated from her husband and returned to her parents' home. At the time of the first visit, only two of the mobile female patients were particularly weak, but by the third visit, one had improved health while the other had actually become completely bedridden. The caregiver of the bedridden female (a sister who was also HIV-positive) had no hope for the patient's recovery.

2.1.4 Mobile Patients-Kamuli

In Kamuli, there were 10 mobile patients. Five of these patients were women (two of whom were widows, two separated from their husbands and were being looked after by the relatives, and one

never got married but had children at home). Of the five men, two of them had separated from their wives and were living alone. Their children were under the care of relatives. One old man had lost his wife and was also living alone. Another man, a Muslim, had moved away from his family (who lives in the nearby district of Iganga) and come to Kamuli to be taken care of by his sister and to receive TASO services. He did not want his family to know that he was receiving these services. Another one of the men was still living with his wife and children who were looking after him.

2.2 Findings on the Implementation of the Small Doable Actions

There were rural-urban variations in respect to the living conditions of the patients. After the initial visit, the team identified risky WASH practices that could be improved and discussed with the families. Following the list of recommended actions presented in Section 1.3, the research team discussed the options for the small doable actions appropriate for each family and mutually agreed as to which option each family would try. The progress of the implementation of the action implemented by each family was recorded during all three visits to each household. The results have been presented for Kampala and Kamuli.

2.2.1 Hand Washing-Kampala

The doable action for bedridden patients was to install a hand-washing station near the patient's bed. The hand-washing station should be comprised of a basin, water container, and soap or ash. Hand rinsing was supposed to be done by pouring water from a jug or small jerry can. For the mobile patients, the proposal was either installing a tippy tap near the latrine or outside the house. Patients were advised to wash their hands during critical times, including after the use of toilets, before meals, and before taking medication.

It was anticipated that in Kampala, where outdoor space was a problem, indoor tippy taps would be set up, yet no one agreed to do so due to limited space in the tiny rooms that served as bedrooms, sitting rooms, and sometimes cooking places. Some of the families in Kampala declined to install tippy taps outside of their houses because they did not have toilets of their own. Others feared the tippy taps would be vandalized by people passing by and for some, there was no space available.

Household 1:

The team explained the importance of hand washing to the family. The respondents found hand washing extremely necessary for the health of their patient and the whole family. Because of difficulties raised on the installation of the tippy tap outside the house, such as lack of space, the household agreed that the family would continue to use the 5-liter jerry can that is kept outside to provide for hand washing after using the toilet. It was recommended that soap should also be provided. It was also agreed that another small water container and a small basin should be placed inside the house to help patient wash hands before eating before taking medicine.

Household 2:

The team advised the family to set up a tippy tap near their toilet. This failed because the toilet the household was supposed to use was shared together with more than 50 other families. Secondly, the family also feared that since it was the neighbor's toilet, they could not easily set up their own tippy tap. They were also worried about vandalism and theft of the tippy tap materials by those passing by.

For the reasons described above, only three of the 12 families visited in Kampala agreed to set up tippy taps near their latrines. Of these, only two families successfully implemented the tippy tap agreement. For the third family, the tippy tap was vandalized on two occasions by a passerby. As a result, this family opted for a small jerry can with water and soap outside of the house near the entrance for washing hands. Hence most of the families that declined to install tippy taps preferred to continue with containers for hand washing placed somewhere in the house or near their door entrances. These were containers that could easily be brought indoors, especially at night, so that they would not be stolen. Installing a hand-washing station in the form of a tippy tap near the patient's bed was negotiated with two families of bedridden patients during the first visit. Although they initially agreed, the two families did not do what they had committed themselves to do by the second visit, claiming that they lacked the materials to make the tippy taps. Besides, when the situation of the patients improved, they saw no need to install the tippy taps and hence no urge to install any hand-washing facilities near the patient's bed. The two families instead set up their hand-washing stations outside of their houses using small jerry cans, a basin, and soap.

During the first visit to two families in Kampala, the team recommended setting up a hand-washing station outside of the house in the form of a small jerry can with soap. The two households consistently maintained the hand-washing stations outside of their houses as was evident during the third visit. The other four families who did not initially agree to set up a hand-washing station with a jerry can and soap eventually changed their minds and began implementing the agreement. By the third visit, a total of six families were operating hand-washing stations outside of their houses.

2.2.2 Safe Water-Kampala

The focus of the safe water doable actions was water treatment and storage. Treatment of drinking water was not a big problem in Kampala. On the first visit, there was only one family who was not treating their drinking water. Four out of 12 households treated their water with WaterGuard, which they had received free of charge from the JCRC and PSI volunteers. The other seven of the 12 families who were treating the water were using the boiling method. Those who were boiling water had a problem dealing with costs of charcoal but did not want to use WaterGuard and AquaSafe because they said their bodies reacted negatively to these chemicals. The one family that was not treating water for drinking was advised to use WaterGuard and by the third visit, they had purchased it and were using it. In conclusion, all 12 families in Kampala were treating their drinking water by the third visit.

2.2.2.1 Water Storage-Kampala

By the first visit, four out of 12 families were storing drinking water in white jerry cans provided by TASO/PSI/JCRC. However, one of the families' water vessels did not have a cover and they were advised to get a lid for it. By the third visit, the family had acquired a second vessel with a lid. Five out of the remaining 12 households were storing their drinking water in ordinary jerry cans (varying between 5 and 10-liter sizes). Two of the five families were using jerry cans that did not have lids. They were advised to get the lids after the first visit. By third visit, they had all acquired the lids for their jerry cans. The remaining three families were keeping drinking water in big pots with wide necks. These three families were advised to keep the water in jerry cans instead. One of the three families had a narrow-neck pot but it was too small to store water for the whole household. They were advised to buy or clean one of the jerry cans that they had at home and use it for storing drinking water. Only one out of three families managed to abandon the wide-neck pot

and was currently using the white jerry can that they received from TASO (which they had initially abandoned because they felt it was not cooling the water). This time, they started using it after the team explained how safe and hygienic it was. The other two of the three families who were using wide-neck pots initially agreed to acquire jerry cans for keeping drinking water, but by the third visit, they were still maintaining the wide-neck pots because of disagreements in the family. Some family members preferred using these pots because they “cooled” the water. These conservative family members also argued that they had been taking water from the clay pots for years without any problem and therefore did not want to change their habits. On the other hand, the patients were convinced that there was less risk of infection if they took water from a jerry can that was clean and well-covered. One of the two families, however, opted for storing water reserved for the patient’s use in a small jerry can. Another household opted to keep the patient’s water in a narrow-neck pot. In a way, this served the goal of making the water storage containers safer, and by the end of the TIPS, all of the patients in Kampala were keeping their water in safe containers.

2.2.3 Feces Management-Kampala

The focus of feces management was proper feces disposal, which included putting the feces into a latrine (for those who had them) or burying the feces (for those who did not have latrines).

For those patients who were very sick, it was recommended that facilities be put in place to help bedridden patients defecate more easily. The recommended facility was a jerry can with a circular hole cut in the side where the patient could squat and defecate. In some instances, however, preferences of the patients were respected, especially if the existing facility already addressed this need. Such preferences for most cases included large buckets (such as old Nomi buckets).

Although some families preferred basins, these were discouraged as basins were often messy and difficult to cover.

Families with patients who were too bedridden to sit were advised to use a mackintosh to prevent the patient from soiling the mattress, which would make it get old quickly. Besides, it was much easier to clean the mackintosh than to clean the mattress. It was also recommended that a piece of cloth be put between the mackintosh and the patient. Caregivers were also advised to use gloves partly to avoid touching the feces of the patient.

Nine out of 12 families already had family-owned latrines which they were using during the day and night. Only three of the families visited did not have latrines of their own. Two out of the three households who did not have latrines were sharing with a neighbor who had one. The third family (with over 10 people) was using a Kampala City Council (KCC) latrine where each user would pay 100 shillings per visit. During the night (when the KCC latrine was locked) the family used buckets, which they emptied into KCC latrines in the morning (after paying).

During the first visit, three patients were bedridden. One of the bedridden patients was defecating in a ½-meter tall bucket. However, this task required two people to lift the patient and a third person to hold the bucket in position as the patient defecated. The research team recommended use of a jerry can with a hole cut in the side it to be used as a bed pan. By the second visit, the cut jerry can was being used comfortably and was preferred by the patient and his family because the patient only needed one person's help to use it. Unfortunately, by the third visit, the condition of the patient had deteriorated so much that he was not able to alert caregivers before defecating. The patient could no longer talk, sit, see, or even hear, and the family had resorted to placing a mackintosh on the bed. A piece of cotton cloth was used to separate the patient's buttocks from the mackintosh. The team had recommended the idea of using a mackintosh to the family during the first visit, but they had declined to use it since the patient could still get out of bed at that time.

The second bedridden patient was living alone and would defecate in a basin which would stay for more than one day before the feces were removed by either a neighbor or volunteer. At first, the research team recommended a cut jerry can, but the patient thought it would be too rough. A Nomi bucket with a cover was proposed as an alternative which the patient accepted. The patient was also advised to continue pouring ash in the bucket before and after defecating to reduce the smell. By the second visit, the patient had managed to get the Nomi bucket with a cover, which she was still using by the third visit. She was also using ash in the buckets as it was agreed on during the first visit. She reported that the ash had the smell and she was therefore willing to continue using it.

The third bedridden patient was being cleaned by the caregiver using bare hands, so the use of gloves was advised when handling the patient's feces. After this recommendation, the family acquired the gloves and as a result, the caregiver was content with the change because she was no longer worried about having to touch the feces.

2.2.4 Menstruation

During the first visit, one mobile female patient was found to have menstrual periods every month. She was using rags as pads and would usually wash them at night and dry them under the bed (sometimes using them before they had dried completely). Her child, who was under 18 years of age, was handling the bloody rags without gloves, especially when the patient was bedridden. It was thus recommended to the family to buy gloves for use by the child in case the mother became bedridden again. They were also advised to use pegs to hang the rags and wait for them to dry sufficiently. By the third visit, the household had managed to acquire the peg and promised to buy gloves in case the patient began menstruating when she was bedridden. The patient was satisfied with the recommendation and promised to continue with the proposed actions.

2.3 Hand Washing-Kamuli

There were three bedridden patients in the Kamuli sample and their families were advised to set up a hand-washing station near the patient's bed. All of the families had agreed that the hand-washing station should be comprised of a basin, container with water, and soap or ash. By the second visit, one of the patients had improved and was no longer bedridden. It was reported that a hand-washing station had been put near the bed of the patient, but when her health improved, they removed the station. Of the other two who remained bedridden, only one of the families implemented this doable action consistently, while the other could not because the caregiver was the patient's elderly mother who could not afford to buy the containers (a small jerry can and small basin). Although she had agreed on the doable action during the first visit, she had expressed concern that she may not be able to do it due to lack of money. She had hoped she would sell part of her maize for money, but she had not sold it by the third visit due to lack of market.

Tippy taps were recommended to all 13 families since all of them did not have hand-washing facilities, and moreover, they had adequate space for tippy taps. For the Muslim families that were visited, the containers with water were stationed inside the latrine. One of the Muslim families preferred using their usual water jerry can in the latrine, but they were advised to use soap or ash while washing hands. The other Muslim family put a tippy tap near their kitchen to help their children wash their hands when they were about to eat. One of the families failed to install a tippy tap because the patient could not afford a container for water. There was no alternative discussed

since it was realized during the negotiation that there were no other materials to be used to keep water for washing hands. During the third visit, the patient was advised to clean up an old container (a small jerry can) and install a hand-washing station near his home. Still, the container could not be used to install a tippy tap because it had many holes on the upper part. Since the container did not have holes in the bottom, the patient was advised to fill the container halfway with water and get ash to place near the house for hand washing after visiting the latrine. By the third visit, this action was being performed.

Throughout the negotiations with the families during the three visits, the team always recommended that heads of the families involve children in activities such as filling the containers with water. By the third visit, in some families, children were taking turns to fill the containers with water and ash. Eight out of 12 families who installed tippy taps successfully and consistently used them: they had water in the container and there was ash or soap in the container hanging near the tippy tap. It was apparent during the second and third visits that they were being used as there was evidence of ash and wet ground below the tippy tap.

The respondents who used ash for washing hands were excited, saying that they felt very clean after using it and that the ash made their hands soft. Some families were concerned about children playing with the tippy taps which would lead to wastage of water. One of the families headed by an old lady reported that some children who passed by the tippy tap would start playing with it, thereby wasting all of the water. This occurrence demotivated her from continuing use of the tippy tap. The nature of houses posed a challenge to installing tippy taps inside.

Setting up hand-washing stations near the patients required many materials that the families did not have, such as a container for water and a basin to catch the water. This was found to be more difficult than installing a tippy tap outside of the house, which simply required one container and sticks that were readily available.

2.4.1 Safe Water-Kamuli

Treatment and water storage were the focus of the suggested small doable actions aimed at improving the quality of drinking water . For water treatment, the team proposed boiling or treating with either WaterGuard or AquaSafe. Three out of 13 families were already treating their

water with WaterGuard that they were receiving free of charge from TASO. In one of the families, the water had been finished and they replenished themselves with untreated water. Out of the three families that were treating water using WaterGuard, two were adding one bottle top into a 20-liter jerry can of water and would keep the water for at least one week. The other family was adding two bottle tops into a 20-liter jerry can and kept the water for more than two weeks because there were only two members in their household and it would take them a long time to consume the water. In another one of the families, the water found in the vessel had turned orange and it was still being consumed. In two of the three families who had TASO jerry cans, the spigots had been damaged and hence the families were opening the jerry can and pouring the water instead of using the spigot. The team advised them to report the damages to TASO for any possible solutions. In another family, the members did not know that the spigot was meant to be used for serving the water. They said they had not been told how to use the spigot. The team demonstrated how it should be done and by the third visit, the family members had learned how to serve water properly.

Out of the 13 families visited, seven were drinking borehole water without treating it. When treatment was suggested, six families chose the boiling option which they implemented on a regular basis. All families had implemented the commitments by the third visit. Three households did not have the required materials (the containers, specifically) to treat the water. However, by the third visit, they had purchased the containers but still needed to clean them. Two out of three households were going to start boiling the water and one out of the three was planning to purchase WaterGuard tablets.

By the end of the third visit, 10 households were treating their water consistently: four families were treating water with chemicals (three were using WaterGuard and one was using AquaSafe) and six families were treating water by boiling. The remaining three families were about to start treating their water because they had purchased the jerry cans which they needed.

2.4.1.2 Water Storage-Kamuli

Ten out of 13 families were storing drinking water in wide-neck pots and jerry cans were the only narrow-neck containers available in the areas that were visited. During the first visit, the 10 families were advised to purchase jerry cans or at least clean or reserve jerry cans to store drinking water in. Four out of the 10 families who were using pots bought new jerry cans of varying sizes

(10 and 20 liters) depending on the method of treatment to be used and the number of people in the households. Five out of 10 families who were using pots cleaned old jerry cans of different sizes instead of buying new ones. The remaining family of the 10 agreed to start storing drinking water in 5-liter jerry cans but had not taken any action by the third visit.

During the initial negotiations, the respondents reported that jerry cans were not good for keeping drinking water because the water remained warm/hot as compared to clay pots that worked as local refrigerators. Throughout the discussions, families began to understand the importance of keeping water in narrow-neck containers (such as the jerry can) for safety reasons. As a result, they were willing to forego the other advantages of using pots (such as having water kept tasty and cool). By the third visit, the patients and some of the family members were already becoming accustomed to the water from the jerry cans.

2.4.2 Feces Management-Kamuli

The focus and rationale for feces management has been discussed in Feces Management for Kampala (Section 2.2.3) and can be applied to Kamuli as well; therefore, there is no need to repeat them here.

Nine out of 13 families already had family-owned latrines which they were using day and night. Four out of 13 households did not have their own latrines. Two out of the four households who did not have their own latrines were sharing neighbors' (who were also their relatives). The other two out of the four households without latrines were burying feces. One of them (a male patient who was living alone), had dug a hole behind his house which he used as a latrine. The team suggested the use of bed pans (in the form of 2-liter jerry cans) to two bedridden patients. One patient's health actually improved and by the second and third visits, she was mobile and already going to school. The second patient who was advised to use a cut jerry can refused because he preferred to continue using a bucket which he felt was more "user-friendly" because it was taller (compared to the cut jerry can on its side). The patient using the bucket said that after defecating in it, he could cover it until the caregiver came back home, and he could not do that with the cut jerry can because it did not have a cover.

The third patient who was very sick could not sit up or even turn himself, could not speak, and therefore could not use the cut jerry can. The caregiver was an old woman who was not strong enough to lift the patient by herself. She could only tell that the patient had defecated when she smelled feces. She was advised to use a mackintosh but she had not yet bought it by the second and third visits because she did not have the money. She said she had owned a mackintosh, but it was stolen from the wire where she had put it to dry. The team advised that she buy old clothes to use to tie around the patient as nappies. She had only one piece of cloth at first, and after the second visit, she bought another to make two pieces. During the third visit, she promised to buy more. The team was sympathetic to her financial situation and gave her the gloves used during their demonstration to enable her to wash the feces-covered rags. She indicated that the rags that she was using as nappies were very helpful in containing the feces. Unfortunately, her patient died three days after the final visit.

One of the mobile patients was weak and had difficulties squatting. The research team recommended installing a rope by the toilet. According to the patient, the rope had not been installed by the third visit because the caregiver (who was the patient's sister) said she did not have time to look for it. However, the caregiver herself reported that the roof was too weak to hold a rope. The team then suggested installing a pole which the patient would hold onto for support while defecating. By the third visit, the pole had not yet been provided and this time, the caregiver admitted that she had not had time to look for one. From the way she talked, it seemed that she was already tired of the patient and even worried that the patient would infect her family members.

2.5 Menstruation-Kamuli

There were no cases of menstruating women in all of the families visited in Kamuli. There were four women of reproductive age but all of them said they had stopped having their periods. Because these women were sick and ardently stated that they had not had their periods for over a year, they were never questioned further about what they used to do when they did have periods.

2.6 Emerging Issues from the Implementation of the TIPS

Some of the small doable actions that had been identified were not implemented by any households because of the small sample size. For example, the small doable actions regarding menstrual blood management were not implemented since most of the women were not menstruating and the participant who was still having periods (from Kampala) did not get periods during the study time period. These factors meant that some of the small doable actions that were meant to be tested during the TIPS required more time.

When bedridden patients' health improved and they became mobile again, the hand-washing stations that had been placed near their beds were removed because they were no longer needed. However, during the discussions, it was emphasized that if the patient became bedridden again, they should set up the hand-washing stations again, and all study participants gladly agreed that this was the proper response to the situation. The tippy taps, which were placed outdoors, were not affected by whether the patient was or was not bedridden.

In Kamuli, the participants were excited about using tippy taps and ash for hand washing. All of the families maintained water and ash for hand washing and were willing to continue with the practice. People argued that ash was preferable to soap not only because it was free of charge, but also because it made their hands feel so soft. Where there were children in the household, and particularly where these children were involved in the discussion, the tippy taps remained filled with water and were not easily vandalized by other children.



The girl in this picture is washing her hands using a tippy tap. The bucket contains ash, which she is using to clean her hands. Although her sick mother was in the hospital when the team visited, the other family members were still using the tippy tap and girl was the one maintaining it.

It was easy for people to shift from the use of a clay pot to a jerry can for storage of water after an explanation was given. This was much easier to promote where the family had several jerry cans for various uses since it was easy to wash one of these jerry cans and use them for storing water. Some households bought jerry cans especially after being convinced that the jerry cans were better for them in terms of hygiene. However, the size of the jerry cans was a big concern because large jerry cans were expensive, making the overall process of water treatment more costly. Patients who were living alone saw no need to have large jerry cans. They preferred the 5 or 10-liter containers.



The man in the picture is from Kamuli. He is a widow who lives alone. He was very enthusiastic about setting up a tippy tap, which he consistently maintained and also decided to buy a jerry can for storing water after hearing the team's recommendation.

Water treatment using WaterGuard and AquaSafe and boiling were acceptable, but there were constant complaints that these methods were expensive. Boiling was more feasible for those patients who did not have much to cook because they had an easier time allocating some of their wood for boiling water instead of cooking food. WaterGuard and AquaSafe are much cheaper in comparison to fuel wood. However, this preference requires that the families become aware of their importance. It also requires that the chemicals be made readily available in the shops in villages. Therefore, some kind of social marketing is needed to promote use of WaterGuard and AquaSafe. Except for those families who were accessing services from TASO, PSI, and JCRC, most households had not heard about these chemicals and how they can be used to treat water.

Some families had a perception that the patient was the only one who needed to drink treated water or wash their hands at critical times: therefore, there was a tendency to keep purified water in small

jerry cans only for the patients. In some families, there were disagreements about which vessels should be used to store drinking water. These disagreements affected the success of the doable actions.

2.7 Conclusions and Recommendations

2.7.1 Hand Washing

Tippy taps were more feasible for the rural communities of Kamuli. The most feasible containers for making tippy taps in the study settings were the 3-liter jerry cans. Communities should be well taught how to set them up, maintain them, and use them to wash hands. For Kampala, more mobile hand-washing stations should be promoted. These can be placed near the entrance door where they are visible. Children played a key role in maintaining the tippy taps. It is therefore crucial to engage the children in the initial discussions about setting up the hand-washing station and maintaining it. It is important that promotion of hand-washing facilities be accompanied by close support until the families get used to hand washing and make it a part of their daily routine.

Hand-washing stations near the patients were feasible in both rural and urban conditions. These facilities were accepted after thorough explanations were given. This education, along with constant monitoring and supervision by the community-based care providers, will be critical to the success of the doable action and would promote hand washing at critical times.

Use of soap and ash for hand washing was also feasible and sustainable once people knew their importance. Ash was most feasible in the rural communities where the high price of soap was a barrier. Both soap and ash should be promoted together in rural and urban areas so that people can choose the more affordable option for their households.

2.7.2 Feces Management

Using a jerry can that has been modified to serve as a bed pan (by laying it on its side and cutting a hole in it) was feasible in some situations, especially when the patients agreed. Other viable options to handle feces for the bedridden patients were a bucket (large and the small Nomi buckets). The choice between a modified jerry can or bucket depended on the individual's preferences, but the emphasis should be on the appropriate disposal of feces after using a bucket/bed pan. The cut jerry can and buckets (both Nomi and normal buckets) should be

promoted. Emphasis should be put on the use of ash before and after defecating in the bucket/bed pan and ensuring that the containers are covered after the patient has defecated.

Using a mackintosh was constraining for poor families because of the cost. The mackintosh should be promoted, but where families could not afford it, other options such as the use of old clothes as nappies for the very sick patients can serve as an alternative. The rags should be washed regularly using gloves for those who could afford them.

2.7.3 Safe Water Use

When well-informed, communities would take up the jerry can as a safe water storage container. More emphasis should also be put on getting covers for the containers. Boiling of water remains difficult for both the rural and urban areas. It would be more cost-effective if there were more education on the use of chemicals to treat the water and at same time ensuring that there is a steady supply of these chemicals in the local shops. More motivation is needed to emphasize that all of the water (whether from the tap or borehole) should be treated before drinking. At the same time, everyone in the house (and not only the patients) should be drinking treated water.

2.7.4 Menstrual Blood

The issue of how to handle menstrual blood remained a challenge as the small sample sizes prevented the research team from testing the small doable actions because none of the participants were menstruating during the time of the study. Further menstrual blood-focused studies with larger sample sizes should be conducted to allow for additional understanding of the practices related to menstruation.

APPENDIX 1: LIST OF TIPS MATERIALS

Materials that the researchers will go to households with:

- tippy taps
- bed pan (jerry can with a hole inside)
- camera
- sheet of mackintosh

Items that can be found at home or purchased by the family:

- rags for cleaning the menstrual blood
- mackintosh to cover the mattress
- piece of cotton cloth to put between the patient and the mackintosh
- cotton rags (to soak up blood or clean patient)
- sand, dirt, or leaves to put on bottom of potty or on top of feces
- cotton wool
- crutches
- walking stick
- ropes, poles, and stool with a hole for the latrine
- small basin/bowl
- jug and small basin
- tippy tap
- jerry can, water vessel, or pot with a narrow-neck
- bars of soap
- ladle
- plastic bags/gloves
- potties
- bed pans (jerry can with hole cut in side)
- camera
- AquaSafe/Pur/WaterGuard

APPENDIX 2: TIPS TOOLS

1.1 FIRST VISIT

TIPS WATER AND SANITATION FAMILY SURVEY

Introduction

(Introduce yourself and your colleague.)

We are asking for your help to learn how and what families can do in their houses so that they can stay healthier. We would like to speak with you about how your family handles certain health issues and what you can do to improve practices at home. At the end of our discussion, we would like you to pick a few things to try to change in your house. Then after a week, we will come back to see how you are doing. After another week, we will return for a final visit to see how you were able to do and how you felt about your experience. Our discussion today will take about 45 minutes to an hour. Your participation is voluntary and all issues discussed will be kept confidential.

Would you like to talk with us today and two more times later and try some new things that can improve your family's health? (If no, terminate the interview; if yes, proceed with interview asking the questions in Appendix 2: 1.1 Section A.)

SECTION A
QUESTIONS TO IDENTIFY CURRENT BEHAVIORS

Date:

Location (circle one): Kamuli Kampala **Household Locator:** _____

Interviewers: _____

Name of Interviewee: _____

HAND WASHING						
1.	ASK:	Please show me where you usually wash your hands.				
	OBSERVE:	<ul style="list-style-type: none"> • Is there a water container? • Is the container a tippy tap? • Has the water container recently been used? • Can you easily pour water from the container for hand rinsing? 	YES	NO		
		<ul style="list-style-type: none"> • Is there a cleansing agent? (circle option) Soap Ash Sand Paw-Paw leaves Other: _____ 	YES	NO		
		<ul style="list-style-type: none"> • Is there a hand-washing station? • Near latrine? • Has it been recently used? • Water in container • Wet surrounding • Soap/ash used • Near patient (if bedridden) • Has it been recently used? • Water in container • Wet surrounding • Soap/ash used 	YES	NO		

2.	ASK:	Can you please show me how you wash your hands?						
	OBSERVE:	<ul style="list-style-type: none"> • Uses cleaning agent? (Circle one) Soap Ash Sand Paw-paw leaves Other _____ • Rubs hands together? • Rinses with pouring water? • Dips hands into bowl of water to rinse? 	YES	NO	YES = small doable			
YES	NO	YES	NO					
YES	NO	3.	ASK:	<i>If you have not seen a cleansing agent, ask:</i> Can you please bring me/show me the soap you use for hand washing?				
	OBSERVE:	<ul style="list-style-type: none"> • Is there soap? • If no soap, is there (Circle answers) Ash Sand Paw-paw leaves • If have soap (ash/sand/paw-paw), does it look used recently? 	YES	NO				
		YES	NO					
4.	ASK:	<p>Can you tell me about the things you do when cleaning a bedridden patient?</p> <p><i>Interviewers: listen for information on <u>when</u> caregivers wash their hands and circle the appropriate response below. If the patient does not mention hand washing, or you are not clear about when they wash their hands, ask:</i></p> <p>When do you wash your hands during the process you have just described?</p> <ul style="list-style-type: none"> • After cleaning up the patient's feces/blood • Before giving them medicine 						
YES	NO	YES	NO					

		<ul style="list-style-type: none"> • Before giving them food • Before giving them water • After caregiver has used the latrine • Other _____ 	YES	NO		
5.	ASK:	Please show me <i>where</i> the caregiver washes his/her hands after cleaning the patient's feces or blood.				
	OBSERVE:	<ul style="list-style-type: none"> • Is the hand-washing location close to patient care area? 	YES	NO		
6.	ASK:	Does the caregiver use anything to protect his/her hands when cleaning the patient's feces or blood? (If no, skip to Q.7) Please show me what the caregiver uses to protect his/her hands.	YES	NO		
	OBSERVE:	Items you are shown that caregiver puts on hands to protect themselves: (Circle items) <ul style="list-style-type: none"> • Gloves • Plastic bags • Rags • Other: _____ 	YES YES YES	NO NO NO		
SAFE WATER						
7.	ASK:	Please show me where you store water in your home.				
	ASK:	Is there a container used to store only <u>drinking</u> water? If yes, please show me the container.	YES	NO		
	OBSERVE:	<ul style="list-style-type: none"> • Does the container have a narrow neck? • Does the container have a lid? • Does the container appear to be clean inside? • Does the container appear to be clean outside? • Is there drinking water in the container now? • Does the container appear to be used? The container is a: (circle one) Jerry can Wide-neck pot Bucket Other: _____	YES YES YES YES YES YES	NO NO NO NO NO NO		

8.	ASK:	Can you please give me some water?				
	OBSERVE:	<ul style="list-style-type: none"> Is the water served by pouring or using a spigot/tap? If not poured/served from spigot/tap, how was the water served? (Circle answer) By dipping a cup/bowl into the water Using a long-handled ladle Other: _____ How was the cup/bowl/ladle/serving utensil stored? (Circle answer) Placed on the floor/table/container lid Hung on a nail/inside of container Other: _____	YES	NO		
9.	ASK:	Did you do anything to the water that is currently in this container to make it better for drinking? <i>If yes, ask: What did you do?</i>	YES	NO		
	OBSERVE:	Are the materials needed to treat the water in the house? (Circle items) WaterGuard AquaSafe Pur Pot/stove/fire for boiling Other _____ <ul style="list-style-type: none"> Do the materials appear to be used? 	YES	NO		
FECES MANAGEMENT						
10.	ASK:	Where does your family defecate? <ul style="list-style-type: none"> In a latrine 	YES	NO	→ Go to #11 → Go to #14	
USE LATRINE – USE LATRINE – USE LATRINE						
11.	ASK:	Please show me the latrine that you use.				
	OBSERVE:	<ul style="list-style-type: none"> Does it appear to be used? (Circle answers) There is material of wiping Evidence of feces/urine Flies Grass is worn on the path to the latrine 	YES	NO		

		<ul style="list-style-type: none"> Wet sound when stone is dropped in the hole Other _____ Is it a private or shared latrine? (circle one) Private (used by 1 family) Shared (used by more than 1 family) <ul style="list-style-type: none"> Has the latrine been modified to make it easier for the patient to squat/stand back up? (Circle answers) Rope Stick Seat Other: _____	YES	NO		
--	--	--	-----	----	--	--

USE LATRINE – USE LATRINE – USE LATRINE

12.	ASK: (MOBILE WITH LATRINE)	If the patient is mobile but needs help to get to and use the latrine, is he/she helped? (Circle answers) Caregiver helps patient Uses walking stick(s) Uses crutches Other: _____	YES	NO		
-----	---	--	-----	----	--	--

USE LATRINE – USE LATRINE – USE LATRINE

13.	ASK:	Does everyone in the family put their feces in the latrine? (Circle answers): <ul style="list-style-type: none"> Adults Elderly Children Infants Sick person(s) 	YES	NO	When finish #13, go to # 16	
-----	-------------	---	-----	----	-----------------------------	--

NO LATRINE – NO LATRINE – NO LATRINE

14.	ASK:	If there is no latrine , what does your family do with your feces? <ul style="list-style-type: none"> Bury it If yes, who buries it? Probe (Circle answers) <ul style="list-style-type: none"> Adults 	YES	NO		
-----	-------------	--	-----	----	--	--

		<ul style="list-style-type: none"> • Children • Infants • Sick person • Elderly • Leave it in the open • Use neighbor's latrine • Other _____ 	YES YES	NO NO	YES = possible small doable	
--	--	--	------------	----------	--------------------------------------	--

NO LATRINE – DO NOT BURY

15.	ASK: (ONLY IF NO LATRINE & FECES NOT BURIED)	If there is no latrine and you do not bury your feces, what do you do with your feces? (Record Answer): _____ _____ _____				
-----	---	---	--	--	--	--

ASK BEDRIDDEN – ASK BEDRIDDEN

16.	ASK: (BEDRIDDEN)	Does the sick person who cannot leave his/her bed have a place to defecate/urinate?	YES	NO		
	OBSERVE:	Please show me where the patient defecates (Circle answer): Bed pan Basin Bucket Jerry can with hole cut in side Other: _____				

ASK BEDRIDDEN – ASK BEDRIDDEN

17.	ASK: (BEDRIDDEN)	Do you put anything under the sick person's hips/buttocks to prevent feces from getting on the mattress if the person soils the bed?	YES	NO		
	OBSERVE:	If yes, please show me what you put between the patient's buttocks and the mattress (Circle answers) Mackintosh/plastic sheet Cloth Leaves Other: _____				

ASK BEDRIDDEN – ASK BEDRIDDEN

18.	ASK:	What do you do if the linen gets soiled with feces?				
-----	-------------	---	--	--	--	--

	(BEDRIDDEN)	<ul style="list-style-type: none"> Use soap and water to wash If don't use soap/water, circle option below: Use paw-paw leaves to wash Use only water to wash Dry soiled linen in sun & reuse Other: _____	YES	NO		
ASK BEDRIDDEN – ASK BEDRIDDEN						
19.	ASK: (BEDRIDDEN)	Does the bedridden patient have items next to his/her bed that will help him/her clean him/herself if he/she soils the bed and no one is available to help?	YES	NO		
	OBSERVE:	Please show me what items the patient has near his/her bed to clean themselves. (Circle answers) Water Rags/tissue/leaves Extra mackintosh/plastic sheet Extra cotton cloths to put under hips Container to put soiled materials in Other: _____				
ASK BEDRIDDEN – ASK BEDRIDDEN						
20.	ASK: (BEDRIDDEN)	Does the bedridden patient have a way to wash his/her hands while in his/her bed?	YES	NO		
	OBSERVE:	Please show me what items the patient has near his/her bed to wash his/her hands. (Circle answers) Container with water Tippy tap Basin to catch water Soap Ash, sand, paw-paw leaves Other: _____				
MENSTRUAL BLOOD (FEMALE PATIENTS ONLY)						
21.	ASK:	Does the female patient still have her menstrual period?	YES	NO	→ If no, end interview	
22.	ASK:	Does the bedridden female patient use anything to absorb blood when she is having her period?	YES	NO		

		What does she use? (Circle answers) Sanitary pads Rags Cotton wool Banana fiber Other: _____				
23.	ASK:	Is there a container near the patient's bed for her to put the material she has used to absorb blood?	YES	NO		
24.	ASK: (BEDRIDDEN)	Does the bedridden patient have items next to her bed that will help her clean herself if she gets blood on herself/the bed and no one is available to help?	YES	NO		
	OBSERVE:	Please show me what items the patient has near her bed to clean herself/the bed. (Circle answers) Water Rags/tissue Extra mackintosh/plastic sheet Extra cotton cloths to put under hips Container to place soiled items Other: _____				
25	ASK: (BEDRIDDEN)	Does the bedridden patient have a way to wash his/her hands while in her bed?	YES	NO		
	OBSERVE:	Please show me what items the patient has near his/her bed to wash his/her hands. (Circle answers) Container with water Tippy tap Basin to catch water Soap Ash, sand, paw-paw leaves Other: _____				

26. How do you feel about your role as a caregiver?

27. What are some of the challenges of being a caregiver?

28. What would make your life easier in caring for the patient?

Thank the participant for their time and ask if you could talk to them again in 30 minutes. Please take into account what the participants are not doing adequately (q.1-25) as well as the answers they provided in q. 25 and q.26 to decide which small doable actions to recommend for the family to try out over the next week.

SECTION B
SUMMARY OF THE ACTIONS AND AGREEMENTS

Date: _____

Location (circle one): Kamuli, Kampala

Household Locator: _____

Interviewers: _____

Name of Interviewee: _____

FIRST VISIT				SECOND		THIRD		
(Fill in this column before presenting small doable actions to family)		(Fill in these columns after discussing small doable actions with family.)						
Recommended by Interviewer	Family Agreed to Try		Barriers Identified	Possible Solutions For Barriers	Family Agreed to Continue Behavior		Family Agreed to Continue Behavior	
	YES	NO			YES	NO	YES	NO

SECTION C
PROCEDURE FOR NEGOTIATING THE DOABLE ACTION

1. HANDWASHING

If hand washing is recommended, begin the conversation by saying:

I have noticed that you are not hand washing with soap at certain times. Hand washing is very important for a number of reasons. Invisible germs get on your hands especially after using the latrine and after cleaning a patient. These germs are very dangerous and can cause diarrhea and make you very ill. The germs from your hands can also spread to other people - especially the weak (such as HIV-positive people and children) and make them very sick. It is important therefore to wash your hands **WITH SOAP** after using the latrine, before handling food, before eating and (for caregivers) after you have cleaned the patient. Washing hands after using the latrine and before eating will prevent you and your family members from getting diarrhea and other related diseases. Apart from causing death, the burden of having diarrhea in the family is that you spend a lot of time helping the sick people instead of doing profitable work. You also spend a lot of money on treatment. When you avoid diarrhea by washing hands, you save money that goes towards treatment and the time you spend caring for the sick.

Hand washing will also get rid of unpleasant smells on your hands and can show others around you that you care for them. However, we do realize that some things can make it difficult to wash your hands and we would like to discuss some options for you to be able to practice hand washing with soap.

1.1-C If a dedicated hand-washing station is recommended:

Many families find it more convenient to wash their hands if they have a place where all of the things that are needed to wash your hands are located. Would you be willing to try to have a dedicated hand washing station during the trial period? If they are willing, ask, “How do you think you could create such a place?” If appropriate, recommend one of the following: (Remember to show the participants how to actually make them.)

- Tippy tap (with soap or ash/sand/paw-paw leaves).
- Basin and pitcher/container with water (with soap or ash/sand/paw-paw leaves).

Help the family think through the details:

- Where will you place the hand washing facility?
- When can you make one?
- Who will be responsible for keeping water in it? Making sure there is soap (or sand/ash/paw-paw leaves)?
- What problems do you think there are going to be with this?
 - What do you think you could do to overcome the problems?
- How are you going to get the materials?
- Will you need to pay for materials? How do you think you could afford pay for them?

*If hesitant, encourage them to try by mentioning one of the motivators mentioned by the interviewee. **Other possible motivators are:***

- Healthier family;
- Healthier patient and less drudgery having to clean them;
- Water saving (tippy tap).

1.2C If improving soap usage is recommended:

Ask the participant: Would you be willing to use soap to wash your hands?

- If yes, recommend that the family should have a bar of soap dedicated to hand washing that is located at the hand washing station.
- If soap is not available, recommend alternatives such as ash, sand and paw-paw leaves.

Help the family think through the details:

- Where will you place the piece of soap?
 - If outdoors, is there a chance that the soap will be stolen? How can you reduce the risk of this?
 - Will the soap be eaten by animals? How can you prevent this?
- Who will be responsible for looking after the soap?
- What problems do you think there are going to be with this?
 - What do you think you could do to overcome the problems?
- How are you going to get the materials?
- Will you need to pay for soap? How do you think you could afford pay for it?
- Is there anything else that can be used when you do not have soap? For example, ash, sand, or paw-paw leaves.

If hesitant, encourage them to try by noting one of the motivators that they mentioned.

Other possible motivators are:

- Improved personal health;
- Healthier patient and less drudgery having to clean the patient;
- Cleaner hands with good scent.

1.3C If an indoor hand-washing station is recommended:

I noticed that there is no place to wash hands close to the patient. This may make it easier for you as well as the patient to wash hands. Are you (caregiver and patient) willing to have a hand washing station indoors close to the patient? If yes, recommend the following:

- A small indoor tippy tap with basin to collect dirty water.
- A jug and basin.

Help the participant think through how they can do this:

- Where will you place the hand washing facility?
- When can you make one?
- What kind of materials will be needed? How will you get the materials?
- What would be some of the challenges?
- What problems do you think there are going to be with this?
 - What do you think you could do to overcome the problems?
- Will you need to pay for soap? How do you think you could afford pay for it?

1.4C If improving the timing of caregiver hand washing is recommended:

From the discussions we have had I realized that you sometimes do not wash hands after (possible options: cleaning the patient, before administering food, water and medicine to the patient). Can I offer some suggestion? If yes, recommend:

- Wash hands immediately after cleaning the patient but BEFORE giving food and medicine.
- If an indoor hand-washing station is a problem, refer to 1.1C above.
- If soap is a problem, refer to 1.2C above.

2. PROTECTION OF CAREGIVERS HANDS

Begin conversation by saying that you have noticed that the caregiver does not always protect his/her hands when cleaning a patient. It is really important to protect yourself

and your other people living in the house from the germs that can be spread by touching feces/blood with your bare hands. Ask: Would you be willing to try to improve the way you protect yourself when cleaning the patient? If yes, recommend one of the following (whichever is feasible):

- Gloves, plastic bags, rags and so forth.

Help the participant think through the details:

- What challenges do you envisage using these materials (including cost and how easy to use).
- Where are you going to keep the materials?
- How are you going to get them?
- Will you need to pay for materials? How do you think you could afford to pay for them?

3. FECES DISPOSAL PRACTICES

In cases where the patient is bedridden, suggest that it would be useful if the feces from the bedridden patient are handled properly and disposed of without messing the patient's bed. Proper handling of feces around the patient prevents him from getting infections. At the same time it eases the work of caring for the patient as it becomes less difficult to clean the beddings of the patient. It also reduces the risk of the caregiver being infected. Proper management of feces can be achieved by using specially designed materials for collecting feces from bedridden patients. Such materials include a bed pan, a potty or a stool with a hole for the patient to sit on while defecating (please show them the pictures). In case these are not available at home ask the participant whether she/he would be willing to acquire any of these to improve management of feces from the patient. In case they accept ask them whether they would easily make/acquire these materials. What would this cost them?

It is also important to prevent the patient from soiling the mattress with urine and feces. If the mattress is soiled, it is difficult to clean. It also gets old very fast. To prevent this, you

can use a piece of mackintosh (show them the sample). Put the mackintosh on the mattress. Over it put a piece of cloth to prevent mackintosh from scalding the skin of the patient. To avoid bad smell and easy management of the feces put ash underneath and on top of feces in the bedpan or potty).

Emphasize the safe disposal of the feces below:

- *Those with access to a latrine:* Sometimes people do not always throw feces (including those of children) into the latrine. **It is important that all the feces are thrown into the latrine to avoid diarrhea and other related infections. Proper disposal of feces will prevent you and your family members from getting diarrhea and other related diseases. Apart from causing death, the burden of having diarrhea in the family you spend a lot time helping the sick people instead of doing profitable work, you also spend a lot of money on treatment. When you avoid diarrhea by proper disposal of feces you save money that goes on treatment and the time you spend caring for the sick. Besides the whole environment becomes clean and it will be easier and more comfortable for you to nurse the patient.** Would you be willing to throw/bury the feces? If yes, ask:
 - What would you need to enable you to throw the feces in a latrine?
 - What is likely to prevent you from throwing the feces in the latrine?
 - How can you overcome this?
 - Where can you get these materials? Do you have to buy the materials?
- *Those without access to a latrine:* Inform the participant that it is important that all the feces are thrown into the latrine or buried to avoid diarrhea and other related infections. If there is no latrine, then ask:
 - Whether there is space around the home to bury the feces. Emphasize that it must be deep enough to completely bury the feces (more than 3 ft.).
 - If there is no space, is it possible to negotiate with the neighbor and throw the feces in their latrine? Or use a public latrine, if available?
 - If there is no place to bury the feces and they cannot get access to a latrine, explore how else the participant will dispose off the feces

- If the participant is hesitant, emphasize the risk of infections and benefits as outlined above (in bold) and below:
- Reduced stench from feces.
- Cleaner, tidier compound and/or living environment.

4. LATRINE ACCESS

Begin the discussion by asking caregivers and patients whether, if given a choice, they would prefer the patient to use a latrine or not. If yes, ask what it would take to a) get the patient to a latrine and b) be able to allow patient to defecate on their own in the latrine.

Recommend one or more of the following:

- Encouraging more people/family members to help get the patient to the latrine;
- To install rope, pole, and/or handle in the latrine for supporting weak patient to squat or stand on their own more easily;
- To build seat to use over the hole of the latrine (show them illustrations);
- Provide walking sticks or crutches to get to the latrine and to use for leverage when squatting/standing.

If participant is hesitant, emphasize the following:

- Less drudgery and stench if the patient defecates in bed;
- Reduces risk of diarrhea disease;
- Privacy and dignity of the patient.

5. MENSTRUAL BLOOD

ONLY FOR PATIENTS THAT ARE STILL MENSTRUATING AND BEDRIDDEN

Explain the importance of having materials to soak up the blood in case the bedridden patient has her menstrual period. It is important to keep the patient clean and comfortable as well as protecting the caregiver from getting an illness from this blood. Ask:

- Can the family afford to buy sanitary pads? If not, what other materials can the family get for the woman to use? Rags? Banana fibers? What else does patient or caregiver suggest?
- Can the family keep a container close to the patient's bed to keep the used sanitary materials in until they can be washed or thrown away? Can the caregiver wash the rags or dispose of them (How? Latrine? Burn? In trash?)
- What can the caregiver use to cover his/her hands when handling bloodied material or cleaning blood from the patient?
- Can the family provide water, soap, or rags for the patient to clean herself? Can these materials be kept within the patient's reach from her bed?

6. WATER QUALITY

Interviewers explain the importance of clean water for health, the fact that germs can contaminate the water the longer it stands, and that germs from hands, dirty utensils and cups can spread germs into the water.

Ask: Would you be willing to try some things over the next week to improve the quality of your drinking water? Recommend:

First option: WaterGuard or AquaSafe

Second option: Boiling (If don't want to use Waterguard /Aqua/Pur Safe)

- Use narrow-neck container (jerry can, narrow-neck clay pot) to store water
- Put a lid on the storage container
- Wash containers at least once a week with soap
- Do not dip your hand when drawing the drinking water
- Pouring water
- If the water container is a jerry can or a pot
- Pour the water into a clean drinking vessel
- Cover the container after drawing the water
- Use a ladle for drawing water from the container (if it is an open container)

- Store the ladle in a clean place (show them a picture)

Help the participant think through the details:

- Will you be able to get these items?
- Will you need to pay for anything? How do you think you could afford to pay for it?
- When do you think you could start?
- Who will be responsible for keeping the water clean? Who will be responsible for keeping container clean?
- What problems do you think there are going to be with what you have agreed?
 - What do you think you could do to overcome the problems?
- How are you going to get the materials?

If patient is hesitant, emphasize the following benefit: Drinking clean water protects you and the family from diseases that one gets from dirty water. **Proper management of water and taking it clean will prevent you and your family members from getting sick. When no one is sick you will have time to engage in profitable work instead of caring for the sick, and you will also not spend a lot of money on treatment. When your children drink clean water, they will remain healthy, and will be able to go to school as well as helping you at home.**

Thank the participant again for their time. Remind them what they agreed they would try and ask if you could come back to see how they are doing in one week. Set up an appointment (day and time the following week) for your second visit.

Interviewers: please remember to complete the table labeled “Section B – Summary of the Actions and Agreements” as soon as you have completed the third visit.

1.2 SECOND VISIT

TIPS WATER AND SANITATION FAMILY SURVEY

NOTE: Take with you the list of the doable actions agreed upon with the participant during the first visit.

Instructions

- Ensure that you talk to the same person you talked to last time.
- Interviewers: please greet the person again and thank him/her for talking with you before. Indicate that you would like to talk to her again about some of the things he/she agreed to try in the previous visit.
- Encourage the participant to feel free and be critical enough about the way he/she feels about the doable actions. He/she can say anything he/she wants as long as that is truly how he/she feels.
- There is no right or wrong answer, only his/her opinions.
- It does not matter if he/she has tried what we discussed or not, his/her answers will be very helpful even if he/she did or did not try the behaviors.
- Please take extensive notes.

Questions

- Thank you for speaking with me last week. Can you remind me what we agreed that you would try? [*For each new behavior ask:*]
- Tell me about doing [name the new behaviors depending on what the participant has listed down]
- Were you able to do what we agreed on?
 - [*If no*] why not?
 - [*If yes*] How is it going?
 - *Please show me how you did it. (If cannot show behavior, then describe it for me).*

- Did you do it as we discussed? Or did you make any modifications or changes? If yes, what changes did you make? What benefits has the changes brought?
- How did you feel about having to do this?
- Has the implementation of the agreed upon action been easy or difficult?
 - What worked well?
 - What did not work well? How would you change what did not work well to make it easier/better? Negotiate how to overcome any barriers that were encountered when trying to carry out the behavior.
 - What was the easiest to do?
 - What was difficult to do?
 - Can you think of any way to make it work better?
 - Was there anything you liked about doing this? What did you like?
 - Was there anything you did not like? What did you not like? Any way to make it better?
 - Is there anybody who has disapproved of you implementing the specific small doable actions?
 - Who disapproves of you implementing the specific small doable action?
 - Who supports you implementing the specific small doable action?
- Do you think you will be able to continue doing this? Why or why not?
- Would you recommend this to other people? Why? Why not?
- If you were to tell someone else what you tried, what would you say?
- Did it change anything between you and the patient? What has changed? How has it changed?
- Is there anything else we should discuss?
- Do you have any questions?

OMITTED SMALL DOABLE ACTIONS

Remind the participants of the actions they omitted. Ask why they omitted them. Explain why it is important to implement the small doable actions omitted. Find out if the participant is willing to implement the action omitted. If the reasons for omission demonstrate difficulties in implementation of the small doable actions, ask participants if they can think of more feasible doable actions. Discuss other options which they can choose from, these options must be ones that are within the family means. Record the modifications or changes made.

BEHAVIORS TO IMPLEMENT BETWEEN THIS VISIT AND THE NEXT VISIT

You need to review what behaviors the family will implement between now and the next visit. These behaviors will be a continuation of the behaviors that they succeeded in doing after the first visit, the behaviors they forgot to implement after the first visit (but they had committed themselves to do during the first visit) and the new behaviors that would be adopted after modification. Enter these behaviors in the summary of actions table (Section B) shown during the first visit.

Interviewers: please thank the participant for his/her time and encourage him/her to continue practicing the new behaviors. Remind him/her that you will be returning in one week to discuss how it is going.

Interviewers: please remember to complete the table labeled “Section B – Summary of the Actions and Agreements” as soon as you have completed the third visit.

1.3 THIRD VISIT

TIPS WATER AND SANITATION FAMILY SURVEY

NOTE: Take with you the list of the doable actions agreed upon with the participant during the first visit.

Instructions

- Ensure that you talk to the same person you talked to last time.
- Interviewers: please greet the person again and thank him/her for talking with you before. Indicate that you would like to talk to him/her again about some of the things he/she agreed to try in the previous visits. Please indicate to him/her this would be the final visit.
- Encourage the participant to feel free and be critical enough about the way he/she feels about the doable actions. He/she can say anything he/she wants as long as that is truly how he/she feels.
- There is no right or wrong answer, only his/her opinions.
- It does not matter if he/she has tried that we discussed or not, his/her answers will be very helpful even if he/she did or did not try the behaviors.
- Please take extensive notes.

Questions

- Thank you for speaking with me last week. Can you remind me what we agreed that you would try?
[For each new behavior ask:]
- Tell me about doing [name the new doable action]
- Were you able to do what we agreed on?
 - *[If no]* why not?
 - *[If yes]* How is it going?
 - *Please describe for me or show me how you did it*
 - Did you do it as we discussed? Or did you make any modifications or improvements? If yes, what changes did you make?

- How did you feel about having to do this?
 - Has it been easy or difficult?
 - What worked well?
 - What did not work well? How would you change what did not work well to make it easier/better? Negotiate how to overcome any barriers that were encountered when trying to carry out the behavior.
 - Was there anything you liked about doing this? What did you like?
 - Was there anything you did not like? What didn't you like? Any way to make it better?
 - Is there anybody who has disapproved of you implementing the specific small doable actions?
 - Who disapproves of you implementing the specific small doable action?
 - Who supports you implementing the specific small doable action?
 - Did anyone comment anything about you doing this? If yes, who? What did they say?
- Do you think you will be able to continue doing this?
 - If you are willing, what are you going to do to make sure you continue doing it? (Include probing for financial and practical viability). What else will you need to continue doing this? Whose support would you require?
 - If not willing to continue with the activity what prevents you from doing so? What are the obstacles?
 - Would you recommend this to other people? Why? Why not?
 - If you told someone else what you tried, what would you say?
 - Is there anything else we should discuss?
 - Do you have any questions?

OMITTED SMALL DOABLE ACTIONS

Remind the participants of the actions they omitted. Ask why they omitted them. If the reasons for omission demonstrate difficulties in implementation of the small doable actions, ask participants if they can think of a better way to do the small doable action that would make it more attractive or likely that they would do it. Record the suggested modifications or changes.

Thank the participant and remind them that you are very grateful for what you have learned from them because it will be used to help shape recommendations that will help many families. Remind the participant that this will be the last time that you visit them. Thank them for their valuable time and for their willingness to try something new and to be open in talking with you about their experience.

Ask one last time if they have anything else they would like to tell you about the small doable actions before you leave.

Interviewers please remember to complete the table labeled “Section B – Summary of the Actions and Agreements” as soon as you have completed the third visit.