Module 2: The Assess Step

Structure of the Module:

The last module provided an introduction to behaviour change theory including the Behaviour Centred Design Model which will be used by WaterAid in its hygiene programming. This module provides an overview of how we can use this same model to inform the process of Assessing what information is known about the target behaviour; Building on this through formative research; using this knowledge to inform the Creative design of an intervention; considering how the intervention will be Delivered; and then Evaluating the intervention – a process called ABCDE. This module will then go into more depth on the first step in this process which involves doing a review of the literature and identifying your behaviour change task. This module is broken into the following sections:

- Why hygiene? 2
- How do you design a behaviour change program? 3
- What is done during the Assess Step? 4
- Background review 4
- Framing Process 5

Key learning points:

- Hygiene behaviour change deserves to be at the heart of all WASH programming because of its potential to improve, health wellbeing and dignity.
- WaterAid country programs should address the following hygiene behaviours: 1) Handwashing with soap at critical moments 2) Faecal management and disposal (including child faeces and sanitation facility cleaning) 3) Safe water management (household treatment and storage) 4) Food hygiene (specifically children's food) 5) Menstrual hygiene management. Country programs may add additional context specific hygiene behaviours as appropriate.
- The Assess stage is the first stage in the ABCDE process and requires implementers to review what is known about the target behaviour by looking at literature from global, national and local sources.
- This review should allow you to map what is known and not known about the behaviour using the BCD checklist.
- The Assess stage also involves deciding the aim and objective of your intervention; the exact behaviour you will be targeting; the target population; and documenting any constraints you have in designing it (such as resources). This is best done by holding a 'framing workshop' with government stakeholders and WaterAid partners.

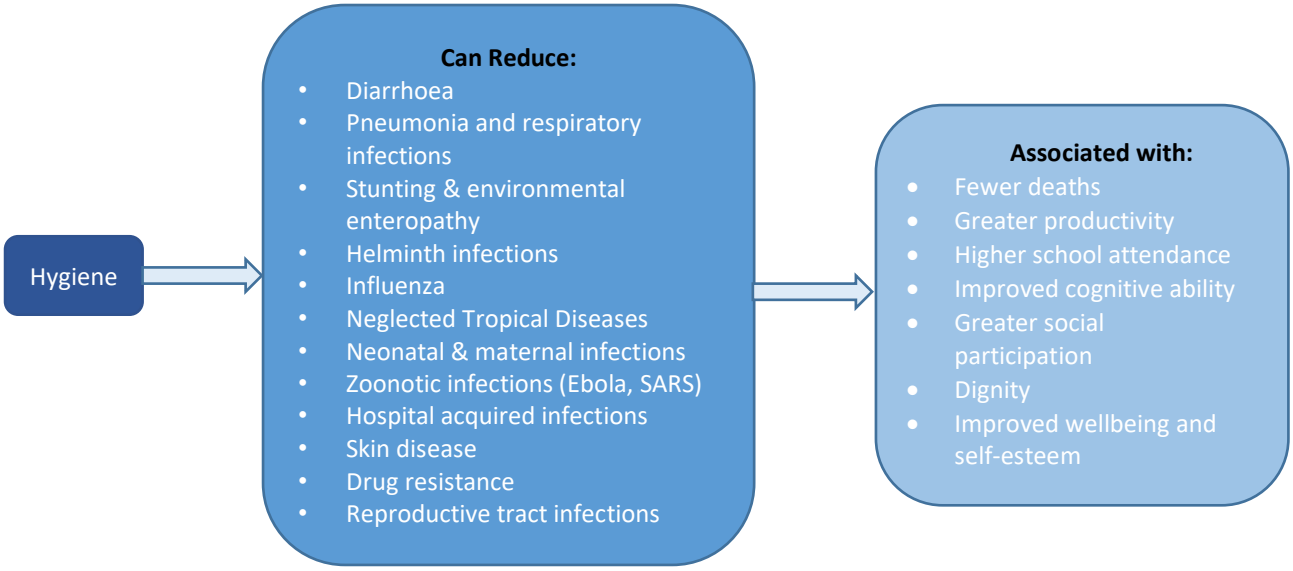
Supporting Resources

- Summary of the evidence relating to WaterAid's behaviours of interest
- BCD Checklist template

Why hygiene?

Globally 3.1% of all deaths (more than 1.7 million people) are attributable to poor water, sanitation and hygiene (WASH). Of the 1.7 million deaths, 68% are children and more than 99% of the deaths occur in developing countries. Furthermore, more than 95% of illness and death associated with diarrhoeal disease can be addressed by improving WASH infrastructure and these targeted behaviours. These figures do not include many of the other causes of ill-health and death that are associated with poor WASH. For example, 25,000 deaths and 7.6 million DALYS associated with the combined effect of Trachoma, Shistosomiasis, Ascariasis, Trichuriasis and Hookworm disease could be averted through improved WASH. There is also good evidence of the effect of WASH on nutritional outcomes; WASH and improved quality of health care (particularly for maternal and new-born health); and WASH and emerging zoonotic infections such as Ebola and SARS. However, many of these associations have not been fully understood or quantified.

Figure 1: Health and non-health effects of improved hygiene behaviour



WaterAid's target hygiene behaviours

WaterAid and partners will adopt an umbrella approach to hygiene behaviour change. Country programs will be asked to address the following hygiene behaviours:


Handwashing with soap at critical moments


Faecal management and disposal (including child faeces and sanitation facility cleaning)


Safe water management (household treatment and storage)


Food hygiene (specifically children's food)


Menstrual hygiene management

In addition to these behaviours, Country Programs should address context-specific hygiene behaviours. These may include face washing (in regions where there is Trachoma) and solid and liquid waste management (specific to hygiene), for example.

Improving these WASH behaviours will also have a range of non-health benefits. Sometimes these non-health benefits are more important from a community perspective than the health benefits.

Improved WASH is associated with significant time and cost savings and often leads to greater dignity and self-esteem. You will notice that menstrual hygiene is not on the F-diagram (below). Although menstrual hygiene management is related to sanitation, water availability and hygiene, it cannot prevent diarrhoea or other faecal-oral diseases. Menstrual Hygiene Management is, however, important for dignity and is a human right, just as the other behaviours are. The literature around each of the main five behaviours is described in the accompanying materials for this module.

Figure 2: The F-Diagram shows how Faecal-Oral pathogens move from one host to another. This diagram shows the health benefits of each of the behaviours WaterAid are targeting.

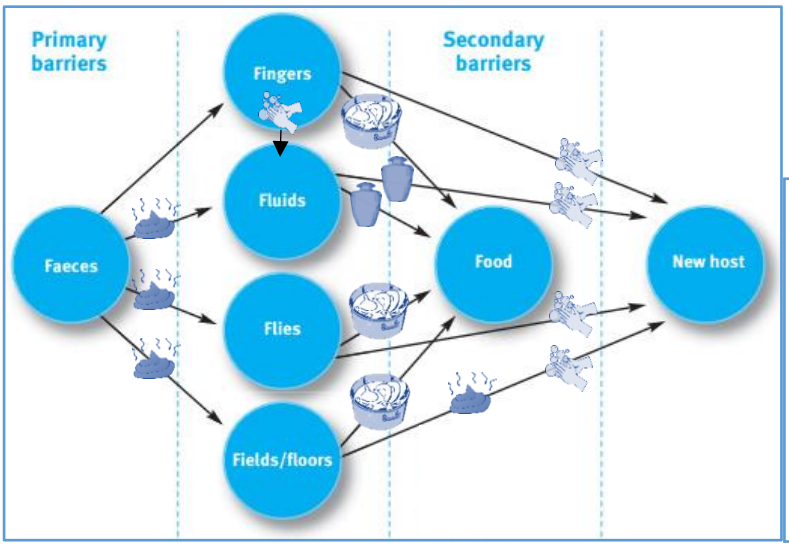
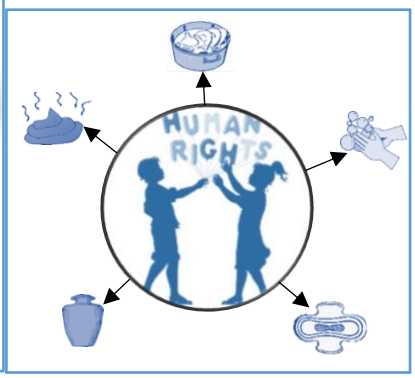


Figure 3: All 5 behaviours are also basic human rights.



How do you design a behaviour change program?

Programs that aspire to change behaviour need to do more than just understand the the **determinants of behaviour**. They also need a methodology for designing, delivering and evaluating behaviour change. The methodology presented here is inspired by theory, public health programming and marketing experience. The process is centred on developing a **Theory of Change** of behaviour that, when implemented, has the desired impact. Having a Theory of Change also helps with delivery and evaluation, so that lessons can be learned and extrapolated to other contexts.

The Behaviour Centred Design approach used by WaterAid divides the program development and execution process into five steps – ABCDE:

Assess: Determine what is known and unknown about current and desired behaviours and their determinants

Build: Fill in the knowledge gaps by collecting data (e.g. through **formative research** that explores what is unknown about the target behaviour and informs the creative process.)

Create: Design a hygiene promotion package, including the concepts, materials, activities which will have an impact on the program objective.

Deliver: Execute the intervention so that the target population are sufficiently exposed to the program's activities.

Evaluate: Determine whether the predicted environmental, psychological and behavioural changes occurred

This process can take considerable resources, many experts and a time-frame of a year or more. If your program is small or you don't have this time, it is still possible to follow each step in some form, as it is the logic of this process that produces results. In this module, we begin the process of

describing what activities should ideally be undertaken to develop an effective program or campaign.

What is done during the Assess Step?

The Assess step, as the first step in program development, should set out the scope of the program and identify what is known about the target behaviour(s). First, all existing information is collated concerning the determinants of behaviour, and second this information is developed and organized into a Theory of Change through a framing process. This provides the basis for the next step: Build, which addresses any remaining gaps in knowledge required by the Theory of Change.

1. Background review

The Assess team first determines what is known already by conducting a background review of the academic and 'grey' literatures (i.e. papers published in academic journals as well as NGO reports etc) as far as is possible. The types and levels of data that should be explored are outlined in the table below. At this stage it may be useful to look for data collected by other WaterAid country programmes or the Programme Support Unit. It may be possible to locate previous research in the country, or from elsewhere, to provide good insights into the determinants of behaviour.

Level of information	Relevance to your program
Global - level (academic journals or NGO reports)	• Understand the association between your target behaviour and the outcome • Understand what determines behaviour in other countries • Understand what has been implemented in other countries
National – level (National NGO reports, large surveys, government data and policy)	• Understand the availability of services/facilities (e.g. water, sanitation) • Understand the local health priorities • Understand what is being done nationally • Understand national goals/indicators associated with your target behaviour
Local – level (Small-scale research, NGO reports, local government data and policy)	• Understand the availability of services/facilities (e.g. water, sanitation) • Understand the local health priorities • Understand what is being done locally and where the gaps are • Understand national goals/indicators associated with your target behaviour • Understand what determines behaviour in the specific context where you are working.

Things to keep in mind when reviewing the literature

There are a few things to bear in mind when reviewing literature:

1) The evidence for any of these behaviours is always changing so if you are planning an intervention make sure to do a new review of the data.
2) Data can broadly be divided into two types: qualitative and quantitative. **Quantitative data** tries to quantify relationships between a behaviour of interest and an outcome (e.g. diarrhoeal disease). When we talk about 'evidence' we are normally referring to quantitative studies. However, relationships can be complex so quantitative studies can have a lot of methodological issues and often cannot specify why a particular effect has been observed. **Qualitative data** is useful for understanding the perspectives of your target population and exploring the 'why' behind quantitative data. A challenge with qualitative data is that it may be quite context-specific.
3) The absence of evidence is not mean that there is no association between the behaviour of interest and the outcome. It just means that either insufficient studies have been conducted

or that the studies which have been done have been done are of poor quality or are inconclusive.

2. Framing Process

In the second half of the Assess step, stakeholders work together to frame the overall task and to agree as to what is known and what is still to be found out. This is typically done through a framing workshop attended by the WaterAid Program Manager, the WaterAid Project Officer, key representatives from the local government and WaterAid's partners. During this workshop it is useful to ask the following questions:

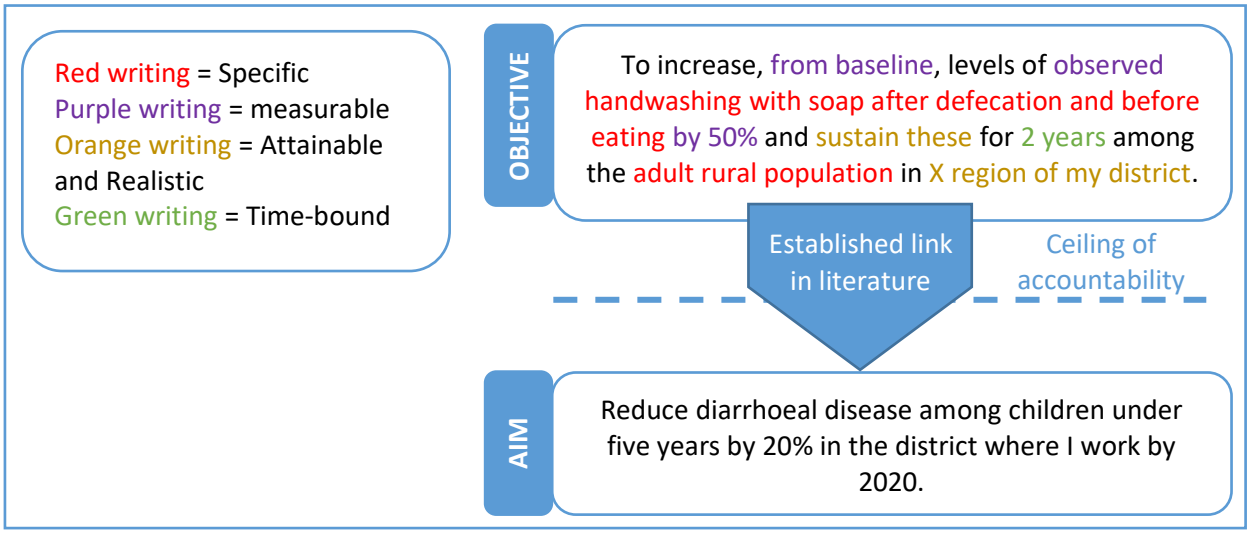
- What is the **Aim** of the program? (i.e. the state-of-the-world the program wants to change)?
- **Who** is in the target population?
- **What** precisely are the current and the target behaviours?
- **Why** is the behaviour performed (i.e. what psychological mechanisms cause it to be enacted)?
- **How** can the target individual's situation be influenced so that they might be induced to change their behaviour?

Now we describe some of the things to think about when discussing the answers to these questions.

Aim

The programme aim can be expressed as the desire to modify some substantial aspect of the world-at-large. Often the aim may be pre-determined by WaterAid or your funder. The aim is often associated with an impact that can only be achieved in the long term, and which may be beyond the program's 'ceiling of accountability'[1]. This means that the program cannot be held entirely responsible for delivering it because the program is not the sole cause of the changes to this phenomenon. Programs should also have an objective which should be considered as the 'reachable' indicator of program success. An objective should be '**SMART**': that is to say that it should be **S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**ime-bound. For many behaviour change interventions, the objective is to change behaviour. This is because health-related objectives are often harder and more expensive to measure. In many cases the link between performance of the behaviour and the larger health impact is already well-established in the literature, such that behaviour change should be a good indicator that the program goal will be achieved.

Figure 4: An example of an objective and an aim for a handwashing intervention



What? Identifying Target Behaviours

The next step is to define the behaviour to be changed. This is rarely a simple task. However, it is vital to define the precise behaviour that the program wishes to change. Behaviour means what people will *do*, not what they will *say* or *think* or *feel* or *know.* So the following statements would not be considered to be *behaviours* to be changed.

People can explain the key times at which hands should be washed with soap.

People feel that handwashing is the most important use of soap in the household.

Below are some examples of different handwashing behaviours that could address the aim stated above.

Make sure everyone uses soap during every handwashing occasion.

Make mothers wash hands with soap after cleaning their child.

Increase handwashing with soap before eating food.

Who? Identifying the Target Population

WaterAid's programs propose to change hygiene behaviours at the household level, the community, through institutions (e.g. schools, health care settings, public places), and at a policy level. So when designing programs it is tempting to say that our intervention should target everyone. However, the more clearly you can define the target group the easier it is to develop the program and achieve change. Hygiene behaviour change campaigns often target mothers. One rationale for this is that they are the primary carers for children under 5, who are most at risk of diarrhoeal disease. However, many other target groups are possible. For example, mothers-in-law or husbands often play important decision making roles within the household. School-children are often targeted by interventions too as they can be easily reached (within the school environment) and behaviours established at school can be a catalyst for behaviour change in the home environment. Some interventions identify secondary target audiences. These are people who are critical for influencing behaviour of the primary target population. Secondary target audiences may include teachers, health workers, social opinion leaders or other key influencers – on the primary targets.

Why? Hypothesizing what determines behaviour

At the Assess stage we want to map what is known about why our target audience act in the way they currently do and what psychological processes determine their behaviour. At this point in time it is likely that you will know very little about this (unless prior relevant **formative research** has been conducted). The BCD approach uses a table to help map what we know and do not know about current behaviour and the behaviour we would like people to adopt. Table 1 provides an example of what this table looks like by applying it to handwashing in an Indian setting. By mapping this systematically the Assess team should be able to develop a list of knowledge gaps, which can be translated into research questions to explore during the Build stage.

Table 1: Mapping what is known and unknown for a handwashing intervention in India. The green boxes indicate what is known, the yellow boxes indicate where some information is known by more information is needed and the red boxes indicate what is not known

		Current behaviour	Desired behaviour
State-of-the-World	Aim	High diarrhoea among children under 5 in India	Reduced diarrhoea rates
	Objective	Baseline levels of observed handwashing with soap after defecation and before eating are 2-4%.	To increase levels of observed handwashing with soap after defecation and before eating by 50% and sustain this for 2 years among the adult rural population in X region of my district.
Behaviour	Target behaviour	No soap used when handwashing	Soap always used when handwashing
	Who does it?	Almost no one	Adults and children
	When do they do it?	Almost never	At all 5 critical times but particularly after defecation and before eating.
	Where do they do it?	No designated place	Where cooking and defecation take place.
Environment	Physical	Low sanitation coverage so many people go to the fields to defecate – no set place where hands should be washed. A limited amount of water is stored in the house.	Handwashing is seen as a priority use of water and water and soap are stored near the kitchen and along the path where people go to defecate.
	Biological	Faeces is present in the environment. Kitchens are often not clean places.	Make it aspirational to be clean?
	Social	Mothers-in-law and husbands are important influencers of the behaviour of women and children. Role models don't use soap.	Mothers and husbands encourage mothers and children to wash hands. Role models use soap.
Brains	Executive	Everyone knows soap use can prevent diarrhoea but this is only practiced when hands are visibly dirty.	Even visibly clean hands can be dirty.
	Motivated	Not yet known	Not yet known
	Reactive	No HWWS habit	HWWS practiced without thinking
Body	Traits	Not yet known	Not yet known
	Physiology	Not yet known	Not yet known
	Senses	Smelly/sticky/visibly dirty hands	Make people more aware of hands being dirty even if they appear clean
Behaviour Setting	Stage	Not yet known	At a convenient place near the place where food is prepared/eaten and where people defecate.
	Roles	Women do most of the cooking and are responsible for cleaning children after defecation.	Not yet known
	Routine and script	Not yet known	Not yet known
	Norms	People around here don't always wash their hands with soap.	Everyone around here washes their hands with soap.
	Props and infrastructure	Soap available in households but not used for handwashing Water source hard to access and water available in the household is limited.	Soap prioritised for handwashing and kept at a handwashing place
Intervention	Touchpoints	Religious ceremonies, rickshaws, local shop vendors, community meetings, schools, health worker visits, water committee.	Not yet known
Context	Programmatic	Existing poverty reduction programs and Vaccination programs.	Not yet known
	Political	Hygiene competes with many other kinds of programs. Less donor funding for this	Not yet known
	Economic	Soap is perceived as expensive	Not yet known
	Social	Caste system influence on perceptions of 'dirty' behaviour	Not yet known

How? What does the intervention have to look like?

The Assess step must document any constraints or pre-determined qualities of the intervention. This may include how much money is available; how many people will receive the intervention (or whether it needs to be scalable in the future); how much time you can afford to spend with an individual or community during the intervention; who the intervention will be delivered by; and what kinds of materials or delivery channels might be used.

Develop a tentative theory of change

By the end of the Assess stage you should at least have sketched out the intervention aim, a specific behaviour and the target population. You should have some information on what drives current behaviour, a list of constraints and a list of questions to explore further. Together this information should allow you to develop a tentative theory of change for your intervention.