Integrating WASH/Hygiene interventions into immunization programmes: WaterAid’s Experiences

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Global WASH context

1 in 3 without basic sanitation (2.37 billion people)

1 in 10 without safe water (844 million people)

Household/Community

19% (13-49%) of people worldwide wash their hands with soap after defecation

Healthcare settings

40% wash their hands with soap after defecation

44% wash their hands with soap at all key moments

39% of health care workers wash their hands with soap at all key moments

School settings

16% wash their hands with soap after defecation

17% wash their hands with soap at all key moments

Only 53% of schools have handwashing facilities with soap
Why should we care about WASH/hygiene?

WASH Diseases

Water-Born Diseases
- cholera, typhoid, amoebic and bacillary dysentery

Water-Washed Diseases
- scabies, trachoma

Water-Based Diseases
- schistosomiasis, dracunculiasis

Water-Related Insect-Vector Diseases
- filariasis, malaria, onchocerciasis, trypanosomiasis

Causes of deaths among children under 5 years, 2019

Pneumonia
Diarrhoea
Undernutrition
Foodborne infection
Environmental Enteropathy
Typhoid

A child dies every 2 minutes from diarrhoeal diseases
An integrated solution: what does this mean in practice?

WHO recommends more holistic approach...

**Global push for adopting new diarrhoea vaccines but is it a ‘Silver bullet’?**

**Rotavirus vaccine efficacy in low income settings (at 43-47% while developed countries around 90%) and nature of diseases**

→ Training or education only using health, germs/diseases, death related poster, leaflets and messaging are not working
Hygiene integration through immunization: objectives

**Aim**: to demonstrate, with the view to nationwide scale-up, the promotion of safe hygiene practices through the routine immunization (vaccination) programme in four districts of Nepal

**Key points to establish through**:
- Is effective in changing behaviours?
- Benefits to immunisation programme?
- Is cost effective and feasible for scale-up?
- Enhances the capacity of FCHVs/HW?

<table>
<thead>
<tr>
<th>Districts</th>
<th>&lt;1yrs population</th>
<th>Health staffs</th>
<th>FCHVs</th>
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<tr>
<td>Jajarkot</td>
<td>4,217</td>
<td>216</td>
<td>270</td>
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<tr>
<td>Bardiya</td>
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<tr>
<td>Nawalparasi</td>
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<td>713</td>
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<tr>
<td>Myagdi</td>
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<td>256</td>
<td>369</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35,285</strong></td>
<td><strong>1,165</strong></td>
<td><strong>2,193</strong></td>
</tr>
</tbody>
</table>
Pathways for hygiene behaviour change integration–Nepal

**Behaviour Centred Design approach**

**A**
Assess – **Scoping Study** on MoH Needs and Capacities & agreements 2012

**B**
Build – **Formative research** to identify factors / enablers for behavior change 2014

**C**
Create – **New models package development** for promotion and sustainability 2015

**D**
Deliver – **Implementation** 2016

**E**
Evaluate **effectiveness** – Monitoring 2015-17

Prioritised hygiene behaviours:
- Exclusive breastfeeding
- Food Hygiene
- Handwashing with soap
- HHs Water and milk treatment
- Hygienic use of toilet; child faeces disposal
Hygiene integration into routine immunization: an example
Innovation and creativity in promotion tools / approaches

- **Campaign desire**: to be an “ideal family”
- Used **emotional drivers** (Disgust, Nurture, Affiliation & Status) and **change settings to change behaviour**
- **Delivery model**: Implemented through Gov’s routine immunization system
- **Components**: Games (Child life, wheel of hygiene, hot potato games), Story-telling, Folk song, pile sorting, Commitment, Illustration demonstration, Visual ‘reminders’, public ‘reward’ etc.
- **Implementation Period**: One year (pilot), 3 year retention
Is effective in changing behaviours and improving immunization?

All key hygiene behaviours improved – (primary outcomes)

Immunisation coverage increased and drop-out reduced (secondary outcomes)

Source: Baseline and Endline. Note: randomly selected mothers’ key hygiene behaviours were observed
Lessons:
• Immunisation: unique opportunity for WASH/hygiene integration
• Hygiene integration strengthen health system: improves behaviour, immunization coverage, reduce drop-out and vaccine wastage
• Additional cost per child: US$ 8 (in pilot), transition to scale (US$4) and scale-up US$1.75

Strength for success:
• Full government ownership (MoH). Government led process, WA as technical support to test innovation with planned transition for scale up
• Implemented through the sustained routine mechanism
• Focused to strengthen health system and change on behaviour using rather than raising awareness
• Used behaviour centric approaches and creative process to design and implement novel intervention
• Intervention has high level of reach / compliance and strong supervision

Strength, lessons and next step?

The Next Steps
At National Level: nationwide scale-up
Piloted: 4 districts
Scale-up: 77 districts (nationwide)

35,000 mothers

700,000 mothers / guardians

At global level
• Replicate same model at scale in other countries (opportunity for wider collaborations)
• Global vaccine policy advocacy?
Thank you