Ministry of Public Health

Islamic Republic of Afghanistan

NATIONAL HYGIENE PROMOTION STRATEGY

2017-2020

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Islamic Republic of Afghanistan
Ministry of Public Health
Afghanistan National Public Health Institute
Health Promotion Department

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Forward

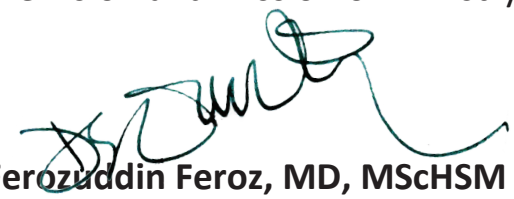
Poor sanitation and hygiene is a cross-cutting health concern throughout the developing world. Inadequate quantities and quality of drinking water, lack of sanitation facilities and poor hygiene cause millions of deaths each year globally. Nevertheless, access to safe drinking water, improved sanitation and good hygiene practices could save lives of many children, decline the dropout rate of children from schools, improve economic and social life of people and communities.

In order to envisage increasing the demand and adoption of hygiene and sanitation practices among people as well as to contribute to building a road map for improved health and well-being, Ministry of Public Health developed National Hygiene Promotion Strategy in consultation with relevant departments of line ministries, donors and development partners.

The strategy document is in line with National Health Policy and Strategy (2016-2020) as well as Citizen's Charter National Priority Program.

This strategy sets out communication approaches mainly advocacy, social mobilization and behaviour change communication that all could be used as a set of directions for hygiene and sanitation promotion at various levels.

The continued strengthening of health promotion and communication is central to the vision and mission of Ministry of Public Health.



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Acknowledgement

We wish to express our deepest gratitude to everyone, who has extended their support and cooperation in developing the national hygiene promotion strategy. The significance of having a strategy for promoting hygiene is widely acknowledged. Having such a strategy in place not only ensures healthy life for people, but also contributes towards overall development of nations.

We would like to express our thanks to all stakeholders who directly or indirectly contributed to the development of this strategy. Our special thanks to colleagues from relevant departments of the Ministry of Public Health and representatives from Ministry of Rural Rehabilitation and Development, Ministry of Education, Ministry of Hajj and Religious Affairs, Ministry of Women Affairs, and other Non-Governmental Organizations.

Finally, we are whole-heartedly thankful to Dr. Shafiqullah Hemat, Ms. Rania Elessawi, Dr. Nasratullah Rasa, Dr. Azizullah Safi and Dr. Sharifullah Alemi, for their untiring efforts in bringing this document to you.

We hope this strategy provides guidance and resources in the area of designing and planning hygiene and sanitation promotion interventions/programs.

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Contents

Acronyms/ Abbreviations

ALCS	Afghanistan Living Condition Survey
BCC	Behaviour Change Communication
CD	Community Dialogue
CDC	Community Development Council
CHWs	Community Health Workers
CSO	Civil Society Organization
FHAGs	Family Health Action Groups
IDPs	Internally Displaced Peoples
IEC	Information, Education, Communication
IPC	Interpersonal communication
HTWG	Hygiene Technical Working Group
JMP	Joint Monitoring Program
KAP	Knowledge, Attitude and Practice
MHM	Menstrual Hygiene Management
MoE	Ministry of Education
MoHE	Ministry of Higher Education
MoHRA	Ministry of Hajj and Religious Affairs
MoPH	Ministry of Public Health
MoWA	Ministry of Women's Affairs
MRRD	Ministry of Rural Rehabilitation and Development
NHPS	National Hygiene Promotion Strategy
NHS	National Health Strategy
NNS	National Nutrition Survey
NGOs	Non-Governmental Organizations
PRRD	Provincial Rural Rehabilitation and Development
SDG	Sustainable Development Goal
STWG	Sanitation Technical Working Group
TLM	Teacher and Learning Materials
UN	United Nations
UNICEF	United Nations Children Fund
VHPs	Village Health Promoters
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WTWG	Water Technical Working Group

Introduction

According to the World Health Organization (WHO) report[1], safe drinking water and sanitation coupled with personal and community hygiene can make a significant impact on the quality of life of many individuals across the globe and can reduce global disease burden by one tenth[2].Globally, around 2.4 million deaths (4.2% of all deaths) could be prevented annually if everyone practiced appropriate hygiene and had good, reliable sanitation and drinking water[3]. Besides, pneumonia and diarrhoea together kill 1.4 million children each year. These childhood deaths occur despite the fact that both illnesses are largely preventable through straightforward and cost effective solutions such as access to safe water, adequate sanitation and sufficient hygiene[4]. The significance of water, sanitation and hygiene and its critical role in determining the health status is well acknowledged in the Sustainable Development Goal (SDG).

The sixth SDG emphasizes on achieving universal and equitable access to safe and affordable drinking water, as well as to achieve access to adequate and equitable sanitation and hygiene, for all and end open defecation[5]. The strategy document emphasizes on increasing awareness and understanding of adverse health impacts of poor drinking water supplies, lack of adequate sanitation facilities, and poor hygiene. In line with this, the Afghanistan National Rural Water, Sanitation and Hygiene (WASH) Policy 2010 envisage to improve the water and sanitation condition in rural Afghanistan by ensuring access to safe drinking water and improved sanitation and promoting the adoption of hygiene practices at the personal, household and community levels. Apart from investing in infrastructural development, the policy also focuses on bringing sustainable behavior change through making hygiene promotion as an integral component of all water and sanitation programs and projects implemented by all the agencies in the country.

This strategy also contributes to National Health Strategy 2016-2020, specifically to sub-results 3.1, 3.3 and 3.7 under result 3 (*reduced preventable death, illness and disability through provision of cost effective, high impact evidence based public health interventions*)[6].

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[1] Joint Monitoring Program (JMP) report (UNICEF/WHO, 2012)

[2] Prüss-Üstün A, Bos R, Gore F, Bartram J. (2008) Safer water, better health: costs, benefits and sustainability of interventions to protect and promote health. Geneva: World Health Organization

[3] Ibid

[4] Ending Child Deaths from Pneumonia and Diarrhoea - UNICEF report 2016: One is Too Many

[5] Sustainable Development Goals: 17 Goals to Transform our World. United Nations

[6] National Health Strategy 2016-2020. Ministry of Public Health, Kabul, Afghanistan

Situation Analysis

2.1 Global Context

During the last two decades, remarkable improvements have been made worldwide in terms of improving the access to sanitation and safe drinking water. According to the Joint Monitoring Program (JMP) progress report (UNICEF/WHO, 2015), about 68% of the world's population has access to improved sanitation, and 91% of the global population uses improved drinking water source. In absolute number this means that since 1990 almost 2.1 billion people have gained access to an improved sanitation facility.[7] However, sustaining and ensuring these improvements is uniformly spread across countries is going to be a challenge due to continuous growing inequity between rich and poor, tightening of government and donor budgets, rising population and urbanization.

Despite the progress, there are still many people who even do not have access to sanitation facilities and improved drinking water source. About 663 million people still do not have access to an improved drinking water source, and 2.4 billion people are without access to improved sanitation facilities[8]. Thus, many people (particularly in developing regions) still are at risk of WASH-related diseases particularly diarrhoea. Therefore, waterborne diseases still remain a cause for concern in developing countries.

It is well acknowledged that much of the high incidence of WASH related diseases is due to the consumption of unsafe drinking water, lack of sanitation facilities, and poor hygiene practices. Diarrhoea is among them and is considered one of the top three killer diseases in developing countries, claiming together with pneumonia the lives of more than 1.4 million children a year. According to WHO and UNICEF, unsafe drinking water, inadequate availability of water for hygiene, and lack of access to sanitation together contribute to about 88% of deaths from diarrheal diseases[9]. The repercussion of unsafe water, poor sanitation and unsafe hygiene practices on children's education is also well known. Lack of proper and safe toilets in school premises is one reason for students' poor performance in education & school drop-out especially for girls. According to the United Nations and UNICEF, one in five girls of primary-school age are not in school, compared to one in six boys[10].

[7] Joint Monitoring Program (JMP) report (UNICEF/WHO, 2015)

[8] Ibid

[9] Prüss-Üstün A, Bos R, Gore F, Bartram J. (2008) Safer water, better health: costs, benefits and sustainability of interventions to protect and promote health. Geneva: World Health Organization

[10] The United Nations. Millennium Development Goals Report 2007.

The Sustainable Development Goals incorporated hygiene as an important element of the target for water sanitation and hygiene. It states that by 2030, countries must achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations. Population having access to handwashing facilities and soap will be measured as a proxy indicator for hygiene. Moreover, the term "Safely Managed Sanitation" in SDG monitoring also stresses the importance of hygiene behaviour change.

2.2 Country Context

Afghanistan has made significant progress on drinking water and sanitation; however, there is still a long way to go. According to Afghanistan Living Condition Survey (ALCS) 2014 around 65% of population use their drinking water from an improved source, and about 39% of people use improved sanitation facility[11]. Moreover, 19% of people in the country still practice open defecation and do not use any type of sanitation facility at all[12]. Although people still use water from rivers, streams and ponds for drinking which are not safe sources of water to communalities[13].

Despite the fact that about 85% of people in Afghanistan use some type of latrine, but majority of them do not fall under the classification of improved sanitation facility. Furthermore, faeces is handled in unhygienic way while used as agricultural manure. Besides, there is no data on hand-washing with soap for age-sex categories at national level, National Nutrition Survey reported that '89.7% women wash hands with soap after defecation ranging from 28.5% in Nuristan to 99.4% in Saripul province, likewise 90% before preparing the meals with provincial variation ranging from 60.0% in Balkh to 99.2% in Takhar province'. However, from observation by

UNICEF and IRC. Water Sanitation and Hygiene Education for Schools: Roundtable Proceedings and Framework for Action.

[11] Central Statistics Organization (2016), *Afghanistan Living Conditions Survey 2013-14. National Risk and Vulnerability Assessment*. Kabul, CSO. (*ALCS defines 'improved drinking water source as, a source that is protected from outside contamination, such as a hand pump (private or public), bored wells, protected spring and piped water (private or municipal). Un-improved sources include surface water (open well, unprotected spring, kariz, river, lake, channel, pool and drainage) and water tanker. An improved sanitation facility is defined as one that hygienically separates human excreta from human contact. Improved types of sanitation facilities are flush latrine, improved latrine and covered latrine. Un-improved sanitation includes no facility, open pit, dump, and open defecation'*)

[12] ibid

[13] United Nations Children's Fund (UNICEF), Water Sanitation and Hygiene (WASH) vulnerability in Afghanistan, draft final document .2012, Kabul

survey team it was found that merely 45.1% households had soap available at handwashing place[14].

Safe disposal of adults and child's faeces is an area of concern and needs to be taken into consideration while taking steps in hygiene promotion. Unsafe disposal of animal dung is another problem, people throw animal dung into an open space; and in rural areas they use the animal dung for agricultural purposes. Although, information on proper waste disposal exists, still people dispose the waste in public areas which pose too many public health hazards.

In Afghanistan, inadequate infant feeding and caring practices, a limited food supply and access to safe water, combined with poor sanitation conditions and hygiene practices that result in a high prevalence of diarrheal diseases and gastrointestinal parasitic worm infestation, are direct causes of the heavy public health burden of malnutrition. The finding of national nutrition survey 2013[15] revealed that malnutrition rates among children 0–59 months of age at national level were as follows: chronic malnutrition (stunting) 40.9%, acute malnutrition (wasting) 9.5% and proportion of children underweight was 25.0%.

Inadequate water, sanitation, and hygiene results not only in diseases and death, but also in higher health costs, lower worker productivity and lower school student attendance. Children have limited access to basic facilities such as school toilets, safe drinking water and basic information on hygiene. Risky behaviours and practices are essential factors in transmission of water and sanitation-related diseases such as diarrhoea, parasitic worm infections, skin and eye diseases, which can be easily improved through hygiene practices among children at school.

All children need a sanitary and hygienic learning environment, and lack of sanitation and hygiene facilities in schools has a stronger negative impact on school child particularly girls than on boys. Based on an assessment conducted in 2011 by the Ministry of Education (MoE) in 97 schools, it has been found that many schools have poor hygiene conditions and/or do not have proper water, sanitation and handwashing facilities. Findings indicate that, traditional toilets were in use in around 75% of schools. Similarly, it found in this assessment that out of 97 schools, only 19 had the hand-washing facilities (19.59%). Only 4.7% of the schools had

[14] MoPH (2013) *National Nutrition Survey (NNS), Afghanistan*
[15] MoPH (2013) *National Nutrition Survey (NNS), Afghanistan*

water container with tap, and soaps were available only in four schools for hand-washing purposes[16].

Although menstruation is a natural process but it is linked with several challenges. A small scale KAP study on MHM[17] reveals that girls' challenges with managing menstruation were related to stress, overcoming shame & fear, managing daily school activities in spite of physical discomforts, limited practical and correct guidance, access, management and disposal of sanitary waste'. This greatly impact adolescent girls' health and education, resulting in including, stress, absenteeism, lack of concentration poor performance.

Food hygiene practices of the families are similarly lacking or unsatisfactory on different aspects. Therefore, microorganisms can be transmitted during food processing from any raw agricultural product or from infected humans handling the food.

2.3 Sector Analysis

To foster synergies, enhance collaboration and avoid duplication in the WASH sector, there is a need to establish an effective coordination mechanism among WASH stakeholders. There are already some efforts made to enhance coordination among the stakeholders under technical forums including Water Technical Working Group (WTWG), Hygiene Technical Working Group (HTWG), and Sanitation Technical Working Group (STWG) have been established by the sector ministries. In addition to improving coordination these groups provide technical guidance, share knowledge and experiences for hygiene and sanitation initiatives, and develop national standards, manuals, guidelines, and communication materials for effective implementation of hygiene and sanitation programs at various levels.

The MoPH serves as the normative body for water quality standards and leads and advises on the hygiene behavioral change content and approaches nationally. The MoPH also maintains a network of community health volunteers who are engaged in hygiene behavioral change interventions at village level. The MoPH is also

[16] Organization for Development and Welfare, 'Report of the School Handwash and Toilet Survey: Afghanistan', 2011

[17] Formative Research on Menstrual Hygiene Management in Afghanistan Knowledge, Perceptions, and Experiences of Adolescent Girls (2016). UNICEF, Kabul, Afghanistan

responsible for maintaining adequate hygiene standards and the provision of WASH services in health centers.

2.4 Audience Analysis

To ensure that the national hygiene promotion strategy is effectively implemented, an understanding of targeted audiences is very essential. The audience analysis is important to design effective and innovative messages, as well as identify the proper communication channels. Based on the literature reviews and in-depth interviews as part of the formative research[18] conducted for the purpose of development of the strategy, the target audience/s are categorized as follows;

a) Primary audiences
b) Secondary audiences
c) Tertiary audiences

a) **Primary audiences** are people whose behaviours are the main indicators of program success. The primary audiences mainly include children, parents, caregivers, and community members.

b) **Secondary audiences** are those people whose behaviours or actions strongly influence the primary audiences' behaviour. They come from the cultural and social environment of the primary participants and could be at family, community, health service delivery, or program level such as fathers, mother-in laws, teachers, religious scholars/ Mullah, neighbours, community leaders, and school authorities like teachers, school management team members, etc.

c) **Tertiary audiences** are those people who create, advocate and support the requisite enabling environment to support the uptake of activities and behaviours. Here they are policy makers, development partners, and government officials specifically from Ministry of Public Health (MoPH), Ministry of Education (MoE), Ministry of Higher Education (MoHE), Ministry of Rural Rehabilitation and Development (MRRD), Ministry of Hajj and Religious Affairs (MoHRA), donors, I/NGOs and district authorities.

[18] The behaviours discussed under this section have come out largely from the findings of KAP study conducted in 2013 by MoPH and supported by UNICEF. (Ref: Afghanistan Centre for Training and Development (2013) Knowledge, Attitude, Practice Study on Hygiene Practices – Baseline Report. Afghanistan.

2.5 Behavioral Analysis

Current and desired behaviors related to WASH[19]

For the essence of simplicity, the current behaviours, desired behaviours, and key messages of water, sanitation and hygiene are summarized in the following table;

Area	Current Behaviors	Desired Behaviors	Key Messages
Drinking Water	▪ Water is collected from unprotected and open sources like open well, streams, springs, rivers, dams, and canals by some households ▪ Drinking water is not stored safely by some households ▪ Drinking water is rarely treated e.g. boiled before consumption	▪ Collecting drinking water from safe sources such as piped water, hand pump, protected dug well, protected spring and protected karez. ▪ Storing drinking water in clean and covered containers ▪ Keeping the drinking water containers clean ▪ Not storing drinking water in metallic containers (that are prone to rust), and in containers which had insecticides or chemicals ▪ Transporting/ carrying drinking water in clean and covered containers ▪ Taking drinking water with clean cups/utensils from containers ▪ Treating unsafe drinking water using methods such as boiling, chlorination, filtration, and exposure to sunlight.	▪ Consuming water from unsafe sources such as river, stream, unprotected well, pond, karez, pools and still water increase incidence of diseases related to WASH ▪ Store drinking water in clean and covered containers—if possible in separate containers with a nozzle or tap or empty plastic containers with a cover ▪ Do not store drinking water in metallic containers (which are prone to rust) and containers used for insecticides or chemicals ▪ Containers used for storing water should be washed thoroughly on a regular basis with soap and water (before refilling) ▪ Use clean cups/utensils/ladles to obtain water from containers ▪ Treat unsafe drinking water through boiling, chlorination, filtering, and exposing to sunlight.

[19] The behaviours discussed under this section have come out largely from the findings of KAP study conducted in 2013 by MoPH and supported by UNICEF. (Ref: Afghanistan Centre for Training and Development (2013) *Knowledge, Attitude, Practice Study on Hygiene Practices – Baseline Report*. Afghanistan.

Area	Current Behaviors	Desired Behaviors	Key Messages
Sanitation	▪ Open defecation is practiced mainly by some men and children (men defecate in open field and in public places while they are away for work while children defecate in yard or nearby house surroundings). ▪ Defecation is practiced by some students in the open areas rather than school latrines ▪ Children's faeces are rarely properly disposed.	▪ Constructing/ improving latrines ▪ Using latrine for defecation ▪ Not defecating in the open ▪ Keeping latrines clean and functional ▪ Dispose child faeces properly	▪ Build the toilet around 20-25 meters away from the water point in order to keep the water sources uncontaminated. ▪ Everyone in the household should use latrine facilities available in the home ▪ Dispose human faeces properly to avoid contamination of water sources ▪ Avoid open defecation as it poses health risks to you and other people ▪ Remove and dispose garbage safely ▪ Surrounding area/yard of home should be kept clean

Area	Current Behaviors	Desired Behaviors	Key Messages
Hygiene	▪ Handwashing with soap is rarely practiced at critical times ▪ Mothers/ caregivers rarely wash their hands with soap after cleaning bottom of babies ▪ Taking regular bath is rarely practiced ▪ Post-delivery women do not take bath for a long period ▪ Family members usually share cloths/towels to dry hands after handwashing	▪ Washing hands with soap at critical times (before eating and after use of toilet) ▪ Washing hands with water and soap at other important times such as after eating; before and after preparing/handling food; before breastfeeding/nursing newborns or babies; after cleaning bottom of babies; before and after changing sanitary napkins or pads). ▪ Brushing teeth regularly ▪ Taking bath regularly ▪ Trimming nails short and keeping them clean ▪ Wearing shoes and avoiding walking bare feet.	▪ Wash your hands with soap at critical times (before eating and after use of toilet) ▪ Wash your hands with soap and water before and after preparing/handling food; before breastfeeding/nursing babies; after cleaning excreta of babies; before and after changing sanitary napkins or pads) ▪ Always wash hands with water and soap before and after touching patient, delivering a baby, dressing a wound ▪ Ask visitors and patients to wash hands with water and soap at critical times. ▪ Regularly take bath in order to stay clean and get rid of body odor. ▪ Clip your nails and keep them clean to prevent infections under nail bed. ▪ Brush and floss your teeth daily, at least twice (after breakfast and right before bed at night) to maintain good oral hygiene ▪ Wear shoes or slippers while waking outside ▪ Keep school WASH facilities such as water supply system and handwashing station clean and functional ▪ Keep WASH facilities of health centers such as water supply system and handwashing station clean and functional.

Area	Current Behaviors	Desired Behaviors	Key Messages
Food Hygiene	▪ Women rarely wash their hands with soap before cooking and preparing food ▪ Cooked food is left uncovered	▪ Washing hands thoroughly with soap before, during and after meal preparation ▪ Protecting food from flies and other insects by keeping it covered or in boxes or cabinets with wire screens. ▪ Washing fruits and vegetables properly before usage; ▪ Washing all cutting boards and utensils with hot water and soap after preparing each food item and before moving on to the next food item. ▪ Preventing cross-contamination by keeping raw meat, poultry, and eggs separate from ready-to-eat foods. ▪ Heating leftover food well before eating to ensure it is clean and safe. ▪ Refrigerating food promptly to slow the growth of bacteria and prevent food poisoning. ▪ Cooking food in the recommended safe minimum internal temperature to destroy any potentially harmful bacteria ▪ Putting vegetable and fruit in chlorinated water for 30 minutes and then washing it before consumption.	▪ Washing hands thoroughly with soap before, during and after meal preparation ▪ Protecting food from flies and other insects by keeping it covered or in boxes or cabinets with wire screens. ▪ Washing fruits and vegetables properly before usage; ▪ Washing all cutting boards and utensils with hot water and soap after preparing each food item and before moving on to the next food item. ▪ Storing fresh food in clean container and at cool place which is protected against flies, mice, rates and other insects and animals.

Area	Current Behaviors	Desired Behaviors	Key Messages
Menstrual hygiene	▪ Dirty cloth/ towels are used during menstruation. ▪ Used cloth/ towels are burnt with other wastes. ▪ Women/ girls rarely take bath during their menstrual period; usually they take bath on the last day of menstruation.	▪ Changing pads, napkins, or clean towel/ cloth every few hours to prevent infections, and bad odor during menstruation. ▪ Washing reused sanitary cloth with soap and water, or drying and exposing them to the sunlight during menstruation. ▪ Using cotton-based napkins/ cloth and pads during menstruation, as polyester and nylon cloths are not good absorbents. ▪ Wrapping-up and disposing the used sanitary towels or napkins in a waste bin. ▪ Regular washing and bathing during menstruation	▪ Menstruation is a normal and physiological process (it is not an unclean or shameful process) ▪ Changing pads and napkins every few hours can help prevent infections, and bad odor. ▪ Regular washing and bathing during menstruation maintains hygiene and health. ▪ Sanitary cloths that are reused should be washed with soap and water, dried and exposed to the sunlight so they are hygienic ▪ Used sanitary towels or napkins should be wrapped up and disposed of in a waste bin.

2.6 Communication Channel Analysis

2.6.1 Existing communication channels

The matrix below describes existing communication channel for promotion of hygiene and sanitation at various levels and settings;

Channel	Engagement with stakeholders	Message reach (including opportunities/equity	Message complexity	Resources
Interpersonal Communication (e.g. community dialogue, mobilisation sessions…)	▪ Excellent for interactive discussions, assuming individuals have good interpersonal skills and received adequate information about the issues to discuss	▪ Can reach all 38,000 villages, mostly through discussions with small groups	▪ Convey simple or complex messages depending on amount of time, credibility of the source	▪ Cost of facilitators' training, time, transportation, materials, remuneration, and supportive supervision can be high depending on the number of individuals or groups reached
Institution-based communication (Schools, Health Centers etc.)	▪ A good platform to communicate messages through opinion leaders such as physicians and teachers	▪ Can reach the catchment population of over 2,000 health centers and student of more than 16,000 schools	▪ Can convey simple messages to students and community members	▪ Relatively low cost as infrastructure and human resource already available
Masjids/ Hussainia	▪ One-way messaging; little room for two-way dialogue ▪ Very effective way to convey messages	▪ Wide coverage throughout the country	▪ Combination. Can start with simple information then move into more complex issues.	▪ Set-up costs may be high, but if part of an ongoing partnership with mullahs, maintenance costs will decline

Channel	Engagement with stakeholders	Message reach (including opportunities/equity	Message complexity	Resources
Folk Media (Theatre, Poetry, Traditional Dance or Attan)	▪ Engage viewers in discussions after the performance ▪ Elicit immediate audience inputs and feedback ▪ Enjoyable for adults & children	▪ Good for audiences in local venues ▪ Reach nomads & mobile groups, IDPs	▪ Messages conveyed in local languages/dialects, mostly simple messages but can be complicated too	▪ Costs of contracting theatre groups, capacity building (for discussions), travel ▪ Takes time to develop scripts, establish enough partnerships with NGOs/CSOs
Mobile vans with loudspeakers & painted with messages	▪ One-way messaging; little room for two-way dialogue	▪ Can be effective in dense urban areas for one-off campaign "spurts" ▪ In rural areas, can be used if combined with theatre or other dialogic channels	▪ Usually simple messaging only, as in announcements of school enrolment or vaccination sessions	▪ Vans are expensive to procure, set up, and maintain on an ongoing basis
Transit media (Buses, trucks and vans and transit stations)	▪ One-way messaging; ▪ Good for reinforcement of previously given messages	▪ May reach mostly male adults so would be selected after careful analysis or for specific messages	▪ Usually simple messages only	▪ Moderate costs for printing and painting
Television (national, local and international	▪ One-way and can be two-way messaging (e.g. live shows); ▪ Can elicit feedback through	▪ Can reach large number of people simultaneously ▪ May be biased toward urban areas or for people	▪ Simple messages can be delivered via public service announcements	▪ Generally high production cost ▪ Cost of broadcasting is higher than radio

Channel	Engagement with stakeholders	Message reach (including opportunities/equity	Message complexity	Resources
with viewership in Afghanistan)	viewer groups that mail, e-mail, text message or phone in comments ▪ Can influence opinions but without much engagement ▪ Gender equity, rights, and ethnic groups can be visually represented to break stereotypes and include all participant groups	with limited resources ▪ Is dependent on electricity supply and reception ▪ Reach differs for government, private terrestrial, satellite and cable channels	▪ More complex messages can be delivered via entertainment-education programmes, talk-shows, soap opera…	
Radio (National, local and international with listenership in Afghanistan	▪ One-way and can be two-way messaging (e.g. live radio shows) ▪ Phone-in or text message to talk shows, debates ▪ Listening groups for discussion after a program ▪ Listener groups that mail, e-mail, text message or phone in comments	▪ Can reach large number of people simultaneously depending on tower reach; ▪ Can be tailored for local populations with local content and language ▪ Good for mobile, low-literate, remote and/or housebound groups	▪ Simple information can be conveyed ▪ More complex messages can be delivered through talk shows, dramas ▪ Community radio can enter into more detail	▪ Lower production and broadcasting cost compared to television
Information videos and public service announcements on public screens	▪ Screens in public can be followed by discussion sessions	▪ Can reach multiple large or small audiences ▪ Can reach audience members in public or at home	▪ Can convey simple and complex messages	▪ Initial cost can be high ▪ Airing and displaying cost is moderately high.

Channel	Engagement with stakeholders	Message reach (including opportunities/equity	Message complexity	Resources
Newspapers and magazines (print and web-based)	▪ Readers can react to articles through opinion letters ▪ Newspaper can elicit feedback to online versions through e-mail or text messages ▪ Can be used in schools, shura discussion sessions, Community Development Council meetings	▪ Can reach large numbers of readers ▪ One paper copy of a newspaper can be read by multiple individuals ▪ Soft copies can also be disseminated through emails, websites, and social media	▪ Can convey simple and complex messages (often supported by photos, cartoons, graphic illustrations) ▪ Suited to in-depth explanations	▪ Cost of production/printing can be reasonable ▪ Cost of placing advertisements can be high
Posters	▪ Good for reinforcement of discussion groups, information passed by health workers. ▪ Can help start discussions by community health workers, mullahs, facilitators	▪ Can reach large number of people depending on distribution and placement	▪ Best for short, specific awareness-raising and action-oriented messages	▪ Cost of printing and distribution can be reasonable
Banners, Billboards, Wall Paintings	▪ Good for reinforcement ▪ Can help start discussions by community health workers, mullahs, facilitators	▪ Can reach large number of people depending on placement	▪ Best for short, specific awareness-raising and action-oriented messages	▪ Cost of production depends on size and complexity ▪ Cost of placement varies by setting

Channel	Engagement with stakeholders	Message reach (including opportunities/equity	Message complexity	Resources
Leaflets/Flyers/ Brochures	▪ Can help start discussions by community health workers, mullahs, facilitators ▪ Can be used as information tools	▪ Can reach many people depending on distribution ▪ One leaflet/ flyer/ brochure can be read by multiple individuals	▪ Can convey simple or complex messages (including photos, cartoons, graphic illustrations)	▪ Cost of production is usually low ▪ Cost of distribution varies by setting
Text Messaging (SMS) and IVR (Interactive Voice Response)	▪ Can elicit immediate text ad voice message responses	▪ Can reach large number of individuals simultaneously depending on network coverage and access	▪ Suited to conveying short, simple messages	▪ Cost depends on local rates for mobile messaging
Internet/Social Media (e.g., Facebook, Twitter, LinkedIn)	▪ Can be highly interactive	▪ Can reach many people simultaneously depending on network coverage and access	▪ Can convey simple or complex messages using text, visuals, graphics, embedded video	▪ Promotion cost is mainly reasonable depending on duration and reach
TLM – Teacher and Learning Materials	▪ Good for two-way messaging and advocacy ▪ Can be used by teachers during classroom discussions	▪ Reaches students enrolled in school	▪ Suited for short, simple messages	▪ Can be high if undertaken at provincial or national level
Adapted from JHU/CCP and from Shefner-Rogers for UNICEF (March 2013)				

2.6.2 Proposed communication channels to reach the target audience/s

This strategy envisages having different combination of communication channels for the three types of audiences, namely, primary, secondary and tertiary audiences according to the context. It is recommended to use mix of communication channels to promote the health/ hygiene behaviours, as one channel may not be suitable for all contexts.

Audience	Specific Category	Proposed Communication Channels
Primary	Children	▪ Classroom activities, demonstration, health education sessions, health related knowledge competitions between two schools or between classes of same school, printing messages on educational materials like notebook, pen, school bags, role play, dramas, etc. ▪ Targeted sermons in mosques (Friday prayers) ▪ Local media (TV channels, community radio, local papers, etc.) ▪ Cloth charts, posters, fliers, leaflets ▪ Sports events such as football or cricket matches
	Parents/ Caregivers	▪ Interpersonal communication ▪ IEC materials (print, audio, and video)
	Family Members	▪ Interpersonal communication ▪ Targeted sermons in mosques (Friday prayers) ▪ Local media (TV channels, community radio, local papers, etc.) ▪ Social media networks (Facebook) ▪ Cloth charts, posters, fliers, leaflets, etc. ▪ Local folk media
	Community	▪ Interpersonal communication (community dialogue, community-led total sanitation, house to house visits, appreciative inquiry, trainings, etc.) ▪ Mass media (electronic media: radio, television; newspaper, magazines and posters in public places) ▪ Targeted sermons in mosques (Friday prayers) ▪ Local media (community radio, local papers, etc.) ▪ Hygiene campaigns, bill boards, etc. ▪ Local folk media

Secondary	Fathers	▪ Interpersonal communication ▪ Targeted sermons in mosques (Friday prayers) ▪ Local media (community radio, local papers, etc.) ▪ Outdoor media like cloth charts, posters, fliers, leaflets, hygiene campaigns, bill boards, etc. ▪ Local folk media
	Mother-In Laws	▪ Interpersonal communication ▪ Local media (community radio.)
	Neighbours	▪ Targeted sermons in mosques (Friday prayers) ▪ Local media (TV, community radio, local papers, etc.) ▪ Outdoor media like cloth charts, posters, fliers, leaflets, hygiene campaigns, bill boards, etc. ▪ Local folk media
	Teachers School authorities	▪ Workshops ▪ Visits to model schools or villages ▪ Mass media
	Religious scholars/ Mullahs	▪ Workshops ▪ Visits to model schools or villages ▪ Mass media
	Community leaders	▪ Interpersonal communication (community dialogue, community-led total sanitation, house to house visits, appreciative inquiry, trainings, etc.) ▪ Mass media (electronic media: radio, television; newspaper, magazines and posters in public places) ▪ Targeted sermons in mosques (Friday prayers) ▪ Local media (community radio, local papers, etc.) ▪ Hygiene campaigns, billboards, etc. ▪ Local folk media

Tertiary	Policy Makers, Development Partners Government Officials Specifically from MoPH, MoE, MoHE, MRRD, MoHRA Donors, I/NGOs, and District authorities	▪ Advocacy meetings; ▪ Conferences, Technical Workshops ▪ Sharing of successful case studies

Vision, Goal, and Objectives of the National Hygiene Promotion Strategy

3.1. Vision

Afghanistan free of diseases related to Water, Sanitation and Hygiene

3.2. Goal

To reduce morbidity and mortality through increased demand for safe drinking water, improved sanitation and adoption of better hygiene practices at households, communities and institutions with a special focus on women and children.

3.3 Objectives

- Policy Makers and key stakeholders support hygiene and sanitation interventions at various levels
- Communities are mobilized to adopt improved hygiene and sanitary behaviours and to declare communities Open Defecation Free
- Students, teachers, health care providers and other community members adopt improved hygiene and sanitary behaviours and influence others' behaviour

4. Communication Strategies

The strategy is centred onto the following three approaches. However, it is not necessary that all the three approaches need to be followed in sequential order. Many activities of these approaches may overlap each other but aims to achieve same vision and goal.

4.1 Strategic Approach I: Advocacy with decision makers and key stakeholders

Advocacy requires continuous efforts to develop evidence-based initiatives and lobby with policy makers, influencers and key stakeholders to speak up and to take action for promoting new policies, change existing laws, policies or rules; redefining public perceptions, social norms and procedures; and influencing funding decisions for specific hygiene and sanitation promotion interventions. Moreover, to encourage partnership with private sectors and commitment for creating an enabling environment.

Approach-I of the national hygiene promotion strategy will focus on advocacy for hygiene and sanitation promotion interventions at various level including MoPH, MRRD, MoE, MoHRA, donors and development partners. The advocacy approach will also target non-government organizations and other gross root level institutions. It will also ensure that enabling environment is created for promoting hygiene and sanitation behaviours and practices at community and institutions.

4.2 Strategic Approach II: Social Mobilization

Social mobilization as a process engage a wide range of traditional, community, civil society and opinion leaders around a common cause or issue to bring positive changes in socio-cultural norms. Social mobilization enlists the participation of institutions, community networks and social and religious groups to use their membership and other resources to strengthen participation in activities at the grass-roots level, and to take action and/or support change a common cause (e.g. hygiene and sanitation promotion, eliminating open defecation).

Examples of groups that may get involved in social mobilization include school teachers and students, school management teams, religious scholars/ Mullahs, influential leaders, health service providers, community development councils, family health action groups, civil society organizations, professional associations, and youth associations.

4.3 Strategic Approach III: Behaviour change communication for adoption of healthy behaviours and practices

Behaviour change enables groups of individuals to engage in participatory processes to define their needs and demand their rights. Addressing individual behaviours, which are shaped by social, cultural, economic and political contexts, requires interactive approaches and a mix communication channels in order to encourage and sustain positive and appropriate behaviours.

5. Implementation Plan

The National Hygiene Promotion Strategy will be implemented through learning by doing which will give time for adaptation or dropping of an intervention in favour of more efficient and effective alternatives. It is recommended to involve communities and frontline personnel to allow generation of a wider range of experiences and lessons learnt, and identify priority areas to strengthen evidence based response.

Ministry of Public Health will have a stewardship role in implementing this strategy. The national level coordination of NHPS will be achieved through the Hygiene Technical Working Group (HTWG) which will comprise of all key stakeholders including health, rural and urban development, education, development partners, NGOs, etc. The Heath Promotion Department of MoPH will lead the HTWG.

At provincial and district levels, the hygiene/ health promotion officer will coordinate the hygiene and sanitation promotion interventions through existing capacities and mechanisms including support of key influential in the community for instance religious scholars, school teachers, natural leaders, community health workers, etc. It is recommended to establish sub-committee at provincial level with representatives from sector provincial departments and I/NGOs, provincial shuras, civil society, etc. to coordinate and support hygiene and sanitation interventions.

5.1 Implementation Framework

The following matrix explains the strategic components of hygiene promotion for each communication objective covered in this strategy.

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
Objective 1 Increase commitment of national, local, and community leadership to improve coordination and collaboration	Policy makers/ officials of sectorial ministries, provincial and district officials, development partners and I/NGOs, donors, religious scholars/ Imams, school administration, school Management shuras, healthcare facility manager representatives	▪ Advocacy meetings ▪ Regular meetings and information sharing sessions ▪ Orientation/ sensitization sessions ▪ Developing advocacy packages ▪ Field visits ▪ Workshop, Conference and Seminar	▪ Advocacy meetings (occasionally) ▪ Strategic and technical working groups on WASH ▪ District shura meetings are conducted in few districts ▪ Insufficient advocacy, orientation/ sensitization materials ▪ Workshops, conferences, orientation sessions and seminars (occasionally)	▪ Formation of steering committee on WASH at national level ▪ Development of evidence based user-friendly advocacy, orientation/ sensitization materials ▪ Regular advocacy meetings, workshops, conferences and seminars ▪ Celebrate national/international awareness raising/ advocacy days relevant to WASH, e.g.	▪ Synergy, and effectiveness enhanced and duplication avoided ▪ Partnership with private sectors, and media improved

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
	of CDC/shuras, representatives of media, private sectors, civil society			handwashing day, toilet day	
Objective 2 Include hygiene and sanitation promotion in school curriculum	Policy makers including MPs, and officials of MoPH, MoE, MoHE, and MoHRA; development partners and I/NGOs; donors; and representatives of media, civil society	▪ Advocacy meetings ▪ Regular meetings with MoE officials including school curriculum development unit(s) and donors	▪ Advocacy meetings (occasionally) ▪ WASH in schools technical working group exists ▪ Insufficient advocacy, orientation/ sensitization materials ▪ Memorandum of Understanding (MoU) exists between MoE and MoPH ▪ WASH topics are not well-reflected in the school curricula	▪ Regular advocacy meetings, workshops, conferences and seminars ▪ Development of evidence based user-friendly advocacy, orientation/ sensitization materials	▪ Students knowledge increased on hygiene and sanitation promotion ▪ Students practice hygiene and sanitary behaviours

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
Objective 3 Improve knowledge and practice of consuming safe drinking water, and its storage	children, parents, caregivers, and community members	▪ Awareness activities through plays, street theatres, dramas, hygiene education sessions, demonstration, and distribution of promotional materials containing hygiene messages on safe drinking water ▪ Awareness activities through - Print media (local newspaper, leaflets /brochures, guidelines, outdoor media including billboard, hoardings, signboard) - Electronic Media (TV & Radio PSAs and roundtables, - Social media (Facebook, twitter) ▪ Interpersonal Communication (Orientation/	▪ Awareness activities are limited to few districts, mainly through support of donors ▪ Awareness campaigns are limited mainly event based (e.g. celebrating world water day) ▪ Mobile text and voice messages do not exist ▪ IEC and orientation materials exist (insufficient) ▪ Health Promotion Department Facebook page and website exist ▪ Family health action groups are	▪ Awareness activities, media campaigns and interpersonal communication on promotion of consuming safe drinking water, and storing drinking water safely ▪ Development of user-friendly orientation/ sensitization materials ▪ Conduct regular training workshops ▪ Partnership with communication companies ▪ Celebrate national/internation al awareness raising/ advocacy days relevant to WASH, e.g. world	▪ Improved practice of consuming safe drinking water ▪ Improved practice of transporting, and storing drinking water safely. ▪ Improved practice of treating unsafe drinking water

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		sensitization sessions and training workshop, group meetings, house to house visits, community dialogue) ▪ Formation of health action groups at family and community levels ▪ Religious sermons, e.g. Friday prayers ▪ Mobile text and voice messages ▪ Exposure visits	established, but are not active in all villages	water day ▪ Develop digital communication strategy to support campaigns	
Objective 4 Improve knowledge and practice of using sanitary latrine, eliminating open defecation and safe disposal of child faeces	Children, parents/ caregivers, family members, community members	▪ Awareness activities through plays, dramas, and distribution of promotional materials containing sanitation promotion messages ▪ Awareness activities through - Print media (local newspaper, leaflets /brochures, guidelines, outdoor media including billboard,	▪ Awareness activities are limited to few districts, mainly through support of donors ▪ Awareness campaigns are limited mainly event based (e.g. celebrating global toilet day) ▪ Mobile text and	▪ Awareness activities, media campaigns and interpersonal communication on sanitation promotion should be implemented as a national program on a routine basis ▪ Development of user-friendly orientation/	▪ Improved usage of sanitary latrines ▪ Increased practice of safe disposal of child faeces ▪ Increased number of open defecation

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		hoardings, signboard) - Electronic Media (TV & Radio PSAs and roundtables, soap operas - Social media (Facebook, twitter) ▪ Interpersonal communication (orientation/ sensitization sessions and training workshop, group meetings, house to house visits, community dialogue) ▪ Formation/ revitalization of FHAGs ▪ Mobile text and voice messages ▪ Exposure visits	voice messages do not exist ▪ IEC and orientation materials exist (insufficient) ▪ Health Promotion Department Facebook page and website exist ▪ Family health action groups are established, but are not active in all villages	sensitization materials ▪ Conduct regular training workshops ▪ Partnership with mobile service providers ▪ Celebrate national/international awareness raising/ advocacy days relevant to WASH, e.g. world toilet day ▪ Develop digital communication strategy to support campaigns	free communities
Objective 5 Improve knowledge and practice on personal hygiene	children, parents, caregivers, and community members	▪ Awareness activities through plays, street theatres, dramas, hygiene education sessions, demonstration, and distribution of	▪ Awareness activities are limited to few districts, mainly through support of donors	▪ Awareness activities, media campaigns and interpersonal communication on hygiene and	▪ Improved adoption of best personal hygiene practices

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		promotional materials containing hygiene messages ▪ Awareness activities through - Print media (local newspaper, leaflets /brochures, guidelines, outdoor media including billboard, hoardings, signboard) - Electronic Media (TV & Radio PSAs and roundtables, - Social media (Facebook, twitter) ▪ Interpersonal Communication (Orientation/ sensitization sessions and training workshop, group meetings, house to house visits, community dialogue) ▪ Formation of health action groups at family	▪ Awareness campaigns are limited mainly event based (e.g. celebrating global handwashing day) ▪ Mobile text and voice messages do not exist ▪ IEC and orientation materials exist (insufficient) ▪ Health Promotion Department Facebook page and website exist ▪ FHAGs are established, but are not active in all villages	sanitation promotion should be implemented as a national program on a routine basis ▪ Development of user-friendly orientation/ sensitization materials ▪ Conduct regular training workshops ▪ Partnership with communication companies ▪ Celebrate national/international awareness raising/ advocacy days relevant to WASH, e.g. global handwashing day, ▪ Develop digital communication strategy to support campaigns	

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		and community levels ▪ Religious sermons, e.g. Friday prayers ▪ Mobile text and voice messages			
Objective 6 Improve knowledge of menstruation and improve its management practices	School going girls, out of school girls, school teachers, and women	▪ Awareness activities in schools either through play or dramas or distribution of communication materials or special sessions by female teachers ▪ Interpersonal Communication (school teachers' meetings, health committee meetings, school management shura gatherings) ▪ Group Meetings (of adolescent girls and women) ▪ Formation/ revitalization of FHAGs ▪ IEC materials specific to MHM	▪ IEC materials exist (insufficient) ▪ Orientation sessions are conducted (occasionally) ▪ Interpersonal communications activities are rare in the community and schools	▪ Develop user-friendly IEC materials ▪ Regular orientation sessions ▪ Conduct information sharing sessions ▪ Orientation session to school management/shura to ensure availability of WASH facilities in schools ▪ Interpersonal communication interventions at community level mainly through FHAGs	▪ Improved menstrual hygiene practices

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		▪ Information sharing sessions			
Objective 7 Improve knowledge and practice on food safety and hygiene	Food handlers, street food vendors, children, parents, caregivers, and community members	▪ Awareness activities through plays, cooking shows, dramas, food hygiene education sessions, demonstration, and distribution of promotional materials containing food safety and hygiene messages ▪ Awareness activities through - Print media (local newspaper, leaflets /brochures, guidelines, outdoor media including billboard, hoardings, signboard) - Electronic Media (TV & Radio PSAs and roundtables, soap operas - Social media (Facebook, twitter) ▪ Interpersonal	▪ Awareness activities on food hygiene is rare ▪ Awareness campaigns are rare ▪ Mobile text and voice messages do not exist ▪ IEC and orientation materials exist (insufficient) ▪ Health Promotion Department Facebook page and website exist ▪ FHAGs are established, but are not active in all villages ▪ No specific programs for	▪ Awareness activities, media campaigns and interpersonal communication on food safety and hygiene should be enhanced ▪ Development of user-friendly information, education and communication materials ▪ Conduct regular training workshops ▪ Partnership with mobile service providers ▪ Incorporation of food safety and hygiene and nutrition program interventions	▪ Improved adoption of food safety and hygiene practices

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		Communication (Orientation/ sensitization sessions and training workshop, group meetings, cooking demonstration, cooking classes, house to house visits, community dialogue) ▪ Formation/ revitalization of FHAGs ▪ Mobile text and voice messages	food handlers and street food vendors on food safety and hygiene	▪ Develop toolkit/ guidelines for food handlers and street food vendors	
Objective 8 Improve knowledge and practice on environmental hygiene	Household and community members	▪ Awareness activities through plays, street theatres, dramas, hygiene education sessions, demonstration, and distribution of promotional materials containing hygiene messages ▪ Awareness activities through - Print media (local newspaper, leaflets	▪ Awareness activities are limited to few districts, mainly through support of donors ▪ Awareness campaigns are limited mainly event based (e.g. celebrating global handwashing	▪ Awareness activities, media campaigns and interpersonal communication on hygiene and sanitation promotion should be implemented as a national program on a routine basis ▪ Development of user-friendly	▪ Improved adoption of best environmental hygiene practices

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
		/brochures, guidelines, outdoor media including billboard, hoardings, signboard) - Electronic Media (TV & Radio PSAs and roundtables, - Social media (Facebook, twitter) ▪ Interpersonal communication (orientation/ sensitization sessions and training workshop, group meetings, house to house visits, community dialogue) ▪ Formation of health action groups at family and community levels ▪ Religious sermons, e.g. Friday prayers ▪ Mobile text and voice messages ▪ Exposure visits	day) ▪ Mobile text and voice messages do not exist ▪ IEC and orientation materials exist (insufficient) ▪ Health Promotion Department Facebook page and website ▪ Family health action groups are established, but are not active in all villages	orientation/ sensitization materials ▪ Conduct regular training workshops ▪ Partnership with mobile service providers ▪ Celebrate national/international awareness raising/ advocacy days relevant to WASH, e.g. world toilet day, world environment day) ▪ Develop digital communication strategy to support campaigns	

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
Objective 9 Improve knowledge and practice on personal hygiene, using sanitary latrine, and eliminating open defecation at schools	School students	▪ Awareness activities through plays, dramas, hygiene and sanitation education sessions, classroom activities, and distribution of promotional materials containing hygiene and sanitation messages ▪ Awareness activities through - Print media (leaflets /brochures, guidelines) - Social media (Facebook, twitter) ▪ Interpersonal communication (orientation/ sensitization sessions and training workshops, group meetings) ▪ Dialogue with school teachers and administration ▪ School assembly/ gatherings	▪ Insufficient IEC/ orientation materials tailored to school children ▪ Interpersonal communication interventions are rare ▪ WASH topics are not well-reflected in the school curricula ▪ Awareness activities in schools are limited ▪ School management/ shura meetings are conducted (occasionally) ▪ Exposure visits do not exist	▪ Develop user-friendly IEC/orientation materials ▪ Interpersonal communication interventions should be conducted regularly ▪ Organize/ conduct awareness activities at schools ▪ Encourage exposure visits to model schools ▪ Conduct management/ shura meetings regularly	▪ Improved adoption of best personal hygiene practices ▪ School absenteeism reduced ▪ School environment is student-friendly ▪ Improved usage of sanitary latrines ▪ Increased number of open defecation free schools

Objectives	Audience/s	Communication Activities, Channels, Materials	Current status/ Opportunities	Requisite tools/ Inputs	Outcome
Objective 10 Improve environmental hygiene, hand hygiene and safe disposal of medical waste at healthcare settings	healthcare personnel, patients, and visitors	▪ Awareness activities through health education sessions, demonstration, and distribution of promotional materials containing hygiene and sanitation messages ▪ Awareness activities through - Print media (leaflets /brochures, guidelines) - Social media (Facebook, twitter) ▪ Interpersonal communication (orientation/ sensitization sessions and training workshops, group meetings) ▪ Dialogue with health personnel ▪ Exposure visits	▪ Insufficient IEC/ orientation/ sensitization materials ▪ Awareness activities are carried out/ conducted at health facility (occasionally) ▪ SoPs, guidelines, and manuals (insufficient, and not used) ▪ Unsafe disposal of medical waste in many healthcare settings	▪ Develop user-friendly IEC/orientation materials ▪ Regular orientation/ sensitization sessions ▪ Conduct awareness activities at health facility regularly ▪ Develop and use SoPs, guidelines, and manuals	▪ Improved adoption of best personal hygiene practices ▪ User-friendly healthcare settings ▪ Reduced incidences of hospital acquired infections ▪ Improved practice of safely disposal of medical wastes

6. Monitoring and Evaluation Framework

In order to monitor and evaluate the effectiveness of hygiene and sanitation promotion (HSP) interventions at various levels, it is essential that baseline and end line surveys are conducted.

The outcome of the strategy is to bring positive changes in the behaviour of targeted audience/s, and promote practicing of key optimal behaviours on hygiene and sanitation. Meanwhile, the impact of this strategy will contribute to the overall vision of having Afghanistan free of diseases related to WASH.

At central level, Hygiene Technical Working Group (HTWG) will serve as coordination forum for HSP programs and interventions. The sector ministries, implementing partners of HSP programs/projects, and development partners are members of HTWG. At provincial and district levels, the existing coordination mechanisms such Provincial Health Officers (PHO), Provincial Development Committee (PDC), and WASH cluster meetings will serve as coordination bodies in planning, implementation, and monitoring of the HSP programs/projects. At village level, the community development councils (CDCs), health posts, CHWs, and FHAGs will contribute to implementation and monitoring of the HSP programs/projects.

The Citizens' Charter National Priority Program could also be used as platform to monitor the activities of hygiene and sanitation promotion programs at community level by developing simple citizens' scorecards to be completed by CDCs and Social Organizers.

It is crucial that Health Promotion Department will advocate and coordinate with relevant stakeholders involved in national scale surveys to integrate key indicators proposed in this strategy in planning and implementation of the surveys.

6.1 Program Wise Indicators

National Hygiene Promotion Strategy 2017-2020: M&E Results Framework												
Targets												
Sub Result(s)	**Key Output**	**Indicator**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
SR3.1 Reduced incidence and prevalence of acute and chronic malnutrition. **SR3.3** Reduced disease burden through promotion of healthy environment and households adopting healthy lifestyles (including use of effective and innovative ways for health education and communication) for	▪ Improved technical and strategic coordination within MoPH and with all other relevant internal and external stakeholders for improved hygiene and sanitation; ▪ Increased knowledge and adoption of hygiene and sanitation practices	Proportion of households having knowledge about importance of using safe drinking water	Percentage	TBD	5%	10%	15%	20%	20%[20]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National Surveys	*'improved drinking water source as, a source that is protected from outside contamination, such as a hand pump (private or public), bored wells, protected spring and piped water (private or municipal)*
		Proportion of households using safe drinking water	Percentage	65%	70%	75%	80%	85%	85%	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National Surveys	
		Proportion of women/ men/ children aged 15 years and above know the importance of using latrine	Percentage	TBD	5%	10%	15%	20%	20%[21]	Periodic/ GD HIS/HPD/ CSO/ Sectoral	National Surveys	

[20] Baseline + 5% National Surveys
[21] Baseline + 5%

National Hygiene Promotion Strategy 2017-2020: M&E Results Framework												
Targets												
Sub Result(s)	**Key Output**	**Indicator**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
the prevention of communicable and non-communicable diseases. **3.7** Empowered communities through health knowledge, skills and attitude, actions, supportive environment, and public health policies.	▪ Reduced incidences of WASH related diseases									ministries		
		Proportion of households using an improved sanitation facility	Percentage	39%	42%	45%	50%	55%	55%	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National surveys	
		Proportion of women / men/ children aged 15 years and above practicing open defecation	Percentage	19%	17%	15%	13%	11%	11%	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National Surveys	
		Proportion of mothers/ caregivers have knowledge about safe disposal of child faeces	Percentage	TBD	5%	10%	15%	20%	20%[22]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National Surveys	
		Proportion of mothers/ caregivers dispose	Percentage	TBD	5%	10%	15%	20%	20%[23]	Periodic/ GD	National Surveys	Safe disposal means to

[22] Baseline + 5%
[23] Baseline + 5%

National Hygiene Promotion Strategy 2017-2020: M&E Results Framework												
Targets												
Sub Result(s)	**Key Output**	**Indicator**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
		child faeces safely								HIS/HPD/ CSO/ Sectoral ministries		hygienically separate human excreta from human contact
		Proportion of people having knowledge about importance of handwashing with soap at critical times	Percentage	TBD	3%	6%	10%	13%	13%[24]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National Surveys	Handwashing with soap before eating and after using toilet
		Proportion of people practicing handwashing with soap at critical times	Percentage	TBD	3%	6%	10%	13%	13%[25]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National Surveys	
		Proportion of health centres using improved sanitation facility	Percentage	TBD	2%	5%	8%	10%	10%[26]	Periodic/ GD HIS/HPD/ CSO/ Sectoral	National surveys	An improved sanitation facility is defined as one that hygienically

[24] Baseline + 3%
[25] Baseline + 3%
[26] Baseline + 10%

National Hygiene Promotion Strategy 2017-2020: M&E Results Framework												
Targets												
Sub Result(s)	**Key Output**	**Indicator**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
										ministries		separates human excreta from human contact
		Proportion of schools using improved sanitation facilities	Percentage	TBD	2%	5%	8%	10%	10%[27]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National surveys	
		Proportion of households having handwashing facility	Percentage	TBD	5%	10%	15%	20%	20%[28]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National surveys	
		Proportion of households having soap at handwashing facility	Percentage	45	55%	60%	65%	70%	70%	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	National surveys	
		% of house premises,	Perce	TBD	5%	10%	15%	20%	20%[29]	Periodic/	National	

[27] Baseline + 10%
[28] Baseline + 20%
[29] Baseline + 20%

National Hygiene Promotion Strategy 2017-2020: M&E Results Framework												
Targets												
Sub Result(s)	**Key Output**	**Indicator**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
		where there is no sign of human faeces	ntage							GD HIS/HPD/ CSO/ Sectoral ministries	Surveys	
		# of open defecation free communities	Number	TBD	500	1000	2000	4000	4000[30]	Periodic/ GD HIS/HPD/ CSO/ Sectoral ministries	Implementing Partners' reports	

[30] Baseline + 4,000

ANNEX 1: Estimated Budget

Estimated Budget for One District (Consisting 100 Communities)												
SN	**Intervention**	**Unit**	**QTY**	**Days/ Months**	**Lunch/ Refreshment**	**Stationery**	**DSA/Perdiem/Salary**	**Transport**	**Subtotal**	**Total in Afs**	**Total in USD**	**Remarks**
1.	Training/ orientation sessions on hygiene and behavior change for Village Health Promoters (VHPs)	Person	200	2	250	50	0	0	550	110,000	1,642	VHP includes CHW, CHS, and Village volunteers
2.	Training/ Orientation sessions on hygiene and behavior change	Person	1,100	2	250	50	0	0	550	605,000	9,030	For hygiene and sanitation promotion committee and family health action groups
3.	Conduct Community Dialogue (triggering)	Event	200	1	0	0	0	0	0	0	0	
4.	Training of district health promoters (DHPs)	Event	4	1	5,000	1,000	0	10,000	16,000	64,000	955	Within Province
5.	Incentive to CHW / VHP for house to house visits	Person	200	24	0	0	150	0	150	720,000	10,746	Each VHP visits all the houses in catchment area in 6 days/ quarter
6.	District Shuras Monthly Meetings	Event	12	1	4,000	0	0	0	4,000	48,000	716	Each month 1 meeting per district
7.	Quarterly Review Meetings with DHPs and relevant sectors	Event	4	1	4,000	0	0	2,000	6,000	24,000	358	

8.	Monitoring and Transportation Cost (Provincial HP Officer)	Visit	120	1	0	0	0	1,500	1,500	180,000	2,687	10 visits/month
9.	Transportation cost for DHPs	Vehicle	4	12	0	0	0	30,000	30,000	1,440,000	21,492	
10.	Operation Cost	Each	1	12	0	0	0	0	4,000	48,000	716	Provincial office
11.	District Health Promotion Officer Salary (average)	Person	20	12			27,000		27,000	6,480,000	96,716	Monthly salary
12.	Provincial Health Promotion Officer Salary (average)	Person	1	12			38,000		38,000	456,000	6,806	Monthly salary
TOTAL										**10,175,000**	**151,866**	