Terms of Reference

Title:	**Formative Research on Hygiene Behaviour Change for Lubombo and Hhohho Region**
Country of Assignment:	Swaziland (eSwatini)
Duty Station	Mbabane
Starting Date:	September 2018
Duration of Assignment:	40 consulting days across a three month period September – November 2018
Assignment Contact Person:	Mr. Ncamiso Mhlanga Swaziland (eSwatini) Country Team Leader E-mail address: ncamisomhlanga@wateraid.org

Background

While investment in the pipes, pumps and treatment systems of wastewater collection systems are often necessary for health improvement, they are insufficient on their own. It has long been recognized that the everyday acts of the individual and the household in managing water and waste can have a profound impact upon health outcomes. These everyday habits are referred to as “hygiene behaviour” which includes such activities as handwashing, the management and disposal of infant stools, household practices of water storage and use, management, disposal/reuse of household solid waste, etc. Efforts to promote (by whatever means) hygiene behaviors that improve health are referred to as hygiene promotion. Around 50% of all disease and death are due to human behaviour (WHO) and 70% of; frequently fatal, diarrhoeal disease is caused by poor hygiene practices. Repeated episodes of diarrhoea in early life can have a long-lasting and irreversible impact on an individual’s nutritional status. Poor hygiene keeps children out of school, causes preventable deaths in medical centres and means millions of girls and women suffer in shame as a result of not being able to manage their menstrual hygiene needs. Swaziland (eSwatini) infant mortality rate was at level of 52.4 deaths per 1000 live births in 2016 and about 8% child mortality is due to diarrhoeal infections. It is acknowledged that the majority of neonatal, child and maternal deaths are preventable, and that improved hygiene practices in households, communities, schools and hospitals, can contribute greatly to improved health outcomes.

Background and Scope of the Consultancy

Hygiene is one of the key aims in WaterAid’s new global strategy (2015-2020) and including the Swaziland (eSwatini) country programme. Sustained hygiene behaviour change (HBC) programming is fundamental to the achievement of the SDGs by 2030 (particularly goals 3, 5, 6) and without good hygiene practices, such as **handwashing with soap, food hygiene, toilet use, water treatment, hygiene in health care centres and menstrual hygiene**, the benefits of other poverty reduction strategies

will be undermined and human dignity will be compromised. WaterAid recognizes that provision of WASH infrastructure is not enough for the adoption of good hygiene practices, and that improved hygiene practices are essential to secure the wellbeing benefits offered by improved water and sanitation services. Therefore, it plans to support strategic promotion of hygiene for lasting behavior change among community members in the targeted communities. While WaterAid has identified five key hygiene behaviors as its primary focus, it also takes into consideration other context-specific hygiene behaviors in its implementation.

WaterAid is therefore seeking service of a local consultant to undertake Formative Hygiene Research that will inform and guide the country programming and communication promotional package, strategy and key messages for WASH. The study will be limited to six Tinkhundla. In the Lubombo region, it will focus on Dvokodvweni, Hlane and Mpolonjeni while in the Hhohho region focus will be on Mayiwane, Ntfonjeni and Ndzingeni Tinkhundla. The study will focus on existing WaterAid and partners projects in the targeted areas including health centres that exists in the project targeted areas.

Purpose and objectives

The main purpose of this formative research is to understand current hygiene practices and their determinants, and to prioritise key hygiene behaviours for inclusion in the WaterAid country strategy and programmes. Further, the formative research will inform the design of the hygiene promotion package and behaviour change strategy. Specifically, information obtained from formative research will allow a comprehensive understanding of the socio-cultural and demographic aspects of the target group and the communities in which they live; knowledge about and practices towards key hygiene behaviours; factors associated with current behaviours; barriers (physical, social-cultural and biological) as well as motives to perform behaviours; and to identify prevalent diseases and associated beliefs and response practices.

Specific tasks

1. Conduct formative research to understand the behaviour determinants (environmental motives and barriers) around specific behaviours and parameters of interventions and their design. Specifically:

   a) Assess current hygiene behaviours and their determinants (physical, social, biological and psychological). Differences by geography and by socio-demographic variability will be documented.
      - Handwashing with soap at critical moments in households
      - Hygienic use of sanitation facilities including faeces management (including child faeces)
      - Water treatment and storage practices
      - Household Waste management
      - Household Food hygiene
      - Menstrual Hygiene

- Hygiene in health care centres
- Other relevant behaviours as identifying through initial mapping i.e. review of documents and previous interventions

b) Assess and prioritize adversely practiced hygiene behaviours in the targeted areas by conducting mapping exercise and identify barriers for performing safe hygiene practices. This research should take into full account whatever is already known about hygiene behaviour in the area and is intended only to fill knowledge gaps.
c) Identify the most promising motivators for change in behaviour, i.e. the aspirations and desires most likely to be effective in promoting change in behaviour. Motives for practicing the different behaviours should be clearly documented.
d) Determine existing women peer groups; composition (age, marital status, etc) level at which they operate; purpose for which they were formed; factors that motivate women to attend these groups; how groups operate (frequency and timing of meetings; organization; collective action etc); how these can be used to promote good hygiene practices
e) Document current routine lessons provided at antenatal and postnatal clinics, during the continuum of care from pregnancy, to delivery, and the postpartum period, and delivery approaches of the sessions and propose possible entry points for good hygiene promotion at health institutions or outreach sessions including community events).
f) Assess and determine various touch-points to reach with different target populations through the robust hygiene behaviour change promotion initiative.
g) Identify the most appropriate means of communication for hygiene promotion, to inform the design of the promotion package.

2. Key questions to be answered by the formative research:

The formative research is a backbone of the assignment therefore, the tool consultant will develop tools that will help to generate answers for the following questions:

- **Prevalent hygiene practices:** What are the prevalent level of understanding, and hygiene practices (observed) among mothers / guardians on key hygiene aspects that are linked with child health in different setting (all key behaviours in selected Tinkhundla)? What behaviour change products (linking with all behaviours) are available in the healthcare and HHs settings to practice routine behaviours?
- **Underlying reasons and barriers for hygiene practices:** Why are mothers / guardians practicing good/adverse hygiene practices (all key behaviours)? What are the current physical, social, cultural, biological and attitudinal challenges/barriers to practicing key hygiene behaviours?
- **Hygiene motives:** What are the motivational drivers and key motivates for health workers including mothers/guardians to practice good hygiene behaviours (all key behaviours)?
- **Hygiene barriers:** what are the current barriers for health workers and community people to perform key hygiene practices?
- **Variation in behaviours:** What are the traditionally routed social, cultural practices among different ethnic and religious groups (target population)

relating to key behaviours? Are there any key differences in social norms among target population residing in different geographic locations?

- **Priority behaviours:** What are the key hygiene behaviours that should be prioritized for addressing by WaterAid Hygiene programme? (prioritize key behaviours and clear rationale should be given)
- **Motivational themes:** What are the key motivational themes that WaterAid programme should use to improve the key prioritized hygiene behaviours? (should be justified with motives for all key behaviours)
- **Touch points:** what are key touch points to reach with the healthcare workers including healthcare clients and community people through the hygiene intervention?
- **Disease burden:** What are commonly reported diseases in the healthcare settings? What are the current health problems experienced by expectant women, recently delivered mothers, newborns and under-five children in the targeted areas? What are common beliefs and responses (care-seeking behaviour) associated with these problems? What are the perceived understanding about the common diseases such as diarrhoea, cholera, undernutrition and fever (sepsis) and its prevention practices among mothers/guardians?
- **MNH services status:** What is the current care for pregnant women, recently delivered mothers and new-borns? What are the motives of expectant women, mothers/guardians in attending all the sessions during the continuum of care for pregnancy? What are the barriers/challenges they face in relation to pregnancy/child bearing? What opportunities for receiving other services/information can mothers/guardians envision during routine antenatal and postnatal sessions? Are mothers/guardians willing to dedicate additional time for participating in hygiene promotion programmes during antenatal and postnatal sessions? If yes/no why?
- **Hygiene provisions in MNH service delivery:** What are the current national hygiene provisions in MNH programmes and delivery approaches? What is the degree of willingness healthcare workers to conduct hygiene promotion during routine sessions during the continuum of care for pregnancy? What are the reasons for/against? Is the antenatal or postnatal clinic the best setting for the delivery of hygiene promotion? What are the challenges/opportunities for the delivery of hygiene promotion through these routine sessions for pregnant women and mothers?
- **Existing communication channels:** What are the current communication strategies used within the health sector to reach mothers/guardians with infants? Are there any hygiene promotion activities being delivered through routine immunization, social mobilization/ mass media or other avenues? Is any hygiene promotion package available?
- **Potential communication channels:** What local communication channels exist? Are pregnant women, mothers and guardians exposed to and aware of those channels? What type of communication channel (interpersonal, group, event) do pregnant women and mothers prefer? What channels are likely to be trusted for hygiene/health messages? Is routine sessions during the continuum of pregnancy an acceptable and desired interpersonal communication channel for hygiene promotion? Are there any media (FM/TV) active in the targeted Tinkhundla through which hygiene messages can be promoted? What would be the appropriate means of communication for hygiene promotion?

- **Key Hygiene stakeholders:** Who are the key stakeholders that work on hygiene issues in the targeted areas? What is their level of investment? What are their main programmes and how are they being facilitated? Is there an opportunity for partnership with on-going interventions?

Deliverables

a) An inception report with detailed methodology, sampling framework and tools as agreed on with WaterAid in discussions following award of contract, clear work plan indicating key outputs persons allocated for implementation at each stage, and budget
b) A draft report Formative research report with finding to be presented to stakeholder on a half-day workshop.
c) Final Formative hygiene research report incorporating stakeholders comments.

Time frame

This assignment will be 40 days distributed across three months period (September – November 2018).

Payment Modalities

First Payment

20 % payment after the submission and approval/ adoption of the inception report

Second payment

50% upon the submission of the draft Formative Research report

Third/ Final payment

30% upon the final Formative Research report

Education:

The preferred consultant should have the following qualifications, experience and competencies:

- Postgraduate qualifications in social sciences research; public health (health promotion) or Behaviour change communication and use of qualitative research methods at least 8 years of relevant experience;

- Basic training and senior level experience in conducting formative research using qualitative methods

Experience:

- Demonstrated experience of conducting similar assessment or work including program formative assessment to inform hygiene behaviour change interventions including hygiene in communities and healthcare facilities in the last five years
- Demonstration of experience as lead person/s of using qualitative research methods
- Lead person to have experience in design of behaviour change communication interventions in the area of hygiene
- Excellent communication and good report writing skills, especially ability to write very well in English.
- Excellent knowledge of issues in WASH (focusing on hygiene behaviour change) in Swaziland (eSwatini)
- Proficient communication and writing skills with a good ability to translate complex technical information across various audiences.
- Timely delivery of expected outputs from assessment
- Knowledge and experience of using statistical packages for analysis of data
- An ability to work closely with communities, districts, and at regional and national levels relevant to the work being undertaken.
- Understanding of Siswati will be an added advantage.

SUBMISSION OF APPPLICATIONS

This opportunity is only open to researchers based in Swaziland (eSwatini) **or South Africa.** Interested and qualified candidates may submit their completed Expression of Interest / proposal (consisting of both narrative and financial proposal, including all costs (Consultancy fees, incidental costs, travelling costs, etc.), together with a letter of interest and pertinent documents to the Team Leader WaterAid Swaziland (eSwatini): ncamisomhlanga@wateraid.org on or before 27th July 2018 marked with a subject "**Formative Hygiene Research.**

ADDITIONAL CONSIDERATIONS:

- Applications received after the closing date will not be considered.
- Only those consultants that are short-listed for further discussions will be notified.
- Qualified female consultants and those with disabilities are strongly encouraged to apply.