

**ToR for ERU Mass Sanitation Module (MSM) 20**

**1. Background**

**1.1 Introduction**

It is common during humanitarian emergencies that access to sanitation facilities are seriously affected due to destruction and/or population displacement. Those affected are often forced to live in unfamiliar circumstances where maintaining hygiene for themselves and their families can be very difficult. This can lead to high rates of mortality and morbidity, in particular diseases spread by faecal-oral transmission. It has been shown that improvements in sanitation and hygiene, particularly hand washing, can reduce diarrhoeal morbidity significantly[[1]](#footnote-1).

Sanitation services can be defined as safe excreta disposal, solid waste disposal, medical waste disposal, control of vectors such as flies, mosquitoes and rats, provision of hand washing and bathing/laundry facilities, promotion of good hygiene practices and management of dead bodies.

Safe excreta disposal entails both ensuring that facilities including latrines are constructed, and that men, women and children use them correctly.

**1.2 Other watsan ERUs**

WatSan Emergency Response Units (ERU’s) are a long-established component of the Movement’s disaster response mechanism. There are currently two different WatSan ERU Modules which can be deployed in an emergency including Module 15 and Module 40, both specialised modules on water supply for 15.000 and 40.000 people respectively. They are capable of being deployed alone or together in a complementary fashion. Equipment and training is standardised. Both modules have limited sanitation and hygiene promotion components.

**1.3 ERU MSM 20 capacity and outputs**

The ERU MSM 20 has a core capacity to provide appropriate sanitation facilities for 20 000 people affected by natural and man-made disasters, with the aim of reducing sanitation and hygiene related mortality and morbidity. Options are available to increase capacity to serve larger of more scattered populations. The ERU MSM 20 will comprise of a self-contained team of trained delegates and pre-packed sets of standardised equipment. The team will work with local Red Cross/Red Crescent counterparts immediately to mobilise volunteers from the community, and will provide rapid training for delivery of both the hardware and software components of the module.

Key outputs from the ERU MSM 20 will be:-

* rapid and comprehensive needs assessment in relation to sanitation
* baseline survey (if conditions allow)
* plan of action
* implementation of activities, which may include:
* *provision of emergency excreta disposal using the rapid latrine if appropriate (in the first 2-3 weeks)*
* *provision of sanitation facilities for the target population according to international standards and for a minimum of 3-6 months duration*
	+ *rapid public health campaigns tailored to the particular disaster situation and cultural practices of the affected population, that emphasise the activities people can take to reduce specific health threats*
	+ *waste management and drainage, medical waste disposal, vector control and disposal of the dead*
	+ *community engament in promoting the use and maintenance of emergency facilities (latrines, hand washing stations etc),and in planning for longer term facilities and reducing public health risks*
* effective field management and logistic support.
* monitoring and reporting
* operation and maintenance, handover, exit strategy

**1.3 Staffing**

The core ERU MSM team comprises a team leader, a sanitation engineer, a hygiene promotion/public health specialist and a specialist support person. Their job descriptions are included in this package. Red Cross/Red Crescent staff and volunteers will make up the staff required to carry out the ERU MSM activities.

**1.3 Technical training**

The technical training package for the ERU MSM staff members will cover core topics (theory and practice) for excreta disposal, hygiene promotion and public health, solid waste disposal, drainage, medical waste disposal, epidemic control, household water treatment and safe storage (HWTS), vector control, disposal of the dead and field management including logistical support. The technical training is based on the project cycle including assessment, planning, implementation and monitoring of the WatSan intervention. Planning sessions must include training on tools such as baseline survey and logical framework/plan of action. Delivery of the training will emphasise an integrated approach to hardware and software implementation and will ensure a balance of time allocation for both components are reflected in the training agenda.

The training will emphasise the importance of coordination with other stakeholders including other ERUs (such as relief, logistic and health) members of the Red Cross movement in addition to other local and international organisations. Sphere is used as a framework of reference when planning activities. Sessions on vulnerable groups, accountability to beneficiaries are included which highlight the importance of addressing the needs for women, children and disable people, through participatory methodologies and adapting materials for use locally.

A simulation exercise during the training is included on how to tailor implementation of WatSan interventions to different emergency scenarios including urban setting, epidemic response, rapid or slower onset and population displacement which include dispersed or concentrated populations.

Activities are accompanied by tools as the means for implementation according to the project cycle. A balanced training agenda is required, with appropriate time for classroom-based activities but also outdoor sessions with more practical, hands-on approach.

**2. Hygiene Promotion**

**2.1 Introduction**

Hygiene promotion is central to the ERU MSM as a strategy for promoting effective development and use of facilities and for maximising health benefits. Major health benefits are expected from appropriate excreta disposal and hand washing in particular.

Hygiene promotion activities include assessment, community mobilisation, hygiene information, education and communication targeted at promoting hygiene practices at the community and household levels, in addition to operation and maintenance of hygiene facilities. Hygiene promotion is key to the reduction and prevention of transmission of water and sanitation diseases.

**2.2 Hygiene promotion and RC/RC water and sanitation programming**

In recent years PHAST (Participatory Hygiene & Sanitation Transformation) has been formally adopted by the Federation long term development programmes. However PHAST takes a minimum of several weeks to implement and is not normally suitable for use during an emergency. Some of the tools used in PHAST can however be adopted and used; materials to support those activities are included within HP Box A.

**2.3 Implementation of Hygiene Promotion**

Hygiene promotion activities which are likely to be undertaken sequentially during an emergency include:-

* public health and hygiene assessment. See Ferron et al. (2007).
* analysing data and sharing information. See Ferron et al. (2007).
* collecting appropriate baseline data for monitoring and evaluation.
* planning for hygiene promotion campaign (including communication plan), identifying human resource needs, and selection and training of Hygiene Promotion Coordinators. See Ferron et al. (2007).
* implementing hygiene promotion including; (see Ferron et al. (2007))
* *mobilising the community and ensuring that vulnerable groups are targeted and gender taken into account; special attention might be given to menstrual hygiene management (MHM).*
* *identification of appropriate hygiene communication and education methods and channels for use in different contexts (e.g. directive, participatory, group discussions, house to house) a sound communication plan must be developed as part of the MSM communication strategy.*
* *identification of ways to mobilise communities affected by disasters taking into account psychological issues and lack of a community structure.*
* *the subsequent design of a campaign to promote improved sanitation and reduce public health risks in a given context; (this may include integration of further health messaging in coordination with health teams such as promoting primary health care services)*
* *drawing up a community hygiene improvement plan.*
* *coordinating with the relief team in selecting appropriate NFIs (soap, water containers, hygiene kits, etc.) is essential. Training and follow up of community acceptance and usage of those items is responsibility of the MSM team.*

As part of this process the key principles of community participation and adult learning must be taken into account and visual aids adapted to the local context.

The construction of hygiene facilities and equipment, establishment of environmental health services, and subsequent operation and maintenance will be organised through an integrated programme of hygiene promotion, community mobilisation and technical design and construction activities.

Accountability to beneficiaries is the responsibility of the entire team however some aspects such as community participation and complaints & feedback, are directly related to hygiene promotion activities.

Community mobilisation and hygiene promotion will be an essential feature of all vector-control and solid waste disposal strategies. See WHO (2005); Malaria control in complex emergencies; Chapter 7.

**3. Provision of sanitation services**

**3.1 Introduction**

The main sanitation services provided by the MSM are:

* Excreta management
* Drainage of wastewater and rain water
* Disposal of domestic solid waste
* Control of disease vectors

In addition, the MSM is expected to be able to provide advice on the following activities:

* Management of health-care waste
* Disposal of dead bodies

Broadly recognized benchmarks (e.g. Sphere Project (2011) will be used in assessment and design of the response.

**3.2 Excreta management**

In acute emergencies, the MSM will respond with rapid solutions, such as the Rapid Latrine, clearing scattered excreta, trench latrines and other immediate and short-term measures (see Harvey, Baghri & Reed (2002) Section 6.4).

If rapid latrines are used as a mass response, they may provide adequate facilities for a number of months. Other rapid solutions have to be replaced in a matter of weeks.

For more long-term and locally appropriate solutions, the MSM will provide communal and/or family toilets that provide the optimum facilities, taking account of criteria including hygiene, comfort, safety, sustainability, cost and available materials. See Harvey, Baghri & Reed (2002) Sections 6.2 for design criteria, and Sections 6.5 to 6.9 for guidance on design.

Hand washing facilities will be provided, as required, as an essential component of toilets. Provision of bathing and laundry facilities will be also considered, especially in refugee or IDP camp settings.

**3.3 Drainage of wastewater and rainwater**

The MSM will design local solutions, based on the amount and type of water to be managed and local ground conditions. See Harvey, Baghri & Reed (2002) Chapter 10 for design criteria and guidance on design. Coordination with water-supply staff will be important.

**3.4 Management of domestic solid waste**

The MSM will assess the quantities and types of solid waste generated and implement appropriate solutions. See Harvey, Baghri & Reed (2002) Chapter 7. As far as possible, the MSM will work with local partners such as municipal authorities to avoid entering into long-term responsibility for waste collection, transport and disposal. Mobilising the community to undertake clean-up campaigns and planning small-scale solid waste disposal activities at household level seem more appropriate for the MSM.

**3.5 Vector control**

The MSM team will liaise closely with health workers when addressing vector-borne disease, to ensure an integrated approach that includes vector control and environmental hygiene promotion. This is particularly important for malaria control. See Sabatinelli (1997) Chapters 3 to 13 for detail of individual vectors, diseases transmitted and recommended environmental control methods).

***Environmental management,*** to limit breeding grounds and reduce contact between humans and vectors, will be the first option for the MSM and will always be carried out regardless of what other methods are used (see Lacarin & Reed (1999) Section 3.2).

***Chemical control*** methods that may be used by the MSM include (see Lacarin & Reed, (1999) Section 3.4):

* Residual spraying on indoor and outdoor surfaces where insect vectors rest
* Space spraying to kill adult insects
* Larviciding to kill eggs and larvae at breeding sites
* Dusting individual people to control personal vectors such as lice and fleas.

Chemical control will be limited in the first instance to short-term use of residual spraying and space spraying in specific and limited locations such as latrines, with a broad-based insecticide. Any large-scale vector-control programme using chemicals will only be carried out after a vector-control specialist has done an assessment and designed a response. The MSM will be expected to identify risks of vector-borne disease that cannot be managed with environmental control measures, and initiate the response process (see Lacarin & Reed (1999) Chapter 4. The MSM team will be able to implement a response with appropriate training and guidance by the vector specialist in the field. See Lacarin & Reed (1999) Chapter 5 and Annexes for guidance on implementation of vector control using chemicals.

***Individual / family protection***, particularly the use of LLITNs (long lasting insecticide-treated nets) is likely to be a major strategy for malaria control in endemic areas. Bednets will not be distributed directly by the MSM (they are distributed by the Relief team or NS), but MSM staff will contribute through advice on types/sizes of nets and promoting and following up on their effective use at community level. See WHO (2005); Malaria control in complex emergencies; Chapter 6 for guidance on ITNs for malaria control.

**3.5 Management of health-care waste**

The MSM team will advise health workers as required on technical aspects of managing health-care waste. In some circumstances, construction of health-care waste facilities may be undertaken. See Harvey, Baghri & Reed (2002) Chapter 8 for guidance on organizing health-care waste management and construction of disposal facilities.

**3.7 Management of dead bodies**

In the rare cases where the number of people killed by a disaster exceeds the capacity of normal systems to manage dead bodies safely, it will be necessary to organise the detection, collection, identification and temporary or permanent disposal of dead bodies. It is not intended that the MSM take responsibility for this, but it may be required to provide advice. For general principles, see Harvey, Baghri & Reed (2002) Chapter 9. For detailed advice, see Morgan, Tindball-Binz & Van Alphen (eds.) (2006).

**3.8 Epidemic control**

The MSM team can be deployed in epidemic response scenarios where sanitation and hygiene promotion activities might considered among those key control and containment measures (for reference see Communicable disease control in emergencies, WHO (2005); chapter 5). More specifically, in cholera response deployments, the MSM will support the provision of sanitation facilities and hygiene promotion services at community level and also within the health facilities (CTC, CTU, ORP).

**3.9 Household water treatment**

The MSM will not get engaged in large-scale distribution of household water treatment products but will assist the relief teams in selecting the most appropriate chemical product and other related NFIs (water containers). Large scale direct distribution of items by the MSM could create security issues and should be avoided as much as possible. The MSM team will be however responsible for demonstrations, training and follow up of community acceptance and usage. MSM and volunteers may attend distribution to demonstrate and train people on-site on product usage. Chlorine testers are included in the MSM kit and should be used when undertaking household follow up visits.

HHWT products will be selected based on technical criteria (see page 27, HHWT booklet, IFRC (2008)). Working close to relief and logistic teams is necessary for ensuring effective procurement and appropriate distribution plan.

**Guidelines cited**

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