



South Asia earthquake – Pakistan

*Ensuring gender equity
and community participation
in the watsan programme*

Banian Union Council, Batagram

The International Federation's Global Agenda (2006–2010)

Over the next five years, the collective focus of the Federation will be on achieving the following goals and priorities:

Our goals

Goal 1: Reduce the number of deaths, injuries and impact from disasters.

Goal 2: Reduce the number of deaths, illnesses and impact from diseases and public health emergencies.

Goal 3: Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability.

Goal 4: Promote respect for diversity and human dignity, and reduce intolerance, discrimination and social exclusion.

Our priorities

Improving our local, regional and international capacity to respond to disasters and public health emergencies.

Scaling up our actions with vulnerable communities in health promotion, disease prevention and disaster risk reduction.

Increasing significantly our HIV/AIDS programming and advocacy.

Renewing our advocacy on priority humanitarian issues, especially fighting intolerance, stigma and discrimination, and promoting disaster risk reduction.

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Nadia Sayeed, Pakistan Red Crescent Society Hygiene Promoter talking to a woman in Batagram.

“Women are custodians of domestic life. They are the ones who draw water, fetch the firewood, clean, cook and care for sick children... So you can see why we needed them to be involved.”

Overview

Over 17,900 inhabitants of Banian Union Council in Batagram district, in northern Pakistan’s North West Frontier Province, suffered from the devastating earthquake on 8 October, 2005.

An estimated 80-90 per cent of the population had their homes, water supply schemes and other water sources damaged, and hygiene and sanitation facilities damaged or destroyed. Community resources such as schools and health centres were also completely damaged or destroyed. The affected population was left with no common resource for personal hygiene and proper sanitation.

People not only had to rebuild their lives but had to be able to ensure that their health and well-being were preserved with dignity.

This case study elaborates some of the activities and interventions that took place in the affected communities to ensure improved hygiene practices and behaviour while encouraging gender equity and community participation.

The activities and interventions are based on the minimum SPHERE standards for emergencies and the Participatory Hygiene and Sanitation Transformation (PHAST) process.

The programme was initially implemented in the emergency phase by the International Federation of Red Cross and Red Crescent Societies and the emergency response unit (ERU) of the German Red Cross. Late in the recovery/reconstruction phase, the German Red Cross was replaced by the Pakistan Red Crescent Society (PRCS), with technical support from the International Federation.

Glossary

BHU	Basic Health Unit
ERU	Emergency Response Unit
GDP	Gross Domestic Product
GWSI	Global Water and Sanitation Initiative
HP	Hygiene Promotion
IEC	Information, Education and Communication
LHW	Lady Health Worker
MoH	Ministry of Health
MSM	Mass Sanitation Module
NWFP	North West Frontier Province
O&M	Operation and Maintenance
PHAST	Participatory Hygiene and Sanitation Transformation
PRCS	Pakistan Red Crescent Society
RWSSP	Rural Water Sanitation Supply Project
VC	Village Committee
WatSan	Water and Sanitation

Background

A massive earthquake measuring 7.6 struck Pakistan, India, and Afghanistan on October 8, 2005, at 8:50 a.m. local time, according to the U.S. Geological Survey. The epicentre of the earthquake was located near Muzaffarabad, the capital of Pakistani-administered Kashmir, and approximately 60 miles north-northeast of Islamabad. The most affected areas in Pakistan were the North West Frontier Province (NWFP), and Pakistan-administered Kashmir, while areas of Indian-administered Kashmir were also badly hit.

About 73,000 people were killed, over 120,000 injured and 3.5 million were made homeless. Following this earthquake the hygiene standards in the disaster areas changed drastically, leaving the affected population with no common resource for personal hygiene and proper sanitation.

Socio-cultural issues and gender roles

Gender roles in Pakistan today reflect the weight of culture and tradition, but Islam is an important and influential overlay. Nearly 96 per cent of the population belong to different sects of Islam. Within the Islamic faith are embedded certain elements that have a bearing on personal hygiene and the choice of sanitation facilities. Pakistan's water supply coverage is among the best in South Asia – according to an Asian Development Bank report, 95 per cent in urban areas and about 87 per cent in the villages and rural coverage is expected to grow to over 90 per cent by 2015. However, gender roles relating to water use remain unchanged, particularly in rural areas. Women make up about 48 per cent of Pakistan's 150 million people and, as in most developing countries, they are required to collect firewood and fodder, work on the farms, raise children, and care for their in-laws and extended families.

A recent study by the Population Council shows how conservative norms already constrain female access to health care in rural Pakistan. Ninety-six per cent of females aged 15-24 need permission to travel to a nearby health outlet. The primary reasons given for travel restrictions all relate to family reputation and family tradition in terms of access to basic health services. Female patients can only be seen by a female doctor. This proves detrimental to women's health, given the lack of trained female healthcare professionals, particularly in rural areas. Pakistan's high maternal mortality rates – one woman in 38 dies from pregnancy-related causes – already impose a significant cost on society. Only 20 per cent of deliveries are attended by a trained professional today.

For males, 'sunnat' or personal body hygiene is performed on Fridays before prayer. The females do not undertake this religious duty as they do not go to the mosque with the men. The Islamic faith demands that a woman should be well covered from head to toe and not expose her body in public (this makes it impossible for women to take a bath in a river even with their clothes on). Sanitation and bathing facilities for women have to be as near to the households as possible, and males from another family are not allowed to use these facilities.

In the pre-earthquake situation, the sanitation and bathing facilities were placed in a corner of dwelling places.

Generally in the earthquake affected areas of Manserha and Batagram districts, it is very rare to see unaccompanied women walking any distance from their usual place of residence. Women are expected to be at home and look after the children, fetch water, wash clothes, cook and do the routine cleaning of their homes. Mainly young teenage girls are seen at the river washing clothes or drawing water.

The men undertake all decision-making roles, while women are not allowed to attend men's meetings. However, the woman plays a very important and powerful role in the education and upbringing of the children within the home. Until the children reach between five and seven, their education is mostly the responsibility of the mothers, including basic hygiene education. After this age, the children are educated in those tasks by both parents and by their teachers.

Generally in the rural districts of the earthquake-affected areas, very little emphasis is placed on educating girls, which explains the low literacy levels among women. Pakistan has for decades grossly underinvested in education, and in particular, girls' education. Expenditure on education is mired at roughly one per cent of gross domestic product (GDP), and in this environment of resource constraints, girls tend to be short-changed. Overall literacy is only 44 per cent, while adult female literacy is less than 30 per cent. Moreover, the gap between male and female literacy rates has widened. In 1975, the literacy gap between men and women in Pakistan was 25 points (11 per cent literacy for women versus 36 per cent for men). By 2001, that gap had inched upwards to 29 points (29 per cent literacy for women versus 58 per cent for men)¹.

Identified hygiene and sanitation needs*

Non-availability of sanitation facilities therefore high percentage of population using the bush/field

Collapsed/contaminated water sources (springs) and damaged piped water schemes

Poor environmental sanitation (poor drainage, human excreta around courtyards, refuse, etc.)

No bathing facilities for performing personal hygiene. Women were more affected than males and young children who could trek down to the rivers.

Increase in BHU attendance for scabies and diarrhoeal diseases

Low levels of knowledge pertaining to hygiene issues among the affected population.

**Needs based on initial rapid assessment*

¹ *Gender Disparities, Economic Growth and Islamization in Pakistan. Author: Isobel Coleman, Senior Fellow for U.S. Foreign Policy, July 2004. Woodrow Wilson International Center for Scholars.*

Implementation strategy and choice of hygiene messages

Emergency Nov 05-April 06

Mass hygiene education campaign
Distribution of commodities
Provision of essential facilities

Objective:

Directing people to take specific actions

Activities based on
community consultation process.

Transition April-Dec 06

Three-step PHAST

Objective:

Knowledge
acquisition

Activities based
involvement and
contribution

Early phase of the emergency: Mass hygiene education campaign (November 2005-April 2006)

Banian Union Council in Batagram district is part of the eight Union Councils and one of the largest with over 19 village clusters. During the emergency phase the International Federation/German Red

Cross had worked in the area to provide hygiene kits, hygiene education and grouped family latrines. A total of 58 per cent of the population in Banian was covered by the International Federation/German Red Cross hygiene promotion and sanitation programme.

Based on the needs identified during the initial rapid assessment and taking the cultural aspects into consideration, the International Federation developed a hygiene/health promotion campaign package targeting women as the custodians of most domestic chores.

“ Key messages – emergency phase

Safe excreta disposal and use of latrines

Hand-washing at critical times

Safe water handling

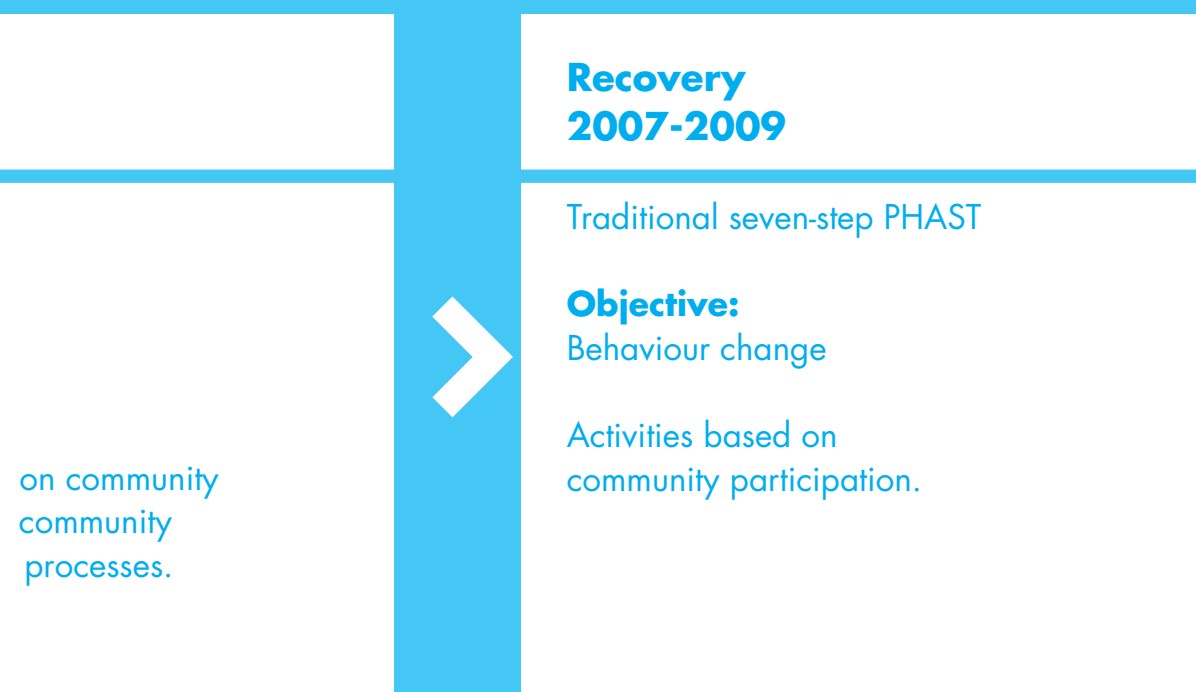
Personal hygiene kit

Safe waste disposal



And due to their role in raising the children, this approach worked well in the emergency developmental stages to:

- Create awareness within the communities on hygiene and sanitation issues.
- Highlight the issues and role of women within the family and community.



- Raise the status of the women and emphasize the important role they have in educating family members and sharing knowledge regarding the prevention of disease outbreaks.
- Form a platform for future implementation of the programme.

During this early emergency phase a lot of activity-planning and decision-making was done through the clusters, with UNICEF as the lead cluster agency.

The cluster ensured that the following were undertaken through the guidance of the lead cluster: a) needs assessment and analysis; b) development of response plans to address priority needs; c) ensuring appropriate delegation and follow-up on commitments from cluster participants to act in particular areas; d) sustaining mechanisms through which the cluster monitored and assessed its performance.

At community level, implementation of some activities was done through the Lady Health Workers (LHWs). The already trained Ministry of Health **Lady Health Workers formed the first line of contact within the affected communities** and were responsible for the actual delivery of key hygiene messages, identification of beneficiaries for hygiene kit distribution and mobilization of communities for latrine construction and other related health/hygiene promotion activities. This approach, however, changed to become more participatory as Pakistan Red Crescent Society volunteers and other community members were trained in the basic hygiene promotion for emergencies.

These activities are summarized in the Gantt chart below and the time frame when they were implemented. The responsibility column shows the cooperation and agency roles within the WatSan hygiene promotion cluster:

Activity	Responsible	Time frame					
		Nov	Dec	Jan	Feb	Mar	Apr
Development of data collection tools and rapid assessments	Cluster lead and agencies	High	High				
Identification and recruitment of volunteers	International Federation PRCS	High	High				
Training of volunteers in basic hygiene promotion in emergencies	International Federation RWSSP, UNICEF, OXFAM, WHO			High	High	Low	
Mobilization and development of IEC* materials	UNICEF, MoH, agencies	High	High				
Key hygiene messages and door-to-door hygiene campaigns	LHW, Red Crescent volunteers	High	High				
Distribution and provision of hygiene kits, communal latrines and bathrooms	Red Crescent volunteers LHW	High	High	High	High	High	High
Development of 3-step PHAST pictures and other materials	Cluster members				Low		
Training in 3-step PHAST	UNICEF, WHO				High	High	High

High-activity level

Low-activity level

Transitional period (April-December 2006): Investing in the community

In the WatSan sector, experience has shown over the years that the effectiveness of water supply and sanitation projects depends not only on the technology choice, but also on gender-responsive WatSan facilities, community management and behavioural change, the core elements of the “Hygiene Promotion” concept. The International Federation advocates for the integration of this element for water and sanitation under GWSI (Global Water and Sanitation Initiative) as the key element for ensuring sustainability and greater impact on public health.

Since it is difficult to attain sustainable behavioural change through the ‘hygiene action’ approach (directing people to take specific actions), the Red Cross worked with other agencies within the WatSan cluster (UNICEF, WHO, OXFAM, RWSSP) to come up with a more realistic, participatory, community-based approach. Participatory Hygiene and Sanitation Transformation (PHAST) process, an WHO initiated approach that enables service providers to work with communities in a participatory manner, was adopted and modified from full seven-step to three steps for the emergency purposes and intermediate recovery phase.

The PHAST approach helps people to feel more confident and empowers them to make decisions on key hygiene practices and behaviour within the family and community.



PHAST seeks to help communities:

- *Improve hygiene behaviour*
- *Prevent diarrhoeal diseases*
- *Encourage community management of water and sanitation facilities*



Getting started

A number of activities were carried out during the transition period from emergency to recovery (March-April) to ensure a smooth exit to the community-based, participatory approach. A baseline survey was conducted in ten villages of Banian Union Council over a period of four days. Five male and female volunteers were trained in the three-step PHAST process and one local female staffer who could speak the local language and understood the cultural aspects of the area was also engaged to coordinate the activities.

Recommendations of the survey

Improve the community water supply and quality, both for drinking and washing, through rehabilitation of existing water schemes and sources

Improve the drainage systems at the household and community level

Intensify hygiene promotion activities with participatory methods and long-term projects to change understanding and practices

Community mobilization through local leadership to support the projects and to implement facilities

Block the vectors from faeces, flies and mosquitoes, since they are a severe threat to the health of the people

Implement private latrines at households and phase out communal latrines

Implement a solid waste collection/disposal system.

During the transition and recovery/reconstruction phases, the International Federation/German Red Cross conducted a survey in Banian Union Council in ten of the clustered villages and prioritized six villages for the participatory, community-based hygiene and sanitation programme. The prioritized villages with population figures were: Dedal (918), Bandigo (917), Qabura (560), Amlook (320), Banian (3,841) and Bhattian (1,742).

The outcome of the survey conducted by the International Federation and German Red Cross showed very little difference to the findings of the initial rapid assessment, even though the International Federation/German Red Cross had provided a number of latrines in some villages of Banian Union Council during the emergency phase. These latrines were viewed as private latrines by families living near to them and this meant that access by other community members was restricted. There was a critical problem of safe water and households lacked containers for water storage. Environmental sanitation was still poor, with a posed danger of vectors such as mosquitoes and flies. Communities still identified respiratory infections, skin conditions and diarrhoea as major health problems and knowledge of good hygiene practices was low, especially among those who did not receive any hygiene education at all.

The objectives

The objectives of the adopted implementation strategy by the International Federation and Pakistan Red Crescent Society were to:

- Promote the active involvement of all sections of the community in project-planning and decision-making.
- Encourage people to take responsibility for the process and outcome, both in the short and long term.
- Help restore people's self-esteem and dignity after the earthquake.



Arne Hodalic/Slovenian Red Cross



International Federation



International Federation

Shafique

*Hygiene Promoter
of Pakistan Red Crescent Society*

Involving women but also men in the hygiene promotion activities has proven to be the key to reach out a wider representation of the community. Working with women as well as men can make changes at the grass root level. Community members formed committees to act as trusted and accepted facilitators of those changes.

Chand Bibi

Health worker in the village of Shigli Paien

It may sound very basic, but many people in my community do not know that the simple act of boiling water can kill bacteria and prevent diseases.

Intervention model:

Community participation and involvement

In order to ensure community involvement and participation, the hygiene promotion team adopted and implemented the three-step PHAST for an emergency. The following activities shown in the table below were prioritized:



Claudia Janke/British Red Cross

Priority activity

Community mobilization through:

- Community meeting
- Village committee (VC) formation
- Problem identification

Training of VC in 3-step PHAST

Replication of PHAST at community level

Conducting clean-up campaigns

Conducting school hygiene sessions

Distribution of hygiene buckets

Distribution of hygiene kits

Construction of family latrines

Environmental sanitation

Monitoring and evaluation

Details of activity

Initial community meetings were conducted with gender-segregated groups through community leaders to decide on the date for the next meeting and formation of VC (village committees) and date for the next meeting.

Gender-segregated meetings and mobilization for VC formation and gave communities time to decide on their own as to who should be included on the VC. Two committees were formed for each village (one male/one female).

Conducted three-pile sorting with separate male and female groups to investigate community practices.

Transect walks and community mapping were conducted mostly with male teams, while the transmission routes chart was used mostly with the females.

2-3 hours PHAST session for village committee members.

This activity was carried out by the trained village committee members and targeted all sectors of the community.

Confirmation and announcement of clean-up campaign through loudspeaker for participation.

Implementation of community clean-ups with volunteers and community members. The Pakistan Red Crescent Society provided tools for this activity.

Key hygiene messages using pictures for school boys and girls through at least one visit per week/school.

Depending upon the size of population distribution this could take few days.

One hygiene kit was provided for a standard family of seven members each month.

Activity was undertaken by the sanitation team, depending on the established needs and encouraged good integration between hygiene promotion and sanitation teams/activities.

Combined with community clean-up days, solid waste containers were provided at a ratio of 1:3 houses and drainage lines were cleared and reconstructed.

Monitoring was carried out through the Pakistan Red Crescent Society and VC members. The monitoring system will be reinforced during the implementation of 7-step PHAST process.

Challenges - Lessons Learned

The post-earthquake situation in NWFP presented an extremely complex range of public health needs and challenges related to topography, weather, scale, access to communities, cultural practices, availability of local staff and national society infrastructure.

Vulnerable populations were constantly on the move and it was difficult to predict population movements accurately. While many were returning to the higher mountain areas at the end of winter, the vast majority of the affected population were in temporary shelter adjacent to their destroyed homes. Risks of water and sanitation-related communicable disease persisted throughout the winter season and with the snow melt and warmer weather, some of the risks were intensified.

All key actors emphasized the particular challenges of implementing sanitation and hygiene promotion programmes in this situation. Some of the challenges that have been seen in many camps, both 'organized' and 'spontaneous' settlements, in terms of providing sanitation facilities, were related mainly to cultural practices.

The cultural practices in Pakistan require that women do not share the same latrine facilities as men (separate and private sanitation facilities must be provided for both men and women). Lack of community consultation at the beginning of the intervention resulted in some of the latrines constructed being sited in locations unacceptable to the traditional practices of 'purdah'. This is where women do not leave their houses unaccompanied and go to the toilet and to bathe only at night. Many latrines were not used also because they were communal toilets and no one in the community was prepared to take responsibility for cleaning them. It was noted that people were only willing to take on the responsibility for operation and maintenance (O&M) when family latrines were provided.

This situation radically changed when the community participation element was developed through three-step PHAST. In the initial stages, the combined teams visited the selected villages far more frequently to mobilize the communities and start formation of the village committees. The visits involved many consultations and meetings took place between the team and the village leadership to discuss having women included on the committees. It was agreed that two village committees should be formed for each village on a gender basis, ensuring that both men and women were represented.

The responsibilities of the village committees were different but the level of involvement in the activities was the same. The male community members participated more in outdoor activities, such as clean-up campaigns, building of latrines and receiving of hygiene kits when this was done at a central place. Both young and older men supported the women and eagerly participated in the clean-up campaigns and other activities that were planned together within the communities. The community members also participated in community mapping, planning of the activities and scheduling community meetings.

Women, on the other hand, were more involved in educational activities and taking decisions on which hygiene practices were to be promoted in the families. They also became very instrumental in passing the messages to other women. A group of women visited in Dedal village stated that they were very happy to be involved in the activities and were now sharing their knowledge with others, especially during gatherings such as weddings.

Banian Union Council provides a good model for the integration of hygiene promotion and sanitation activities. Both teams of five hygiene promotion community facilitators and four sanitation technicians worked together to ensure maximum community participation to prioritize a number of the sanitation and hygiene promotion activities recommended in the community surveys. Adopting the three-step PHAST as a model for activity implementation ensured that all sectors of the community were involved in planning and taking decisions concerned with the selected activities and therefore improving their health status. Activities were therefore more likely to be appropriate and sustainable. Though it is too

early to measure the impact of these interventions, it was notable that Banian Union Council had the lowest number of acute watery diarrhoea cases when there was an outbreak in Batagram. In fact, there were no cases reported in the villages where these Red Cross/Red Crescent interventions took place.

It is therefore highly recommended that the approach and strategy adopted by the International Federation and Pakistan Red Crescent Society should be developed in a long-term programme and that a full, developmental, seven-step PHAST should be adopted and implemented by the Pakistan Red Crescent Society in future, community-based health programmes. It is also recommended to link PHAST to the disaster preparedness programme. When a disaster occurs, those Red Cross and Red Crescent National Societies that have been working on participatory methodologies as part of the emergency prevention and preparedness are able to introduce the participative elements in the response efficiently from the outset of the emergency.

Link to MSM (Mass Sanitation Module)

In the Pakistan Earthquake Operation, it has been seen that access to sanitation facilities has been seriously affected due to destruction and/or population displacement. Those affected were often forced to live in unfamiliar circumstances where maintaining hygiene for themselves and their families was very difficult. The establishment of sanitation services (excreta disposal, solid waste disposal, provision of hand-washing and bathing/laundry facilities) and promotion of good hygiene practices have been among the very first priorities to reduce and/or contain the resultant morbidity and mortality caused by the lack of such services.

To better address these needs, the International Federation deployed experts to focus mainly in this field and in cooperation with the British Red Cross redesigned the existing **Mass Sanitation Module (MSM)** within the ERU (emergency response unit) system to incorporate an effective hygiene promotion component for use worldwide. Reviewing the hygiene and sanitation promotion activities carried out in Pakistan in the early stages of the emergency was an excellent opportunity for extracting lessons learned and good practices and for supporting the process of developing the new MSM.

A brief description and content of the MSM are attached (Annex 1).

The way forward

In an emergency, when rapid action is needed, it is too easy for relief workers to make assumptions about people's needs and priorities. It may be actually very difficult to set up an effective mechanism for consultation and participation in the early phase of the emergency, however, it is recommended to make a special effort at least to establish the principle of consultation and participation, which can be developed over time. Community participation in the response phase and in the communication of specific hygiene messages in the immediate aftermath of a disaster ensure sustainable and incremental improvements in environmental health and establish a great foundation for long-term development.

To ensure this approach is implemented at ground level, WatSan engineers and hygiene promotion delegates must be deployed at the same time and work in coordination from the outset. Even where, as in the Pakistan example, there are obvious and urgent sanitation 'hardware' requirements, the hygiene promotion delegate can at the same time be gathering and analysing important baseline information about the situation, such as priority public health risks, needs and gaps in provision, existing levels of knowledge and common practices around sanitation and hygiene within the affected communities. In other situations, however, it could be that the hygiene promotion component precedes the 'hardware' interventions.



Annex 1:

Mass Sanitation Module (MSM)

Mass Sanitation Module: Brief description

Purpose

- To deliver essential sanitation and hygiene promotion services to populations in emergency situations.

Capacity

- The module has a core capacity to provide services according to SPHERE standards to 20,000 people, with options for adding resources for serving larger or more scattered populations.

Approach

The module is designed to do the following:

- Provide an integrated response to hygiene and sanitation problems in emergencies, based on public health needs assessment, community mobilization, and the use of rapid and effective sanitation technology and hygiene promotion.
- Be deployed as a stand-alone response or as part of a broader WatSan and/or Health ERU deployment.
- Provide a platform for longer-term rehabilitation and recovery programming as appropriate.

Principal tasks

The principal tasks of the module are:

- Assessment of needs and resources; planning of sanitation and hygiene promotion activities; monitoring of activities and public-health conditions; preparing and managing the end of the deployment.
- Construction of emergency latrines and development of community-based latrine programmes; management of solid waste and wastewater; disease-vector control (principally through environmental management); management of dead bodies.
- Planning, design, implementation and monitoring of hygiene promotion activities, including assessment, community mobilization, hygiene information, education and communication targeted at promoting protective hygiene practices at the community and household levels, and operation and maintenance of hygiene facilities.

Indicative staffing patterns

- Team leader (manager with experience of emergency sanitation).
- Sanitation engineer (environmental, civil, mechanical, chemical engineer).
- Hygiene promoter/community mobilizer (with public health training and skills).
- Specialist support (with experience of programme administration and field logistics).

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The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary Service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.



The *International Federation of Red Cross and Red Crescent Societies* promotes the humanitarian activities of National Societies among vulnerable people.

By coordinating international disaster relief and encouraging development support it seeks to prevent and alleviate human suffering.

The International Federation, the National Societies and the International Committee of the Red Cross together constitute the International Red Cross and Red Crescent Movement.

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