# Supplementary materials for the Hygiene Promotion orientation package

In addition to other materials available on the CD/website (see below) included here are:

# Handouts:
1. Terminology and definitions[1]
2. HP FAQs
3. Gender checklist for WASH programming
4. WASH HP tools quiz sheet
5. Evaluation form

## Supporting materials

- **Briefing paper** Short paper describing Hygiene Promotion, what it is and how to do it in emergencies. It is aimed at WASH coordinators to disseminate to all stakeholders to promote common understanding of Hygiene Promotion and consistency of quality.

- **Menu of indicators** for monitoring Hygiene Promotion, for use by field practitioners and promoted by WASH coordinators.

- **Annotated bibliography** List of Hygiene Promotion tools and resources (books, manuals, training modules, and audio visual materials) as reference materials for WASH coordinators and others.

- **List of essential Hygiene Promotion equipment for communication** to inform WASH coordinators and guide field implementing agencies.

- **Non-food items briefing paper and list** A briefing paper achieving maximum impact from the distribution of hygiene related non-food items (NFIs).

- **Generic job descriptions and overview** for field hygiene promoters and community mobilisers/workers as well as alternative potential structures. These aim to inform and guide WASH coordinators and implementing agencies, in order to encourage consistency and minimum standards.

---

[1] Adapted from Oxfam's Public Health Promotion Guidelines for Emergencies and IFRC ERU-MSM Guidelines and training package

# Terminology and definitions[2]

**Public Health** is often defined as the 'promotion of health and prevention of disease through the organised efforts of society'. A public health intervention aims to ensure coordination between sectors (e.g. in Humanitarian programmes with those involved in food and nutrition, water and sanitation, shelter, health care etc.) and to base its actions on sound public health information that is aimed at the maximum impact for the greatest number of people.

**Health Promotion** is the process of enabling people to increase control over, and to improve, their health. The Ottawa Charter[3](1986) defined five key principles of health promotion:
- To build healthy public policy
- To create supportive environments
- To strengthen community action
- To develop personal skills
- To reorient health services

The Jakarta Declaration (1997) reaffirmed that health promotion was most effective if it adhered to these principles and emphasised also the importance of participation.

**Hygiene Promotion** is a term used in a variety of different ways but can be understood as the systematic attempt to enable people to take action to prevent water and sanitation related disease and to maximise the benefits of improved water and sanitation facilities. Sphere notes that there are three important factors in Hygiene Promotion: 1) mutual sharing of information and knowledge, 2) the mobilisation of communities, and 3) the provision and maintenance of essential materials and facilities. Hygiene Promotion includes the use of communication, learning and social marketing strategies and combines 'insider' knowledge/resources (what people know, want, and do) with 'outsider' knowledge/resources (e.g. the causes of disease, including social, economic, and political determinants, engineering, community development, and advocacy skills).

**Hygiene Education** refers to the provision of education and/or information to encourage people to maintain good hygiene and prevent hygiene related disease. It is a part of Hygiene Promotion and is often most effective when undertaken in a participatory or interactive way. In the past health or hygiene education has sometimes been carried out as a response to an assumed lack of knowledge or understanding within the target population. This approach often missed the opportunity to build on existing knowledge within the community and was often undertaken without consideration of the overall social and economic context. The terms 'health promotion' and 'Hygiene Promotion' give greater

---

[2] Adapted from Oxfam's Public Health Promotion Guidelines for Emergencies and IFRC ERU-MSM Guidelines and training package

[3] The Ottawa Charter was the outcome of a the first meeting of health promotion professionals held in Ottawa in 1986 held as a response to growing expectations for a new Public Health Movement. It built on the progress made by the Declaration of Primary Health Care made in Alma Ata. A subsequent key meeting was held in Jakarta in 1997.

weight to the context in which people live and the terminology has thus evolved to take account of this.

**The difference between Hygiene Promotion and health promotion;** Hygiene Promotion is more specific and more targeted than health promotion. It focuses on the reduction – and ultimately the elimination – of diseases and deaths that originate from poor hygiene conditions and practices. For example, good hygiene conditions and practices are enhanced when people can consume water that is safe, use sufficient amounts of water for personal and domestic cleanliness, and dispose of their solid and liquid wastes safely. A person may have good hygiene behaviour, but not be healthy for other reasons. Good or bad health is influenced by many factors, such as the environment (physical, social, and economic). For example, in social environments where people are marginalised because of their gender, economic status or religious affiliation, and have no influence whatsoever on decisions that affect their daily lives, they are likely to be prone to anxiety or depression, which can lead to mental problems.

**Hygiene Promotion approaches** refers to a specific system of methods that are used to promote hygiene. Formalised approaches are usually governed by particular principles of engagement e.g. social marketing, PHAST, or Child to Child. Campaigns and peer education have a much looser framework that can be interpreted in different ways. Most Hygiene Promotion initiatives take either a directive or participatory approach or combine the two. It is possible to use a mixture of methods from these different approaches and combine them into an individualised approach for a specific emergency.

**Hygiene Promotion methods** refers to the stand alone activities and tools that can be used for Hygiene Promotion e.g. focus group discussions, three-pile sorting, pocket chart voting, and mapping.

**Behaviour change communication (BCC)** is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education, and communication (IEC) programmes to promote more tailored messages, greater dialogue, and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programmes to ensure sustainable change in attitudes and behaviour.[4]

**Community** is a group of people who:
- are interdependent of each other and limited by geographical boundaries
- share common natural resources
- share a common culture
- experience the same problems

Despite common characteristic traits, there is a general recognition that even within a

---

[4] Behaviour Change Communication Toolkit for the Workplace, ILO-FHI HIV/AIDS

community, there would still be sub-groups, each with specific interests and goals, and development facilitators should be sensitive to such groups even though it might be impossible to satisfy the needs of all sub-groups within a community. An example to illustrate this could be the difference in the level of enthusiasm for sanitation awareness campaigns among village members who already have and are using latrines and those who do not have them. Similarly, even within the same community, there will be people who are better off than others or who are more influential than others.

**Community mobilisation** is a strategy for involving communities in TAKING ACTION to achieve a particular goal. The emphasis of mobilisation is on the action taken rather than the longer-term concept of behaviour change and it thus provides a more useful model for the emergency context.

**Community participation** does NOT simply involve people contributing labour, equipment or money to a project, but aims to promote the active involvement of all sections of a community in project planning and decision making. It aims to encourage people to take responsibility for the process and outcomes, both short and long term, of a project. Encouraging participation in an emergency can help to restore people's self esteem and dignity, but achieving participation within a short time-frame can present significant challenges. It should be remembered that at different stages of the emergency different levels of participation are possible and therefore a flexible response is required.

**Connectedness** – see 'sustainability' below.

**Enabling environment** refers to the existence of a favourable social environment – whether at the community, municipal, regional, or national level – that supports the integrated technology and hygiene interventions proposed. If these interventions are to be accepted and implemented they will need the support and co-ordination of other WASH stakeholders AND other actors in the emergency context. An Enabling Environment is one of the three main components of the **Hygiene Improvement Framework** – along with **Access to Hardware** and **Hygiene Promotion**. This model has been adapted to the emergency context by the WASH Cluster HP project.

**Environmental health** is a broad term that encompasses water and sanitation interventions as well as such issues as air and noise pollution. Environmental health services are defined by the World Health Organisation as:

> *"those services which implement environmental health policies through monitoring and control activities. They also carry out that role by promoting the improvement of environmental parameters and by encouraging the use of environmentally friendly and healthy technologies and behaviours."*

The Environmental Health profession had its modern-day roots in the sanitary and public health movement. Many countries have EH officers who may be recruited to the team either as core delegates or as field officers/local staff.

**Gender** refers to the socially and culturally defined roles and responsibilities associated with being either male or female. Gender determines how men and women are seen and expected to behave and varies according to time and place whereas a person's sex is (usually) fixed and the same everywhere. It is important to remember that gender, like culture, is dynamic and constantly changing. Even in traditional societies, a woman's or man's experience of gender will be different from that of previous generations. In emergencies, men and women may be forced to change their roles and responsibilities but they may need support to do so.

**Health** is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. It is a fundamental human right and attainment of the highest possible level of health is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector. (World Health Organisation – WHO)

**Outputs** refer to the specific deliverables or products of a water, sanitation, and hygiene programme. This could be the coverage of latrines, protected water sources, handwashing facilities, community mobilisers, or household distributions of hygiene items. **Outcomes** refer to the expected consequence of having such outputs e.g. the use and maintenance of latrines and handwashing facilities or the effective use of hygiene items.

**Sanitation** refers to the disposal of human and animal excreta, vector control, solid waste disposal, and drainage. It may also include the disposal of hospital waste and the disposal of mortal remains.

**Social mobilisation** is a broad-scale movement to engage people's participation to achieve a specific development goal through self-reliant efforts. It includes the process of bringing together multi-sectoral community partners to raise awareness of such development goals, and demand and progress towards them.

The terms **software** and **hardware** are frequently used to refer to different components of a water and sanitation programme. Software refers to the community aspects of the intervention i.e. how people use the facilities, and hardware refers to the physical infrastructure such as new hand pumps, tanks, pipes etc. While engineers may be predominantly responsible for the construction of water systems and sanitation facilities, it is a misconception to think that they have no responsibility for the way that these facilities are used and maintained. In the same way, the hygiene promoters also have a role to play in ensuring that feedback on the appropriate design of facilities is incorporated into the programme. Some feel that the term 'software' has negative connotations but if you continue with the computer analogy, the hardware is of little use without innovative software programmes!

**Sustainability** refers to the potential for lasting improvements that a project offers. In the emergency context, sustainability may not always be possible or necessary to prevent

significant mortality but, where possible, work should be carried out in such a way that opportunities for lasting benefits are actively sought and resourced as required. A term that is often used instead of sustainability in the emergency context is **connectedness.** This refers to the importance of not undermining the potential for lasting improvements or changes. This may be done by working, as much as possible, through existing structures and making use of existing capacities.

December 2007

# Hygiene Promotion Frequently Asked Questions

**1. Can I use PHAST in an emergency?**

Given the time limitations and the difficulty of working consistently with disrupted communities, it may be difficult to apply the PHAST process in the manner suggested in the PHAST manual. However, the PHAST philosophy of employing a participatory, problem solving approach to motivating and mobilising affected communities can be applied to varying degrees at different stages of the emergency. The methods and tools employed by PHAST such as three-pile sorting and mapping are also useful in facilitating interaction and discussion with affected communities.

In some emergency situations e.g. a cholera outbreak, there may be facilitators who have already been trained in the PHAST process, and communities may not necessarily be disrupted or displaced. In such a situation it may be much easier to apply the PHAST approach as outlined in the PHAST manual.

**2. Can I use social marketing in an emergency?**

Undertaking a social marketing programme in an emergency is not usually possible as a significant amount of time is required to research and understand the problem and identify an appropriate strategy. However, the emphasis on understanding the 'consumer's' viewpoint, creating a demand for water, sanitation, and hygiene, and emphasising the positive benefits of engaging in improved hygiene rather than the negative consequences (i.e. death or disease) as in traditional hygiene education, are important principles that can be applied even in an emergency.

Where there are cyclical emergencies e.g. cholera outbreaks, social marketing has been used to good effect following the necessary formative research.

**3. Should community mobilisers be paid?**

The most commonly used approach to access the population in emergencies is that of identifying and training community outreach workers (volunteers /mobilisers/ animators). Strictly speaking, the term volunteer is used when the person receives no payment.
If the health risks are very acute e.g. a high risk of a disease outbreak, it may be unrealistic to require people to work for long hours for little remuneration, but it will be important to try to reduce public health risks by intensifying contact with the population at risk. Payment in kind e.g. bicycle, tee-shirts, hygiene items etc. may be an option but some agencies, such as the government, may not have the resources to provide financial or other incentives and unilateral decisions by incoming agencies may undermine efforts to ensure future sustainability. The issue is complex and needs to be addressed through the coordination mechanism; a balance must be sought between addressing the risks and ensuring that long-term development initiatives are not jeopardised. (See table in Generic job descriptions paper.)

### 4. Is behaviour change possible in an emergency?

Contrary to popular belief, changes in practices or behaviour do not always take a long time to occur and even short-term changes can be important where the risks to public health are high. If change is enabled it can happen very quickly, for example, if handwashing facilities are provided to make it easier to wash hands or if hygiene items are provided that encourage improved hygiene. If people feel themselves to be at risk then they are also more likely to change their behaviour quickly (Rosenstock, Strecher and Becker, 1994).

Whatever the focus of Hygiene Promotion, the emphasis must be on enabling and mobilising women, men, and children to take ACTION to mitigate health risks (by adhering to safe hygiene practices) rather than simply raising awareness about the causes of ill health.

### 5. Do I have to do a questionnaire survey?

The use of a questionnaire survey is an important method of obtaining quantitative data for a Hygiene Promotion programme. If the survey is carried out well using a random sampling method, the quantitative data collected can be said to be representative of the whole population. However, carrying out this type of quantitative survey well requires a degree of expertise and significant resources and it may not be feasible to do this in every emergency. Where the population is highly mobile and the situation is changing rapidly, it may not be worth carrying out a survey as by the time the data has been analysed the situation may have changed significantly. Coordination and collaboration are key factors in ensuring that expertise is identified, resources are not wasted or duplicated, and that the specific context is suitable for carrying out a survey. Qualitative data must be collected as a minimum requirement for the initial rapid assessment and to provide a baseline for monitoring. Quantitative data should also be collected.

December 2007

# Gender checklist for WASH programming
# (adapted from IFRC Gender Checklist)

### General data
- Total number in family. Data disaggregated by age and sex.
- Number of families headed by females, and number by males.
- Child-headed families.
- Number of unaccompanied boys and girls, elderly, and disabled people.

### Water collection, transportation, and allocation at household (HH) level
- Patterns of water collection (water fetching and carrying): time spent (hours / day).
- Relationship between water collection and girlchild school attendance.
- Gendered division of access to means of water transportation. When the family has access to private transport (bicycle, donkey, motorbike, etc), do men retain priority use, leaving women more reliant on travel by foot?
- Patterns of water allocation among the family members (sharing, quantity, quality).

### Access to, and control over, water sources
- The different uses and responsibilities for water by men, women, and children (e.g. cooking, sanitation, gardens, livestock, etc.).
- Who makes decisions about different water use in the community (water for irrigation, domestic use, livestock watering, water selling, brick making, etc.)?
- Do women have access to income generation activities related to water?

### Gender division of time-use in the HH
- Who makes the decision about the time spent at HH level?
- What is the normal means of handling, storing, and treating water at HH level?
- Who is responsible for HH hygiene? Who is responsible for hygiene and sanitation practices at community level?
- If women are responsible for the hygiene status of themselves and their families, what level of knowledge and skills do women have?

### Technical options / operation and maintenance (O&M)
- What is the division of responsibilities between men and women for maintenance and management of water and sanitation facilities? Are women equally represented in community development committees, water committees, community associations, etc? Which roles do women take on in those associations? Do they have access to the treasury?
- Who usually maintains the latrines/water points?
- Does the community need technical training on latrine operation and maintenance and hygiene, and/or managerial training for maintenance?
- What are the options for convenient user-friendly designs, low cost and affordable facilities?

- Are the physical designs of water points and latrines appropriate to water source, and the number and needs of users?
- Does the community need facilities adapted for disabled/elderly people (especially women)?

### Privacy and security
- Location and design for privacy and security of water points/latrines and bathing facilities. Safety around water sources, especially if women and children are primary users.
- Do women feel constrained to travel alone in public to the water point/sanitation facilities because of real danger of aggression or social disapproval?
-

### Sanitary habits of women and girls
- What is appropriate to discuss? What types of materials are appropriate to distribute? How are children's faeces dealt with?
- What are the cultural assumptions with regard to water and sanitation activities during pregnancy, menstruation, anal cleaning, etc?

### Cultural issues
- What are the main cultural issues which impact upon women's and men's access to water and sanitation?
- Do men and women share the same latrine (at HH level and Community level)?

### Traditional gender roles and power structure
- How do women perceive themselves in traditional roles and active participation? How much of this can be changed and how much cannot be changed?
- Who decides how much money should be spent on water?


## Suggestions for improving gender awareness

### Community consultation
- Ensure recruitment of men and women on the team.
- Ensure that women are available to talk to women, and men to men, in the assessment (especially when discussing sanitation and personal hygiene).
- Work separately with women's and men's groups, where necessary, to counter exclusion and prejudice related to water, sanitation, and hygiene practices.
- Women and men need to be consulted about convenient times and locations for meetings, and they need time to be given time to reorganise their schedules.
- Involve both men and women in discussions on water and sanitation, including personal hygiene habits, general health, and the needs and fears of children (do not just focus on women).

- Conduct consultations in a secure setting where all individuals (including women and girls) feel safe to provide information and participate in discussion and decision making.
- Include questions on cultural and ethnic beliefs on water usage, responsibilities, and sanitation practices.

### Link to hardware / community training
- Provide 'coaching' advice to engineers and hygiene promoters on how to work with the community and make effective use of women's knowledge of the community.
- Provide formal and on-the-job training for both men and women in construction, operation, and maintenance of all types of water and sanitation facilities, including wells and pumps, water storage, treatment, water quality monitoring, distribution systems, latrines, and bathing facilities.
- Ensure that the training is suited for the specific needs of women (timing, language, educational requisites, etc). The training needs to be especially tailored to the specific requirements of poor women and vulnerable groups.
- Offer training in water management to men (preferably using men to men training), especially for single male-headed HHs in which they have previously relied on women to collect water and to manage the cooking, personal hygiene and domestic needs for the family.
- Work with community groups to expand, operate, and maintain communal facilities, and dispose of liquid and solid wastes.

### Social research
- Through interviews with key informants, try to understand the power and social relations in the target communities. Examine the roles, responsibilities, processes and workloads of children, women, and men, and the rich and the poor, in terms of labour in their homes, hygiene practices, and water use and management.
- Determine how women's and men's participation and skills acquisition influence power dynamics at the HH level. Be aware of possible increases in domestic tensions and provide basic conflict resolution and support where possible.

### Gender sensitisation
- Develop special activities on gender sensitisation for men.
- Target hygiene programmes not only to mothers, but also to fathers and other carers of children.

# WASH HP tools quiz sheet

1.  What is a baseline survey (in the context of an emergency intervention)?

2.  Why is Hygiene Promotion relevant in an emergency?

3.  List four key activities of hygiene promoters.

4.  How might you ensure that the different needs of men and women are met during an emergency?

5.  What does HIF stand for?

6.  List the factors that are important in a WASH response.

7.  What should a hygiene kit contain?

8.  How would you ensure that chlorine solution/sachets are used appropriately?

9.  List three key books/documents that could provide information on how to do Hygiene Promotion.

10. List three key indicators for a Hygiene Promotion programme.

11. List three ways that a WASH cluster coordinator might facilitate the inclusion of Hygiene Promotion in a WASH response.

12. What Hygiene Promotion approaches might be useful in an emergency?

13. How can Hygiene Promotion facilitate accountability in an emergency?

14. How might you ensure that you cater to the needs of disabled men, women, and children in an emergency?

**WASH** | **Hygiene Promotion**

# Evaluation Form

**The orientation** (tick one box for each question)

|  | | 1 | 2 | 3 | 4 | 5 | |
|---|---|---|---|---|---|---|---|
| Pace of the orientation | Too slow | ❑ | ❑ | ❑ | ❑ | ❑ | Too fast |
| Clarity of the content | Confusing | ❑ | ❑ | ❑ | ❑ | ❑ | Clear |
| Level of participation | Too little | ❑ | ❑ | ❑ | ❑ | ❑ | Too much |
| I enjoyed the sessions | Disagree | ❑ | ❑ | ❑ | ❑ | ❑ | Agree |
| I was able to participate | Disagree | ❑ | ❑ | ❑ | ❑ | ❑ | Agree |

**Relevance** (tick one box for each question)

|  | | 1 | 2 | 3 | 4 | 5 | |
|---|---|---|---|---|---|---|---|
| The sessions were relevant to me | Disagree | ❑ | ❑ | ❑ | ❑ | ❑ | Agree |
| I now know more about Hygiene Promotion | Disagree | ❑ | ❑ | ❑ | ❑ | ❑ | Agree |
| In my work I will refer to the tools presented and/or share them with others | Disagree | ❑ | ❑ | ❑ | ❑ | ❑ | Agree |

How would you rate the orientation overall?

0❑      10❑      20❑      30❑      40❑      50❑      60❑      70❑      80❑      90❑      100❑

---

What was the most satisfactory aspect of the orientation?

---

What was the least satisfactory aspect of the orientation?

---

How could any particular sessions have been improved?

---

Other comments?

---

Please use the other side to make any further comments you wish.