IFRC GUIDELINES TO HYGIENE PROMOTION IN EMERGENCIES

A Guidance to Hygiene Promotion in Emergencies

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IFRC

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## **List of Acronyms**

CHS Core Humanitarian Standard

CLTS Community-Led Total Sanitation

ERU Emergency Response Unit

HNS Host National Society

HP Hygiene Promotion

IFRC International Federation of Red Cross and Red Crescent

KAP Knowledge, Attitude and Practices

KII Key Informant Interview

NDRT National Disaster Response Team

NFIs Non-Food Items

NS National Society

PNS Participating National Society

RCRC Red Cross Red Crescent

RDRT Regional Disaster Response Teams

WASH Water, Sanitation and Hygiene

## **List of Figures**

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**NOTE**:

This Hygiene Promotion in Emergencies pack consists of several parts

1. IFRC Guidelines for Hygiene Promotion in Emergencies *(this document)*

* This document has guidance on how to plan and implement hygiene promotion in emergencies with links for further information

1. A short one-page summary of the IFRC Guidelines to Hygiene Promotion in Emergencies

* To give an overview *(as Annex 1.4)*

1. A 6-page summary of the IFRC Guidelines to Hygiene Promotion in Emergencies

* A summary, which describes the outline, with a brief description of all the steps

*(as Annex 1.3)*

1. A training manual to help put these IFRC Hygiene Promotion guidelines for Emergencies into practice; with learning objectives and session plans that can be adapted to the context.

IFRC GUIDELINES TO HYGIENE PROMOTION IN EMERGENCIES

## **Introduction**

The aim of these guidelines is to ensure that all Red Cross (RC) emergency water, sanitation and hygiene (WASH) programmes include effective hygiene promotion (HP), which is relevant to the context. The Red Cross, unlike many organisations is in an unique position of having community based staff and volunteers, and is well-placed to work with the community, which is essential in hygiene promotion. However, experience has shown that during an emergency response the approach generally focuses on ‘delivering’ hygiene promotion in the form of giving messages. These guidelines assist RC staff and volunteers to work systematically, working through all the important steps for planning, implementing and monitoring hygiene promotion, starting with understanding the problem, the barriers and motivators for behaviour change; with the community involved at all stages – listening and working with the affected community, ensuring the response is effective and appropriate to the needs. Although every situation is different, this approach with a clear pathway assists with quality assurance, linking with agreed standards; assuring effective implementation, with monitoring and training appropriate to the needs.

This document is summarised in a short six-page document and there is also a one-page (quick fix) overview document and a training manual with suggested sessions for training on emergency hygiene promotion linked with this document is produced. All these documents and the links to tools, resources and reference material mentioned on the documents is linked and will be available on the IFRC [watsanmissionassistant](http://watsanmissionassistant.wikispaces.com/Software+hygiene+promotion).

## **Who is this document for?**

This document is for all RCRC staff and volunteers responding to an emergency situation; including community-based volunteers, NS staff, NDRTs, RDRTs and ERUs, especially those working in the WASH sector.

The specific target audience are hygiene promoters who may have different levels of experience and capacity for an emergency WASH response. The aim is for these guidelines and training materials to be used by all hygiene promoters in different situations; providing guidance to those with limited experience and also to be of use to those with more experience who may work in situations where experience and judgement are needed to adapt activities for more challenging environments.

## **What is Hygiene Promotion and why is it is important in emergencies?**

|  |
| --- |
| rcrc dEFINITION OF HYGIENE PROMOTION IN EMERGENCY |
| Hygiene promotion (HP) in Emergencies in the Red Cross is defined as: ‘a planned, systematic approach delivered by RCRC community based volunteers to enable people to take action to prevent water, sanitation and hygiene-related diseases by drawing on the affected population’s knowledge and resources and supporting their mobilisation and engagement.’ |

Health of individuals and communities are influenced by many factors, such as the environment, socio-economic situation, health systems and behaviour. It is essential to ensure that everyone has the means to be healthy rather than only focusing on individual behaviour. Ensuring access to water, sanitation and hygiene facilities is part of hygiene promotion, along with influencing attitudes to change behaviour.

The main aim of a WASH intervention is to reduce WASH related disease transmission. Hygiene Promotion is an essential part of a successful WASH intervention.

According to the Centre for Disease Control (CDC)[[1]](#footnote-1):

* “An estimated 801,000 children younger than 5 years of age perish from diarrhoea each year, mostly in developing countries. This amounts to 11% of the 7.6 million deaths of children under the age of five and means that about 2,200 children are dying every day as a result of diarrheal disease. Unsafe drinking water, inadequate availability of water for hygiene, and lack of access to sanitation together contribute to about 88% of deaths from diarrheal diseases.
* Improved water sources reduce diarrhoea morbidity by 21%; improved sanitation reduces diarrhoea morbidity by 37.5%; and the simple act of washing hands at critical times can reduce the number of diarrhoea cases by as much as 35%.”

These figures are not specifically for emergency situations; the numbers are likely to be higher following a disaster. This demonstrates the need to have an integrated emergency WASH programme as part of an emergency response. An emergency situation can impact on health in different ways; water sanitation and hygiene facilities may be limited, e.g. if people are displaced living in temporary shelters, left their homes (e.g. due to conflict, or a natural disaster), the infrastructure is damaged (e.g. following earthquake, floods), there is a lack of resources (e.g. soap), lack of health care facilities, lack of food, lack of shelter, overcrowding etc.; all of which can make the risks for water and sanitation related diseases increase.

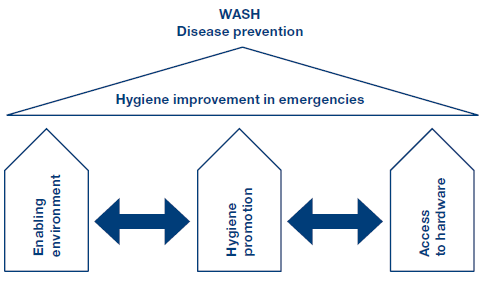
The focus of hygiene promotion is:

* Safe disposal of excreta
* Effective handwashing
* Reducing the contamination of household drinking water

Hygiene Promotion involves ensuring that optimal use is made of the water, sanitation and hygiene facilities that are provided. Previous experience has shown that facilities are frequently not used in an effective and sustainable manner unless Hygiene Promotion is carried out. Access to hardware (e.g. latrines, drinking water and handwashing facilities) combined with an enabling environment and Hygiene Promotion make for hygiene improvement, as shown in the model of the Hygiene Improvement Framework for Emergencies (Figure 1), The overall aim of hygiene improvement is to prevent or lessen the impact of WASH related diseases.

Source: [Hygiene Promotion in Emergencies, WASH cluster briefing paper](http://file/view/HP%20A%20Briefing%20Paper%20JAN%2009%20-%20WASH%20Cluster.pdf/606788307/HP%20A%20Briefing%20Paper%20JAN%2009%20-%20WASH%20Cluster.pdf)

The key point is that the affected population are aware of the key public health risks and are enabled to adopt safe hygiene practices and make the best use of WASH facilities and services (including their operation and maintenance).



**Figure 1: Hygiene Improvement Framework (Source:** [**Sphere Handbook 2011**](http://www.spherehandbook.org/en/water-supply-sanitation-and-hygiene-promotion-wash/)**)**

**Key components of Hygiene Promotion are:**

* Community participation
  + E.g. consult with the affected men, women, and children on the design of the facilities, the hygiene kits and the outreach system, identifying the vulnerable and working with existing community structures
* Use and maintenance of facilities
  + E.g. feedback to the engineers on design and acceptability of facilities, encouraging a sense of ownership and responsibility with a system of cleaning and maintenance
* Selection and distribution of hygiene items
  + E.g. working with the community on the type of hygiene items needed
* Community and individual action
  + Using principles of behaviour change communication, training community based volunteers as Hygiene Promoters, organising community activities such as dramas, and engaging individuals with home visits
* Communication with WASH stakeholders
  + Collaborate with Government, other organisations (both international and national) working in the area, participate in coordination mechanisms, such as the WASH cluster
* Monitoring
  + E.g. the use and the community’s satisfaction to the programme and facilities

For more information on these points refer to the [WASH Cluster Hygiene Promotion briefing paper](http://file/view/HP%20A%20Briefing%20Paper%20JAN%2009%20-%20WASH%20Cluster.pdf/606788307/HP%20A%20Briefing%20Paper%20JAN%2009%20-%20WASH%20Cluster.pdf). All RC WASH programmes should include all these components.

**Principles and Standards**

All RCRC Staff and volunteers involved in hygiene promotion activities need to be familiar and adhere to humanitarian principles and standards, including:

* [The Red Cross fundamental principles](http://www.ifrc.org/who-we-are/vision-and-mission/the-seven-fundamental-principles/)
* [The Red Cross Movement Code of Conduct](http://media.ifrc.org/ifrc/who-we-are/the-movement/code-of-conduct/)
* [The Standards in the Sphere handbook](http://www.spherehandbook.org/en/)
* [The Core Humanitarian Standard](https://corehumanitarianstandard.org/the-standard)
* [Gender in water, sanitation and hygiene promotion- Guidance note](http://watsanmissionassistant.wikispaces.com/file/view/Guidance%20note-Gender%20in%20water%20and%20sanitation-EN_LR.pdf/391531082/Guidance%20note-Gender%20in%20water%20and%20sanitation-EN_LR.pdf)
* [Gender and Diversity in Emergency WASH Programming Standards – Page 23](http://watsanmissionassistant.wikispaces.com/file/view/Gender%20Diversity%20Minimum%20Standard%20Commitments%20in%20Emergency%20Programming.pdf/608022417/Gender%20Diversity%20Minimum%20Standard%20Commitments%20in%20Emergency%20Programming.pdf)
* [Community Engagement and Accountability (CEA)](http://watsanmissionassistant.wikispaces.com/file/view/Tool-24-CEA-brochure.pdf/608027557/Tool-24-CEA-brochure.pdf)
* [Accountability to Beneficiaries (AtB) Minimum Standards in MSM response- BRC](http://watsanmissionassistant.wikispaces.com/file/view/Part%202%20-%20HANDOUT%20AtB%20in%20MSM%20response%20-%20minimum%20standards%202013.pdf/608027859/Part%202%20-%20HANDOUT%20AtB%20in%20MSM%20response%20-%20minimum%20standards%202013.pdf)

**Sphere Handbook**

The main aim of Sphere handbook[[2]](#footnote-2) is to improve the quality of the humanitarian response in situations of disaster and conflict, and to enhance the accountability of the humanitarian system to disaster-affected people.

There are two standards for Hygiene Promotion in the Sphere handbook (2011), which should be used with the key actions and indicators.

**Sphere Standard 1: Hygiene promotion implementation**

Affected men, women and children of all ages are aware of key public health risks and are mobilized to adopt measures to prevent the deterioration in hygienic conditions and to use and maintain the facilities provided.

**Sphere Standard 2: Identification and use of hygiene items**

The disaster-affected population has access to and is involved in identifying and promoting the use of hygiene items to ensure personal hygiene, health, dignity and well-being.

Hygiene Promotion is a means to involve the affected population in the implementation of a Water and Sanitation programme.

As the Sphere handbook states Hygiene Promotion gives the affected community an opportunity to get involved, ensuring that the facilities are appropriate to the risks and the needs and are therefore used appropriately.

Experience has shown that during an emergency response, the RCRC has generally used the ‘campaign approach’, with the emphasis on giving messages with Information Education and Communication (IEC) materials, with the aim of changing behaviour. This approach is not effective if we do not work together with the affected population to understand the problem, the motivators and barriers and to enable the community (individuals, households and the wider community) to address the public health problem together. Just increasing the knowledge of the affected community may not change behaviours and attitudes – they are not empty and ignorant people waiting to have information poured into them.

**Common Pitfalls in Hygiene Promotion[[3]](#footnote-3)**

Several reports, reviews and guidelines have observed a variety of pitfalls in hygiene promotion

* Too much focus on disseminating one-way messages without listening to the perspective of different groups in the population
* Too much focus on designing promotional materials such as posters and leaflets before understanding the problem properly
* Too much focus on personal hygiene and not enough on the use, operation and maintenance of facilities
* Not enough focus on practical actions that people can take and how to communicate these
* Trying to address too many behaviours and audiences at the same time
* Not enough use of motivations such as nurture, disgust and affiliation and the belief that the promise of better health is the key motivator
* Not enough emphasis on listening, discussion and dialogue so that people can clarify issues and work out how to adapt required changes to their specific situation

Community mobilisation is especially appropriate during disasters as the emphasis must be on encouraging people to take action to protect their health. Promotion activities should include, where possible, interactive methods rather than focusing exclusively on the mass dissemination of messages ([Sphere handbook, 2011](http://www.spherehandbook.org/en/water-supply-sanitation-and-hygiene-promotion-wash/)). If the methods are interactive with all of the community (men, women, children, marginalised groups), with the opportunity to share information, discuss and ask questions, there will be more in-depth knowledge about what influences what people think and do.

**Accountability**

It is important to acknowledge that our fundamental accountability must be to those we seek to assist. All RCRC WASH activities must emphasise: providing information, active listening to those affected, respectful attitude and empathy to those who we assist.

The [WASH cluster Accountability Project](http://watsanmissionassistant.wikispaces.com/file/view/wash-accountability-handbook.pdf/353942476/wash-accountability-handbook.pdf) developed some simple tools to help WASH fieldworkers understand the practical aspects of accountability. Accountability is described as having five dimensions:

* Participation
* Transparency
* Feedback and complaints
* Staff Competencies and Attitudes
* Monitoring and Evaluation

The WASH Accountability Checklist lists key activities for both the first acute phase and the second phase/chronic emergency. The Accountability Booklet elaborates on all of the dimensions of accountability.

The WASH Accountability booklet explains that accountability comes in many shapes and forms: upward accountability to e.g. donors, lateral accountability to e.g. government and downward or forward accountability to e.g. beneficiaries.

Forward accountability means you have to:

* Explain and take responsibility for what you do and do not do
* Provide accessible and timely information on your actions and decisions to affected men, women and children
* Ensure on-going dialogue with those affected and invite and seek out feedback and/or complaints
* Identify opportunities to enable those affected by disaster to make decisions about WASH interventions
* Monitor user satisfaction and learn from your work

[WASH Accountability project booklet, page 5](http://watsanmissionassistant.wikispaces.com/file/view/wash-accountability-handbook.pdf/353942476/wash-accountability-handbook.pdf).

The template leaflets in the WASH Accountability project tools can be adapt to provide information to the communities on what they can expect from the Red Cross WASH programme staff and volunteers.

NOTE: the Humanitarian Partnership (HAP) no longer exists, where there are references to this in this WASH Accountability tools – refer to the [Core Humanitarian Standard (CHS)](https://corehumanitarianstandard.org).

[The Core Humanitarian Standard](https://corehumanitarianstandard.org) on Quality and Accountability (CHS) sets out nine Commitments that the Red Cross can use to improve the quality and accountability to communities and people affected by crisis; the CHS places communities and people affected by crisis at the centre of the humanitarian action and promotes respect for their fundamental human rights. It links to the Red Cross fundamental principles of humanity, impartiality, independence and neutrality.

Remember:

* Are we being open and transparent?
* Are we listening to the community?
* Are they participating?
* How are the views of the community being considered?
* Is there an effective feedback mechanism?
* Does the community have adequate information on the response?
* Does the staff recruited have the proper skills and attitudes?
* Identify community groups and social networks at the earliest opportunity and build on community-based and self-help initiatives
* Involve a representative section of community members, including a good representation of women, different ages, ethnicities etc.
* Identify (and consult with) groups with specific needs and vulnerabilities – if needed hold separate meetings with different groups to ensure that everyone has a voice
* Joint identification of public health risks – with local health staff and key informants
* Provide information about each stage in an accessible format and language
* Proactively collect feedback on the design and acceptability of facilities and hygiene promotion from all different user groups and act on it
* In discussions, let nominated representatives from within the community (potentially RC volunteers) facilitate the discussion

**FAQ:**

**Q:** **Is there any evidence that hygiene promotion in emergencies works?**

**A:** Whilst we may lack academic evidence to demonstrate that hygiene promotion in emergencies works (especially in acute emergencies) there is plenty of anecdotal evidence. Hygiene promotion is not just about behaviour change, e.g. getting people to wash hands, it is also about getting people involved and enabling them to take action, and it has been seen that the more people are involved and the programme is led by the community, the more effective it will be.

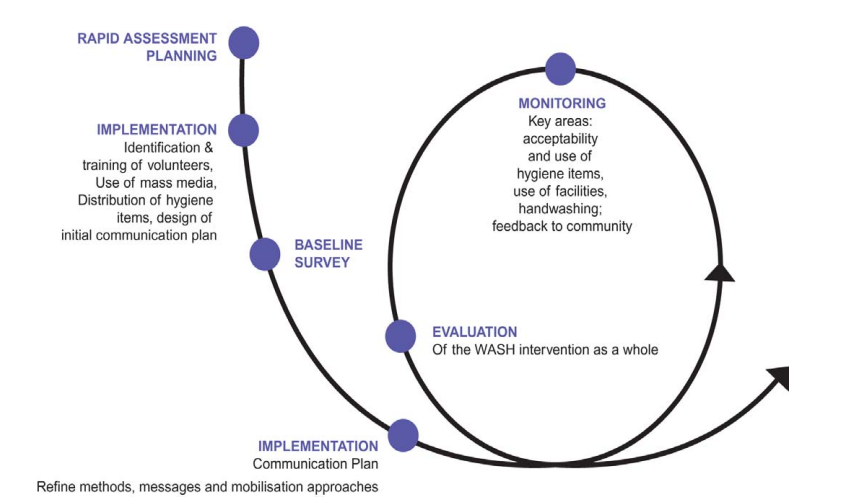
## **How to implement Hygiene Promotion in emergencies?**

To implement an effective hygiene promotion programme, with a focus on safe disposal of excreta, effective hand-washing and reducing the contamination of household drinking water; it is important to be systematic, and make a plan that enables people to take action to prevent water, sanitation and hygiene related diseases, addressing the needs (linked to the impact of the disaster), and also considering the barriers and motivators to behaviour change. This can be challenging in an emergency response, the situation is often confusing and chaotic.

The implementation of the Hygiene Promotion programme follows a circular process, which begins with an assessment and ends with a review. It is iterative process; feedback and lessons learnt must be incorporated to ensure the programme is always appropriate to the needs of the affected people. The intervention process should look like this:

**Figure 2: Hygiene promotion project cycle**

**(Source: WASH Cluster, Hygiene Promotion – A Briefing Paper)**



**8 STEPS FOR HYGIENE PROMOTION IN EMERGENCIES**

In summary, there are 8 steps for hygiene promotion in emergencies for the RCRC.

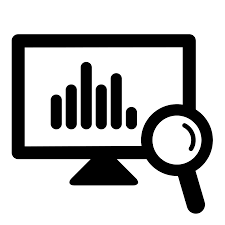
1. Identifying the problem
2. Analysing barriers and motivators for behaviour change
3. Identifying target groups
4. Formulating hygiene behaviour change objectives
5. Planning
6. Implementation
7. Monitoring and evaluation
8. Review, re-adjust

These steps are described in more detail below, with links to approaches and tools.

Although this is described as a process of steps, it is not always a straightforward linear process; the context of emergencies can be very varied; e.g. the scale (e.g. large or small scale), or several emergencies (e.g. one earthquake after another resulting in population movement and the need to re-assess the situation), or those with much higher public health risks. But, what is important is all consideration is given to all the steps and the process is documented.

## 

## **STEP 1: IDENTIFYING THE PROBLEM**

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The aim of the assessment is to understand the situation in order to identify the problem(s), the source of the problem(s) and consequences of the problem(s), the needs and capacities of the affected population. “Whilst good information does not guarantee a good programme, poor information almost certainly guarantees a bad one.”[[4]](#footnote-4)

Although it is an emergency, the assessment should be planned; consider the critical information that is needed, the sources of this information and the data collection methods. An emergency response is often chaotic; coordination can be difficult, if there are lots of organisations, communication can be challenging if the phone network/power supplies are not working. There may be a lack of NS staff and volunteers – they may be affected by the disaster themselves.

An initial rapid assessment is essential in the first couple of days to highlight the priority interventions needed, more information can then be added with a more in-depth assessment.

Once the assessment is done, a baseline survey should be conducted, to document the current situation, (see Step 5).

**Figure 3: Rapid Assessment**

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| **Rapid Assessment**  The objective of an initial rapid assessment is to have a quick overview of the situation, and identify:   * Acute risks and needs associated with water, sanitation and hygiene, for prioritising initial actions * Important physical, health and social resources and conditions that need to be taken into account when designing an initial response * Early baseline data to start a monitoring system * Areas where more detailed assessment is need for a longer-term response * Funding needs | **Challenges**   * It is often difficult, especially in large-scale emergencies to identify the most at-risk and vulnerable groups; coordination and collaboration with other organisations is essential, to ensure there are no gaps and to avoid duplication. Aim to gather information from the most affected areas. * As the initial rapid assessment may target the most vulnerable groups, it is not always possible to generalise this information for all the affected area * The data can quickly become out-dated or irrelevant, particularly in disaster that involves on-going population movement * Rapid assessments may take time to complete, especially in a chaotic environment, so care should be taken not to spend too long on the assessment and delay the implementation to respond to the priority needs. |

**KEY POINTS**

The key points to consider for assessment are:

* Impact of the disaster
* Risks to health
* Current hygiene behaviours and how they have changed as a result of the disaster and which ones can be potentially harmful
* What the community knows, does and understands about water, sanitation and hygiene
* Possible solutions

**WHAT INFORMATION?**

A rapid assessment should provide information about:

* Public Health situation
  + What are the main public health problems or risks and what changes will have the largest impact on public health?
  + What is the water and sanitation related morbidity and mortality?
* Community structure
  + Who are the key stakeholders in the area? E.g. community leaders, other organisations?
  + The main method of communication used by different sectors of the community (e.g. literacy rates, use of radios etc.) and what method would be trusted to promote hygiene?
  + The ways of working with the community; who are the influencers, effective and trusted communication routes and power structures?
* Safe drinking water
  + Whether people have access to safe water: collection point, containers and storage and whether facilities are appropriate and how they are used?
* Safe excreta disposal,
  + Current defaecation practices and changes in practices; access to toilets for everyone (including children) for safe disposal of faeces?
* Handwashing
  + Knowledge and hand washing behaviour, what is being used? Access to soap?
* Hygiene practices, Vector Control, Waste management
  + What people know and do not know about hygiene?
  + Existing good and bad hygiene practices, who and how many people have ‘risky’ practices, who uses ‘safe’ practices and who/what motivates them to use these?
  + What practices can be changed and how change can be supported?
  + What preferences and cultural norms need to be considered when providing WASH facilities?
  + Is there a need for non-food items to improve hygiene and dignity
  + What are the vector-borne risks?
  + How do people dispose of their waste?
* Menstrual Hygiene
  + How are women managing their menstrual hygiene, what are the needs and challenges?
* Priority and vulnerable groups
  + Who are the most vulnerable and/or hard to reach groups?

**HOW?**

The assessment should be done jointly with Hygiene Promoters, WASH engineers and government officials, in collaboration and coordination with the NS, RDRT, ERUs and other stakeholders; e.g. WASH cluster partners and colleagues from other sectors, e.g. Health, Shelter etc. The assessment team should include representatives from the affected community, a balance of men/women, staff/volunteers from the NS – who know, understand and respect the culture of the affected community and have good observational and listening skills. As hygiene promotion combines insider/affected population knowledge (what people know, do and want) with outsider knowledge (e.g. the causes of diarrhoeal diseases), it is essential to involve the affected population.

The assessment should use interactive participatory methods, with all sectors of the community; men, women and children, and different groups of people (not forgetting marginalized, less visible vulnerable groups, including people with disabilities), to gather information, and engage with the community to identify the problem to help them find a solution. The choice of the methods depends on the context, access, resources and timing. It is useful to use a combination of methods, including quantitative data (e.g. number of available latrines per population), and qualitative information (e.g. whether all the people are using the latrines are satisfied with the design, location etc.). It is important not to make assumptions: observe and talk with people.

All data should be disaggregated by age and sex. Gender and other social/cultural factors (including age, disability health status, social status, ethnicity, etc.) shape the extent to which people are vulnerable to, and affected by emergencies. Unless we know who is affected – which women, girls, men, boys; and who among them are the most vulnerable, the emergency response may not be effective.[[5]](#footnote-5) Refer to the [IFRC Minimum standard commitments to gender and diversity in emergency programme](http://watsanmissionassistant.wikispaces.com/file/view/Gender%20Diversity%20Minimum%20Standard%20Commitments%20in%20Emergency%20Programming.pdf/608022417/Gender%20Diversity%20Minimum%20Standard%20Commitments%20in%20Emergency%20Programming.pdf), to ensure that commitments to dignity, access, participation and safety of the affected communities are addressed in the assessment, planning, implementation and monitoring of the WASH programmes.

**Primary and Secondary Data**

Primary data (collected as part of the assessment) must be relevant: e.g. an understanding of hygiene behaviour and changes in behaviour. Do not collect information that is already available – it wastes time, resources and can be annoying to a community that has many needs and feel they are constantly being asked the same questions. Collect secondary data from a variety of sources: the NS (staff and volunteers), WASH cluster, local Government Agencies and local NGOs. Triangulate all the information, comparing and filling in the gaps.

The potential tools and sources of information for assessments are given below, and further information on tools can be found in **Figure 4: Assessment Methods** and in [here](http://watsanmissionassistant.wikispaces.com/file/view/Working%20with%20communities%20-%20complete%20document%20%28IFRC%29.pdf/355683896/Working%20with%20communities%20-%20complete%20document%20%28IFRC%29.pdf). Some of these tools could be combined with the same group of people, e.g. Three-pile sorting with a Focus Group Discussion, depending on the context – people’s time etc. These participatory, interactive methods may not be easy in the early stages of an emergency response, but use these methods as much as possible during the initial assessment, working with the NS and the community.

**Figure 4: Assessment methods**

|  |  |
| --- | --- |
| **Methods** | **Tips for implementation** |
| Existing reports, maps and other secondary data | Able to get an overall panorama of the community in a time- and cost-effective way. Very useful for cross-referencing information and verifying the challenges facing the community and to find the history of what was done.  Verify authenticity and stick to relevant sources! |
| Observation during [transect walks](file:///D:\Users\Mariyam.Asifa\Documents\EHP\123\STEP%201%20Identifying%20the%20problem\Transect%20walk.pdf) | Direct observation through a walk in the community is to find things that may be hard for members of a community to verbalise. But observation is subjective to the observer and interpretation can be biased and information can change quickly in emergencies. |
| Interviews with community members and representatives | Interviews can address and respond to new information about the community. When interviewed on individual basis people may be more open to discuss sensitive issues. |
| Interviews with local authorities, ministries, local and international NGOs, UN agencies, WASH cluster, RC/RC staff and volunteers | Allows the interviewer and the person being interviewed the flexibility to probe for details or discuss issues.  Collect and provide information and establish coordination. |
| Health care facility reports and interviews | Information on surveillance of disease from the community health facilities reports and data will help to target different community sectors and to formulate the hygiene promotion objectives |
| Three pile sorting with different groups, to identify levels of knowledge, perceived good and bad practices; pictures for Three-pile sorting are in the Hygiene Promotion box | Discuss common hygiene practices and explore individual attitudes to them, using pictures (ensure the pictures are appropriate for the context and are understood).  In a large group, some people might not be so open about their attitudes, so keep the group small to allow more honest participation. |
| Focus Group Discussions, with groups of specific groups of people, e.g. women, youth groups etc. | The facilitator’s role in a focus group discussion is to stimulate and support discussion and try to keep focus of the issue. Encourage a discussion, not a ‘question and answer’ meeting. |
| Proportional piling or pocket chart, which can be used to identify which people would be willing to use different types of sanitation, who is openly defecating etc. | Pocket chart voting activity is to discuss preferences or practices within a community.  Before people start voting, make sure everyone have a common understanding of the pictures. |
| Mapping, to identify locations of infrastructure, open defecation areas, areas of flood risk etc.) | Useful for visualizing the resources, services, vulnerabilities and risks in a community and also assists in planning and designing the activities.  The map can be used at a later stage and the community might like to display it, so making it in good quality paper will be a good idea.  Aerial photograph and GPS printouts can be used but in some situation, it might be difficult, expensive and may contain sensitive information. |

[Annex 1.1 -Sample HP in Emergencies Assessment Form](#_Rapid_Assessment_Tools)provides an outline checklist of information to collect and the type of collection sources: this should be adapted to the context

As the data is collected, it should be analysed; comparing information from different sources, checking the information being gathered is relevant and is useful to answer the key questions about the problem, the affected population, the capacities and needs. Analysis is a very vital step that will help to understand the situation and respond more effectively. Do not leave the analysis until the end of the assessment. Triangulate the information, analysing data from different sources with different methods, to check for gaps and inconsistences.

A clear assessment report is essential, this will provide the basis for programme planning and monitoring. **Remember: record it, share it and use it!**

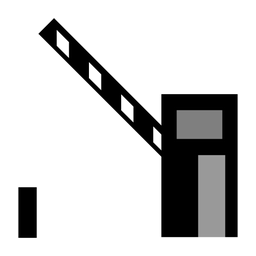
**FAQ**

**Q**: Should the team wait until the assessment is completed before responding?

**A**: No – if there are immediate urgent needs, the response could start; e.g. in a response to a cholera outbreak, the population might need urgent help and information on treating drinking water; BUT – a rapid assessment should always be done; e.g. with a cholera response it will not be effective to give out posters if the population is illiterate, etc.

## 

## **STEP 2: ANALYSING BARRIERS AND MOTIVATORS FOR BEHAVIOUR CHANGE**

In Step 1 the key public health risks and the needs were identified. As part of the hygiene promotion emergency response, understanding people’s behaviour is important; listening and discussing with all sectors of the community is essential in order to understand their behaviours and what motivates these behaviours; these are influenced by the context, their beliefs, values and social pressure. In an emergency context there will be many barriers and constraints.

There are many models that describe the complex issue of behaviour change; linking the influences and the reasons for actions. It is clear that it is more complex to change behaviours than simply giving out information; e.g. telling someone to wash their hands and expecting them to do it. A simple way of approaching behaviour change is to examine the barriers and motivators – they are not always what you think!

During the assessment, the team gathers information about the different motivators that can trigger change in the affected population.

* **Motivators:** anything that would motivate people to practice correct hygiene behaviours. For example: disgust – dirty body and environment; comfort – having clean hands; nurturing – protecting children; affiliation – following what others do; status – being clean can be perceived as affecting position in the community; fear – of being ill.

The assessment should also provide evidence of what stops people taking action by themselves:

* **Barriers:** anything that will hamper people from practicing correct hygiene behaviours; e.g. physical barriers – access to facilities such as soap, water, suitable toilets; social barriers – norms and customs, lack of trust of health works and health information; biological barriers: mental state.
* Is it lack of knowledge (e.g. they may not be familiar with malaria if they are displaced and come from a non-malaria region)?
* Is it a different understanding (e.g. the word diarrhoea might be translated with different meanings)?
* Is it different beliefs (e.g. they may think the baby’s faeces are not infectious)?
* Is it lack of resources (lack of water, soap, clean latrines, etc.)?

The **Figure 5. F-Diagram Disease Transmission Routes** shows the transmission routes of most diarrhoeal diseases and the barriers that prevent people to avoid diarrheal infection.



[Figure 4. The F-Diagram Disease Transmission routes. Source: Hygiene Promotion – A briefing paper by WASH Cluster](http://watsanmissionassistant.wikispaces.com/Software+hygiene+promotion)

The analysis of the factors that prevent the uptake of safe practices should be done with community members and other relevant stakeholders. A barrier chart as shown on **Figure 6** can be used to analyse the barriers and to find the (most easy and most effective) solutions, with the community.

For example: to reduce the diarrhoea in a community the barriers could be identified as ‘not having toilets’, ‘not handwashing at critical times’ and ‘not covering food from flies’. The Barrier Chart helps to find the most easy and effective activities to focus on; but this does not mean the ‘hard to do’ things are forgotten, we should aim to eliminate/reduce all barriers to improve hygiene and health.

**Figure 6. Barrier Chart**

|  |  |  |  |
| --- | --- | --- | --- |
| **Impact on public health** | **Easy to do** | **In-between** | **Hard to do** |
| **Very effective** | Handwashing |  | Building proper toilets |
| **In-between** | Covering food |  |  |
| **Not very effective** |  |  |  |

|  |
| --- |
| barriers to behaviour change |
| Remember that those factors stopping people to behave safely are not always related to lack of knowledge about the theory of germs or disease transmission paths. More often those barriers are related to socio-cultural factors (in some cultures a woman and her father-in-law cannot share the same toilet), religious (specific siting of facilities) or physical (absence of facilities or no access to them).  Assumptions should not be made that people do not have the knowledge, they may understand differently! It is the task of the hygiene promoter to discuss with the community, and analyse how people think, in conjunction with what they know.  Hygiene Promoters should try to reduce the barriers and build on the motivators |

**FAQ**

**Any suggestions?**

## **STEP 3: IDENTIFYING TARGET GROUPS**

## **D:\Users\Mariyam.Asifa\Pictures\Target%20group.jpg**

Before finalising the Hygiene Promotion plan, it is important to identify the target groups who need to be prioritised for each identified objective.

Important considerations must be given to the following.

* Identifying who are most at risk. The beneficiary selection and prioritisation criteria for participation in all WASH activities is informed by a gender and diversity analysis to ensure that the activity reaches the most vulnerable[[6]](#footnote-6)
* Identify who are the influencers (e.g. community and religious leaders) in the affected community.
* Identifying all sections of the affected community, considering their different needs: (including children, older people, people with disabilities) and other stakeholders
* Special emphasis on the needs of babies and young children, as they need different WASH facilities
* Ensuring that often-neglected issues are considered, including menstrual hygiene management for women and adolescents.

The behaviour objectives must be linked to the target groups - specific actions are targeted to different groups within the population.

People’s decision-making depends on the information they have, their ability to participate and engage in the programme. Their full participation may not be achieved at the onset of the emergency, especially in those disasters with high level of destruction, human loss and trauma, but at least some basic level of consultation and information needs to be established from the beginning of the operation. As soon as the situation becomes more stable, the affected community needs to be fully engaged in the planning process, including the selection of behaviour change objectives.

**FAQ**

Q: In an outbreak of cholera everybody in a community is affected, so isn’t it important to target everyone?

A: Yes, in a cholera outbreak, hygiene promotion is important for all the community; but the approach will be different for the different groups - the primary target groups are the members of the household, i.e. the children, parents, grandparents and child caregivers. Each of these groups should be targeted differently – the method to reach them (to provide information and involve) will be different.

The secondary group will be people who have influence, take-action and help (e.g. the local community leaders who can help to spread the information on proper hygiene methods, government).

## **STEP 4: FORMULATING HYGIENE BEHAVIOUR OBJECTIVES**



When setting the objectives, work with the community, the engineers and other key stakeholders (e.g. Government) and consider:

* The risk practices with the most impact on public health?
* Who is the most vulnerable – those most at risk?
* Are there any existing coping mechanisms?
* What capacity does the community have?
* What assistance is being provided by others?
* What are the gaps?

The objectives can be related to hygiene behaviour (such as increasing handwashing practice at key times) or an enabling factor (e.g. availability of handwashing facilities with soap)

Specific Operation & Maintenance (O&M) objectives should be included in the planning (e.g. engaging the affected population in maintenance of toilets and water systems).

The involvement of RCRC Engineers (and other Government technical staff) in charge of WASH construction activities is essential in setting objectives, as facilities are key elements for enabling behaviour change. The entire team should do this step: hygiene promoters and engineers together.

An example of an objective is:

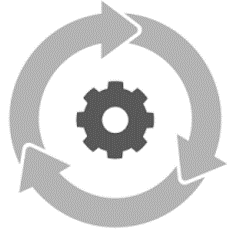
Percentage of men/women and children washing hands at critical times, i.e. before eating, after toilet use and before preparing food. It will be good to link the objectives identified with the objectives given on the [IFRC PoA template](http://watsanmissionassistant.wikispaces.com/file/view/WatSan%20PoA%20Template.docx/356028366/WatSan%20PoA%20Template.docx) and the [WASH activities](http://watsanmissionassistant.wikispaces.com/file/view/WatSan%20PoA%20Template%20%28Outcomes%2C%20Outputs%20and%20Activities%29%20FINAL.docx/552516192/WatSan%20PoA%20Template%20%28Outcomes%2C%20Outputs%20and%20Activities%29%20FINAL.docx) list for emergencies. The objectives and activities chosen may not be the same but it will provide guidance.

**FAQ:**

**Q:** What do you do if you find that knowledge levels are high, but hygiene practices are still unsafe? For example people know how diarrhoea is transmitted, but do not practice handwashing at critical times.

**A:** It is important to find out the root causes. Knowledge is not the same as action. It may due to a lack of resources – e.g. no soap. Has anything altered since the disaster? It may be that men and women may have to share emergency toilets, which may be culturally unacceptable. If information received from the rapid assessment is not enough or clear, then gather additional information using a variety of methods with different groups of people and adjust the hygiene behaviour objectives.

## **STEP 5: PLANNING**



The team implementing the hygiene promotion activities during an emergency response needs a work plan stating the problem, the objectives, activities with methods and tools, resources needed (both financial and human) and a monitoring and evaluation plan.

The plan should not be made in isolation by the hygiene promotion team. This plan is more effective when hygiene promoters work with others; the engineers (who are designing and implementing hardware such as toilets, water and washing facilities), the affected community, local government, other agencies, NS staff, and etc..

It is essential that the Hygiene Promotion plan focuses 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.

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 e.g. if handwashing facilities are provided to make it easier to wash hands. If people feel themselves to be at risk then they are also more likely to change their behaviour quickly. ([WASH Cluster, Hygiene Promotion in Emergencies – a briefing paper](http://file/view/HP%20A%20Briefing%20Paper%20JAN%2009%20-%20WASH%20Cluster.pdf/606788307/HP%20A%20Briefing%20Paper%20JAN%2009%20-%20WASH%20Cluster.pdf)).

The hygiene behaviour objectives are set from the identified problems for the different target groups with the motivators and barriers. These objectives will be the basis of the planning. The approach and methods must be selected to meet these objectives.

Important activities for planning are:

1. **Completing the Logframe, with a monitoring plan**
2. **Preparing and conducting baseline survey**
3. **Recruitment of the Hygiene Promotion Team**
4. **Designing the methods, tools and materials**
5. **Pilot and pre-test the materials and methods**
6. **Completing the Logframe, with a monitoring plan**

The WASH team together should compile an ‘integrated’ (i.e. hardware and software) logframe (Logical Framework) for the Emergency WASH programme as a tool to guide the programme; including the hygiene promotion, the hardware – i.e. the WASH facilities, and any Non-Food Items (NFIs) needed. The logframe should have a goal, outcomes and outputs, which have objectively verifiable indicators with means of verification and a consideration for the flexible projections, i.e. the situation may change. The activities for each output should be listed with the inputs needed. The full list of indicators is given [here](http://watsanmissionassistant.wikispaces.com/file/view/WatSan%20PoA%20Template%20%28Outcomes%2C%20Outputs%20and%20Activities%29%20FINAL.docx/552516192/WatSan%20PoA%20Template%20%28Outcomes%2C%20Outputs%20and%20Activities%29%20FINAL.docx).

A monitoring plan must be made as part of the planning process. The indicators for the basis of the monitoring and should give a clear idea of what changes are needed. The indicators should be: specific, measurable, achievable, relevant and time-bound (SMART). Indicators are linked to the outcomes and outputs – not inputs. The selection of indicators and the ways to measure will change according to the context but each indicator should have a target group. The indicators should be based on the Sphere standards and any national standards, as possible. The monitoring should be done to measure the changes as they happen or fail to happen, so changes to the activities can be taken on time. The monitoring plan can include many different simple tools to monitor so information can be collected by different means.

|  |  |  |
| --- | --- | --- |
| **Example of part of a logframe (**from BRC MSM Handbook)**:** | | |
| **Outcome** | **Indicators** | **Means of Verification** |
| Men, women and children in the target population (x no.) have sufficient access to, and make optimal use of, sanitation and hygiene facilities, and take effective action to protect themselves against threats to public health. | * Areas within X m radius of all dwelling and water points free from observable excreta by end of Phase 1 * X% of target population using sanitary latrines by end of Phase 1 * X% of latrines are clean on spot inspections * X% of the target population washing hands with soap /alternatives by the end of Phase 1 | * Exploratory walk reports * Focus Group Discussions * Information from other organisations * Surveys * Community monitoring tools |

1. **The Baseline survey**

Once the target group and programme plan are agreed a baseline survey needs to be done to establish the current situation and to enable programme impacts to be measured. This will be the starting point of monitoring the hygiene promotion activities and will be repeated as needed to monitor impact (endline survey).

* **Questionnaire design:** The baseline questionnaire is developed based on the indicators. Only include those changes that you are hoping to achieve – each question should be linked directly to an indicator. The questionnaire should be short and simple, based on approximately 10-15 questions. Make sure the questionnaire is translated and checked for accuracy. Triangulate questions with some qualitative data such as observation.
* **Sampling:** A simple random sample is the best approach to use, so every subject in the sampling frame has the same probability of being selected. The sample size can be estimated using free online calculator: <http://www.surveysystem.com/sscalc.htm>. Random sampling requires a sampling frame of the target population, if there is not a complete list of the population, use a sketch map, and allocate areas of similar size to a pair of interviewers working together (it is preferable for interviewers to work in pairs). For more information and guidance on sampling, refer to [the IFRC ERU-MSM sampling document](http://watsanmissionassistant.wikispaces.com/file/view/Guidance%20notes%20on%20sampling%20_ERU%20MSM%20-%20IFRC.pdf/355686040/Guidance%20notes%20on%20sampling%20_ERU%20MSM%20-%20IFRC.pdf).
* **Survey implementation:** Working with the NS to get access to the community, including informing the community and gaining consent, with permission from authorities/armed groups. Ensure the logistics is organised, and security is considered. Make sure you are not putting the volunteers or target population at risk by involving them in the survey. Questionnaires should be anonymous. Ensure the team is trained and they are involved and understand the process. Think about whom you want to question in each household – household head, caregiver or women 15 – 49 years? Pilot the survey to ensure the questions are clear, appropriate and the sampling method works. Record the methods used, so the endline survey repeats the same methods. Document the results and feedback to the team, the users (e.g. WASH team, NS other organisations) and the affected population.

1. **Recruitment of the Hygiene Promotion Team**

Identifying appropriate Hygiene Promotion staff and volunteers is important for an effective hygiene promotion programme. The existing system of NS volunteers may be adequate, but it is likely to respond to an emergency, the team will need to be expanded, depending on the context. The structure of the Hygiene Promotion team will depend on the context, such as the size of the emergency, the capacity, the needs, the risks, the presence of ERU teams. One model is:

* a Hygiene Promotion Coordinator, (this may be an ERU delegate, or someone from the NS)
* who manages a team of Hygiene Promoters
* who work with community level volunteers: ‘Community mobilisers / Outreach Workers’ from the affected community
* with community committees such as WASH committees

The numbers of staff and volunteers at each level would depend on the context; e.g. if there are high numbers of population with many risks, more volunteers would be needed at community level. The Sphere handbook suggests 2 community level hygiene promoters/mobilisers at community level per 1000 members of the affected population, who may work in pairs. Depending on the logistics and geographic spread of the population one Hygiene Promoter may supervise 10 community level volunteers, with a Hygiene Promoter providing the overall support, supervision and coordination.

The issue of remuneration and incentives for staff and volunteers should be agreed before the recruitment and selection of the team. This should be led by the NS, with other key stakeholders such as ERU delegates, and in coordination with other organisations working in the areas.

There should be clear job descriptions established before the recruitment for all the staff and volunteers, organised by/with the NS, which should be agreed with all the stakeholders. The job descriptions should include lists of key skills and competencies, and may need translation if working in a context where different languages are spoken, e.g. refugees from another country.

In an emergency response, it can be challenging to get the ideal qualified staff and volunteers from the NS local branches. When selecting staff and volunteers for Hygiene Promotion team. When selecting Hygiene Promotion staff and volunteers, consider:

* Security (will they be safe to work in the area),
* Access (will the volunteers have access to the different community groups),
* Ethnicity (ensuring the staff and volunteers are representative of the community they are working with),
* Age (older people often command more respect),
* Gender (some communities it will not be acceptable for men to work as a Hygiene Promoter with groups of women, and they will not be able to discuss topics such as menstruation with women)
* Communication skills (emphasis must be given on those with good communication skills, who are respected and can easily engage with the affected community)
* Existing skills (volunteers working in long term WASH programmes may have strong mobilization and engaging skills; they are often familiar with NS Hygiene Promotion methods; e.g. PHAST)
* Existing networks of people who could be engaged – either as hygiene promoters (e.g. MoH staff or teachers) or as community outreach (e.g. women’s groups, clubs and committees)
* Previous experience and training (volunteers trained in emergency response (e.g. NDRT members) may have the quick and flexible mindset required for a quick a response)

General IFRC guidelines on Volunteer and Youth engagement can be found [here](http://watsanmissionassistant.wikispaces.com/file/view/Volunteer%20Management%20%28IFRC%20Toolbox%29.pdf/356652642/Volunteer%20Management%20%28IFRC%20Toolbox%29.pdf)

All staff and volunteers should have contracts, with their terms and conditions and copies of key documents such as the Principles of the Red Cross (in the appropriate language).

A schedule of training should be made and agreed as part of the planning process (see Step 6: Implementation)

1. **Designing the Hygiene Promotion methods, tools and materials**

**SELECTING THE APPROACH AND METHODS**  
It is important to select the most suitable approach and methods for Hygiene Promotion; ensuring they are the most appropriate for the community, context and the hardware facilities. It is essential that the approach focuses on ‘enabling the community’, helping them to agree on community actions and facilitating the implementation of the actions; rather than simply ‘we are doing hygiene promotion’ which often translates into teams of hygiene promoters telling communities what to do, or educating others with standard messages, acting as if they know better; this approach is rarely effective.

**Key points to consider for planning methods to promote hygiene**

* Ensure the methods for hygiene promotion **respond to the hygiene behaviour objectives,** the overall aim, and the context, based on the risks identified in the assessment
* Ensure the methods consider **the barriers and the motivators appropriate to the context,** based on the findings of the assessment, aim at encouraging healthy behaviours
* Use a **combination of methods** with different type of communication tools that can be used for different purposes (increasing awareness, sharing knowledge, influencing & inspiring others, make decisions, etc.).
* **Focus on the target group.**
  + When designing the methods, tools and materials, focus on the target group, involve the community in choosing the most appropriate methods and tools for their situation
  + Consider the public health risks, and chose the methods appropriate for the different target groups. For example, children under five years of age, who are more at risk for diarrheal disease, involve their mothers and caregivers to focus on proper hand washing at key times (e.g. after using a toilet, before feeding a child) but also involve children in interactive activities, (such as games, puppets, clowns, dramas), to promote action such as hand washing. Games such as Snakes and Ladders board game are popular with children (going ‘down the snake’ for problems – e.g. open defaecation or ‘up the ladder’ for good behaviour, e.g. knows the key times to wash hands). People follow what they like or they are part of rather than what they hear.
* **Focus on participatory methods**
  + Not all methods for hygiene promotion require the use of ‘hygiene messages’. Participatory techniques, for example three-pile sorting, are focused on creating debate rather than simply passing on a message. The aim is to identify problems and agree on potential solutions that require community action, by working with the community.
* **Choose an appropriate channel for communication**
  + Through a trusted channel; are there particular people (gatekeepers/influencers) or channels which people do and do not trust – this may be specific to the information/activity
  + Reaching the audience in the planned setting;for example, the majority of households may have radios, but they may be only used by certain family members.
  + Tailored to the target group, e.g. for children in schools - use something that is suitable to them such as puppets or dramas.
  + Culturally appropriate in this context. In some contexts, dancing and singing are acceptable; in others they are not appropriate.
  + Enjoyable / Participatory:people should enjoy the activity and feel involved, are able to discuss the information, so that it is two-way communication – not simply passing on messages.
* **Choose an appropriate location**
  + Schools, youth groups for young children
  + Community central areas for group meetings
  + Quiet areas for Focus group discussions
* **Work with the engineers to ensure that the hygiene promotion methods link with the hardware**
  + With the engineers, work with community groups such as WASH committees to strengthen and promote the community engagement (e.g. maintenance of facilities), ownership and sustainability.

The list of methods for rapid assessments in Step 1 can all be used for promoting hygiene.

There are a wide range of hygiene promotion methodologies which are split here into five groups:

|  |  |
| --- | --- |
| **Mass communication through the media** (TV, radio, SMS, social media, leaflets, etc.) | Think about who has access to the media used and what groups will be reached. Mass communication may be helpful in the early stages of the response, but there needs to be more emphasis on working with the community as a two-way process. Include some interaction, e.g. ‘phone-ins’ with questions on radio programmes. Some good examples of using mass media in emergency hygiene promotion are given [here.](https://watsanmissionassistant.wikispaces.com/file/view/fs_mass_media.pdf/355041196/fs_mass_media.pdf) |
| **Community activities** (e.g. drama/mime, songs, storytelling etc., focusing on key hygiene practices such as hand washing. Activities specifically for children, e.g. puppet shows, clowns, games etc. | Teams from the community are trained to put on shows in a small number of communities. Also short shows with music and songs to be sung together. More ideas can be found [here.](https://watsanmissionassistant.wikispaces.com/file/view/fs_mass_media.pdf/355041196/fs_mass_media.pdf) |
| **Group activities** (e.g., visual aids, such as posters and flip charts, F-diagram/diarrhoea transmission, community mapping, three-pile sorting, pocket chart voting, board games; all linked with discussions | Trained hygiene promoters and community mobilisers work with groups of varying types and sizes, depending on the activity and the context. Most of these are taken from the PHAST and CLTS toolkits (see below for information on PHAST and CLTS), but need to be adapted to the emergency context; i.e. the process should be quicker |
| **Identify and work through community ‘champions’** | Families/individuals which are influential in the community and whose positive hygiene behaviours can be taken as examples by other community members. These community ‘champions’ can be used to promote positive behaviours and be involved in promotion activities. |
| **Personal communication:**  home visits, group discussions | Working with volunteers (e.g. NS volunteers), community mobilisers, community leaders, religious leaders etc. |

**Existing/current methodologies used by the NS**

It may be easier to adapt the Hygiene Promotion methodologies, which are known and used by the NS and the local Health Authorities. The advantage of adapting these methods are that the volunteers/NS will have the knowledge of the methodologies (minimising the need for training for the volunteers) and they are able to use the existing hygiene promotion materials (adapted to the culture of the community) and the activities can be started quickly (less time needed to pre-test). However, normally these methods use a long process, which is not suitable in an emergency when the response needs to be fast; so the tools need adapting.

* [CLTS:](https://watsanmissionassistant.wikispaces.com/file/detail/FRC+-+CLTS+Field+Guideline.pdf) Community Led Total Sanitation (CLTS) is an approach widely used by many NSs to eliminate open defecation by triggering shock of the ‘disgust’ in rural communities. It is the government policy of many countries in Asia and Africa and the NSs use it. The initial aim of CLTS of shocking people into action may not be relevant or useful in the aftermath of a disaster. Similarly, negative images and ideas should be used with caution especially if practices were good prior to the disaster and the main barriers are linked to lack of services.
* [PHAST:](https://watsanmissionassistant.wikispaces.com/PHAST) The Participatory Hygiene and Sanitation Transformation (PHAST) approach aims to improve hygiene behaviours to reduce diarrheal disease and encouraging effective community management of water and sanitation services The principle of the approach is the participation of communities in their own projects, empowering and engaging them in the decision-making about the services they need and want to improve or maintain. PHAST tools can be adapted for use in the assessment and as participatory group activities during implementation. Community Action Plans could be a useful tool to get a community to work together to take action to improve their situation.

**Sharing information with the affected community: Don’t disseminate – communicate!**

Mass dissemination of information with messages will largely be ineffective. Two-way communication will be more effective, working with the community, giving them the opportunity to be involved and to discuss. **Combine messages with participatory activities**, including practical information to enable the affected community to take some action to address the health risks.

**Messages should be:**

|  |
| --- |
| Image result for icon for simple**Simple:** use simple wording and use words commonly used in the local language/dialect so people can understand. Remember what you say can make a different on how you say it. Do not overload people with too much information at one time, depending on the context and the circumstances, there is only so much information people can store and digest, especially if it is new information and they are in what is likely to be a traumatic emergency situation. |
| http://wiki.guildwars2.com/images/c/c6/Tailor_tango_icon_200px.png**Tailored:** to both the cultural context and the actual hygiene problems; you need to use messages that beneficiaries will not find offensive or insulting; hygiene issues may be very specific. Information needs to be tailored for each stage of the response and developed in parallel to development of hardware. |
| http://landsker.co.uk/wp-content/uploads/2014/03/planning-feasibility.png**Feasible:** the messages and the changes you want to trigger need to be feasible. For instance, it would be pointless to encourage beneficiaries to practice hand washing with soap if you find out that there is no soap available. |
| http://hydrive-engineering.de/wordpress/wp-content/uploads/2013/06/test-icon1.png**Accurate and Consistent:** Provide people with consistent information. Collaborate and coordinate with other organisations, Health Authorities etc. to ensure there are no potential discrepancies. |
| http://personaltrainer.ebhasin.com/images/icons/motivation.png**Contain a mix of information and emotional motivators:** Linking to an emotional motivator can lead to a higher impact than information based messages which people may already be aware of. CLTS has some strong emotional motivators around disgust and shame which can be adapted. Messages can bring in ideas of conforming with social norms and emphasizing the benefits of convenience, comfort and privacy. |

1. **Pilot and pre-test the materials and methods**

Once the methodologies to be used are agreed; prepare the staff/volunteers and the materials, for example: recordings for radio shows, printed images, props for dramas, equipment for games, photos for pocket chart voting etc.

It is important to pilot and pre-test each activity to check they are clear and understood; this could be done with a small group before using it more widely. Involve the community in the pre-testing (e.g. radio show, songs, group activity) followed by a group discussion (and/or several semi structured interviews) to help identify the following points:

* **comprehension (visual and aural):** Any misunderstandings or unintended impacts should be identified. E.g. aspects of scales in drawings – a picture of a large fly may be irrelevant to some people if they do not understand scale.
* **recall of the key points:** Is the activity memorable? People must be able to remember and rephrase the information or what they understood from the activity
* **action triggers:** Are activities likely to trigger any kind of action? Ask the group what they would do or change following the pre-testing
* **presence of sensitive or controversial elements:** Discuss with the community members to ensure the wording or pictures are not offensive or misleading to them.

The information gathered during the pre-testing should be used to amend the activities. Ensure there is flexibility in the budget for additional preparation of material as the pre-tests may identify changes needed and the situation and needs may change rapidly.

**FAQ:**

**Q: There are so many methods, which methods work best?**

**A:** The selection of the method needs to match the target group and the need; there is no ‘best method’, as some will work best with some groups and some contexts than others. Some methods work very well with children, and others are better for adults. An ideal is to have a selection of methods, with some interaction with the community. Pre-test the methods to see how they work.

**FAQ:**

**Q: How do I practically pre-test?**

A: You should select a small group of intended recipients of your methodology and implement, as it would be a real session. Prepare in advance some guiding questions to be asked to the beneficiaries regarding comprehension and controversial elements. Ask the questions as if in a focus groups discussion and note answers. Don’t forget to probe and to include different groups in the pre-testing since they might have some different perceptions.

## **STEP 6: IMPLEMENTATION**

As it is an emergency response, the implementation needs to start quickly, as soon as all the key stakeholders agree the plans. Pre-tests of materials and methods may lead to some adjustments and adaptations, working with the affected community to ensure that they are realistic and appropriate.

**REMEMBER: the focus of hygiene promotion is:**

* Safe disposal of excreta
* Effective handwashing
* Reducing the contamination of household drinking water

Linking with the **Hygiene Improvement Framework (Figure 1),** key points to consider when implementing an emergency hygiene promotion programme are[[7]](#footnote-7):

**Enabling environment**

* Security Human Rights frameworks and existing policy and legislation
* Government leadership and support
* Appropriate siting of camps/settlements/facilities
* Co-ordination between WASH agencies and other sectors
* Donor support
* Recognition of importance of gender/HIV/AIDS marginalised groups
* Access to health care, availability and access to food, shelter and other requirements for health
* Affected community informed of their entitlements

**Hygiene Promotion**

* Community/social/individual mobilisation using participatory methods and mass media
* Feedback on design/siting of facilities
* Selection/distribution/information on hygiene kits
* Community organisation
* Community management of facilities

**Access to hardware**

* Water systems: water quality and quantity
* Toilets
* Drainage
* Rubbish disposal facilities
* Household level technologies e.g. water containers, water filters, soap (contents of hygiene kits),
* Handwashing facilities
* ORS
* Insecticide treated mosquito nets (ITNs)

**Training of the Hygiene Promotion team**

Although it is an emergency, and there will be pressure to respond quickly; all staff and volunteers should have some basic training on how to work/volunteer for the Red Cross; this includes knowledge, understanding and how to put into practice the Red Cross Fundamental Principles, Code of Conduct and humanitarian standards. If staff/volunteers are newly recruited in response to the emergency, they should receive the short but enough relevant training.

As it is an emergency, it is not realistic to start with a long training programme; start with a couple of days covering the essential points and build on the kills with additional training sessions. The training should be very contextualised, and practical, building on the existing knowledge and skills and focusing on the needs. All the staff and volunteers should know the objective of hygiene promotion. In summary:

* **Hygiene promoters:** should know how to plan and implement a hygiene promotion programme, with a monitoring system, selecting appropriate methodologies for effective hygiene promotion with community engagement, including an accountability and feedback mechanism.
* **Hygiene Promotion community level volunteers**, **‘Community mobilisers / Outreach Workers’**: should know how to implement the selected methodologies, ensuring the community are able to make the best use of the water and sanitation facilities, that action is taken to prevent diarrhoea and other water and sanitation related diseases.

Depending on the context, the Hygiene Promoter coordinator would start by training/refresher training the Hygiene Promoters and the training would cascade down to the Community Mobilisers and the community groups, such as WASH committees.

The Trainer’s Manual (in this IFRC Guidelines to Hygiene Promotion in Emergencies pack) is divided into three parts.

* Part 1- overview on how to implement HP in emergencies according to this new guidelines.
* Part 2- how to train new volunteers and staff on Hygiene Promotion in emergencies.
* Part 3- additional skills on facilitation and conducting training for experienced and Hygiene Promoter at supervisors level.

The WASH Cluster has a set of training materials (with a Visual Aids library) that can be used for training a Hygiene Promotion team adapting to the context as needed. These training materials are available on the [WASH Cluster website.](http://washcluster.net/training-resources/)

**Managing the hygiene promotion team**

As with all the team, it is important that all the staff and volunteers are well managed – that they are clear of their role are able to follow their job description and they are not overloaded with work, it is likely the staff and the volunteers will be affected by the emergency themselves.

The Hygiene Promotion team should be easily identified, with T-shirts, caps, or aprons, and should all have name badges to assist with accountability.

There should be an accountability system, set up after discussing with the affected community, so it is suitable to the context. A notice board with description of what the RC WASH team is doing, the staff, the programme, the activities etc., and where the community can go to get further information and how they can give feedback – such as a message box, if that is suitable (people can write, have paper and pens etc.). The Hygiene Promotion Coordinator should set up a system of managing the feedback, so it is acted upon and information is fed back to the affected community.

**Hygiene Promotion with the Community**

The selection of methods is discussed above in Step 5: Planning. Remember to ensure the methods are appropriate to the needs and the context. Use a combination of methods, with as much focus on interaction as possible, with community engagement, not forgetting the emphasis is to enable to affected community are able to take action to prevent water, sanitation and hygiene related diseases.

Collaborate with the engineers, so they are part of the hygiene promotion activities in the community.

**Using the Hygiene Promotion Box**

The Hygiene Promotion box is a box (or set of boxes) with a selection of items that are useful for hygiene promoters to rapidly start hygiene promotion activities immediately after a disaster. The IFRC box contains useful items that may not be instantly easily available including stationary, coloured paper, scissors, paints, a basic laminator, camera, megaphone, sets of pictures (3 sets adapted for different regions), and a sewing kit for making puppets, a full list is [here](http://watsanmissionassistant.wikispaces.com/Software+hygiene+promotion#IEC). Many NS and the MSM ERUs have made their own context specific HP boxes.

**Choose an appropriate setting and timing**

The setting will depend upon the target population and methodology. When choosing a setting consider; the most appropriate way, time and place to reach the different groups/community members, where they are able to participate in the activity and discuss. Work with teachers to include some activities for children in schools, and youth clubs. Depending on the context, it may be appropriate to have community discussions/activities where groups gather such as water points. Include some hygiene promotion in conjunction with distribution of hygiene items. Think about the other demands on the time of the target population and when people are likely to be most receptive.

**Contracts and Scheduling for mass media**

Mass media can be used to maximise the reach of the program in the first few days after the disaster. The frequency of mass media will depend on the necessity (for example if access to communities are not easy) and the budget. The contracts with TV and Radio stations can done with the assistance from the NS. It is important to co-ordinate with other WASH implementers to ensure consistency of message etc. But it will be better to have the TV or radio programmes done separately from other organizations to avoid other messages being attributed to the RCRC Movement.

**ORS Preparation**

Despite the efforts of the hygiene promoters to reduce the diarrheal cases in an emergency, there will be children and adults having diarrhoea. ORT is a proven life-saving intervention to prevent dehydration caused by diarrhoeal disease, including cholera. As hygiene promoters have close contact with the communities, they should be able to provide information on the importance of oral rehydration treatment (ORT) and how to prepare oral rehydration solution (ORS). This should be done in collaboration with the local health authorities and any health workers working in the community.

**Working together with engineers and others**

The hygiene promoters are part of a wider WASH team, and this team should work together and not in parallel. The team should have regular team meetings.

Support to the siting, design, operation and maintenance of WASH facilities – the hardware

Hygiene promoters should work hand in hand with RCRC Engineers and local Government staff involved in the construction of WASH facilities to ensure that the response is appropriate to the needs of the affected population and they are able to make the best use of facilities provided. The construction and promotional activities need to be connected; e.g. there is no point constructing a latrine that is technically sound but in the views of the population inappropriate for their use – perhaps in an unsafe location or not the type of toilet they are accustomed to. Hygiene promoters are responsible for translating people’s preferences, desires and aspirations related to the design and siting of WASH facilities to the engineers. The hygiene promotion team should facilitate discussions with all sections of the community: men, women, children and disabled to ensure that their views are heard concerning the design and siting of all WASH facilities; for example, are laundry facilities for washing clothes are at the correct height, are children able to reach the tap stands, is there provision for sanitation for children?

All sections of the community should be involved in testing the facilities to see they are appropriate, and working with the engineers if changes are needed.

Plans should be made for operation and maintenance. Depending on the context, the Hygiene Team can help establish WASH committees who could be responsible for the maintenance of facilities, such as water pumps, tap stands etc.

The Hygiene Promotion team works with the Engineers to ensure there is:

* Acceptability – are the facilities in line with local preferences and norms; e.g. the type of toilets, provision for anal cleansing.
* Accessibility – for all sections of the community; certain disabilities may need access to adapted toilet, provision needs to be made for sanitation for infants and young children
* Security – the risks of sexual and gender based violence can increase significantly after a disaster; discuss with the community, ask are there any concerns, check there is sufficient lighting near the toilets, are there locks on toilet doors
* Inclusion - existing divisions and power structures may become more pronounced post disaster; are there ethnic groups that are being marginalised?

Access to safe drinking water

Hygiene promoters might also work in collaboration with the engineers for ensuring the population has access to safe water. Depending on the context, if needed - the hygiene team will promote household water treatment at community and household level, supporting the RCRC Engineers in conducting training with the community of water treatment products; and doing follow up to ensure the community are using any water treatment products correctly and the water is safe for drinking, ensuring it is safely stored at household level, in clean containers.

Access to appropriate hygiene items: Relief distribution

Relief distribution in the RCRC is usually done by the Emergency Relief Teams. Hygiene promoters do not conduct massive distribution of hygiene related items (hygiene kits, soap, buckets, etc.), but they might get involved in small-scale distribution as part of training, demonstration or promotional activities. If major gaps are identified in terms of access to essential items (soap, buckets, menstrual hygiene materials), this needs to be reported to the Relief Teams operating within the NS and / or IFRC Operation. Hygiene Promoters however have an important role to play ensuring that all members of the community (men, women & children) get hygiene items that are appropriate to their needs; they should be helping with the critical link between listening to the community and communicating with the relief teams. They should also be assisting with information exchange between the Relief Team and the community, e.g. providing feedback from the community after hygiene kit distributions. The hygiene promoters should be involved with information about the hygiene items, ensuring all the community are aware about their entitlements; and information and messages about the hygiene items are appropriate.

**Menstrual hygiene management**

This is important and should not be forgotten. The role of the hygiene promoter is to discuss with the women to find out what common practices exist, their preferences and current resources for menstrual hygiene; and use that information to influence the design of family kits (also called dignity kits, menstruation kits, women kits, etc.).

**Cash Transfer Programming**

There is a trend for cash transfer programming instead of traditional distribution of materials to the affected population. The Hygiene promoters work will still be very important; it is essential to consult with the communities to understand their needs and preferences and if a cash/voucher system would work for them, ensure the people understand the process and monitor how they make decisions (e.g.: buying necessary hygiene items for family) to reduce their exposure to the public health risks in disasters and follow the correct usage of the items. For example; if cash transfer programming is used for acquiring sanitation facilities for community, the hygiene promoters can do the community mobilization to ensure the project follows the specifications from the engineers and check if things are going on track. Or if cash vouchers are distributed instead of Hygiene kits, the hygiene promoters can monitor the system, which hygiene items people are buying and getting feedback from them, if they don’t the items, discussion their reasons.

**Coordination and communication with all key stakeholders**

Other considerations that should be considered when implementing hygiene promotion plans include ensuring there is good coordination with all the key stakeholders

* The hygiene promotion sub-groups within the WASH cluster may provide the links to other partners working in the sector and may also set up technical recommendations that will need to be considered.
* Other agencies responding with hygiene promotion activities may also share resources and ideas. Coordinating with them is essential to avoid duplication: coordinate, share and learn!
* The affected community may have resources available to support the activities. The NS may have resources available – e.g. do they have a HP box, IEC materials or toolkits? The Government might also have their own standards (e.g. National Polices may state a specific approach to use).

**FAQ - suggestions**

**Q**: **How do we make ORS?**

**A**: If you have ORS sachets, follow the instructions on the packet. It is a simple process of dissolving the content in the sachet in the quantity of clean water in the instructions (normally it is 1 sachet to 1 litre of water).

In 2006, WHO published new guidelines for ORS. In emergencies, if the ORS sachets (which follows WHO recommended contents) are not available then home-made ORS can be given. The formula widely used for homemade ORS is 8 level teaspoons sugar, ½ teaspoon salt and 1 litre of clean safe water. More information on ORS can be found [here](file:///D:\Users\Mariyam.Asifa\Documents\EHP\123\STEP%206%20Implemention%20of%20activities\ORS%20instructions.doc).

Ensure whatever type of ORS is being used, the community understand and can demonstrate how to use ORS. It can get confusing if packets are in unfamiliar languages, or the amounts of water needed are different.

## **STEP 7: MONITORING AND EVALUATION**

**Monitoring** is important to demonstrate progress - whether the objectives are being achieved and feedback is heard and acted upon. All the team (including the engineers) should be involved and must understand the monitoring process; this should be part of the training programme for the community-based volunteers.

Involve the affected population in the monitoring; not only in the collecting of the information, but also they should be involved in the analysis to help ensure the programme is appropriate to their needs – they will know best what has happened and why and by including all sectors of the population, it will help empower them to have to more control and ownership of the programme.

The indicators in the logframe should be used, ensuring they link with the [WASH Indicators.](https://watsanmissionassistant.wikispaces.com/Assessment+Tools) The team needs to monitor the progress and impact of the hygiene promotion programme. This is to identify trends, e.g. latrine usage; and the need for re-adapting activities and approaches. A critical question to ask is whether all sections of the community (men, women, children, disabled etc.,) are satisfied with the WASH facilities, and are using them.

Methods for monitoring include:

* Transect walks, observations, talking with the affected community
* Focus group discussions
* Observations with basic tally sheets
* Pocket chart voting
* Mapping
* Community meetings
* Team meetings

Regular reports and updates of the monitoring information should be compiled and shared; the information should be discussed and analysed, for example – considering not only whether the objectives are being achieved, but also, whether they are the correct objects related to the needs. The timing and frequency of the monitoring will depend on the context; e.g. the scale of the emergency.

Monitoring should not only focus on quantitative indicators (such as numbers of latrines), but should also include qualitative indicators (with feedback from the affected population, whether all sectors of the community are using the latrines and are satisfied with them). Monitoring forms, which can be adapted, are provided [in Annex](https://watsanmissionassistant.wikispaces.com/file/view/M%20and%20E%20guide%20-%20Revised%20version%20Final%20Draft%20%28IFRC%29.pdf/356022586/M%20and%20E%20guide%20-%20Revised%20version%20Final%20Draft%20%28IFRC%29.pdf) 1.2. One team member should be responsible for collating, recording and sharing all the monitoring data.

**Evaluation**

The main aim of an evaluation is to make a judgement on the value of the activities and their results. Has the programme made a different, has it helped saved lives, and alleviate suffering?

There are two main purposes of evaluations – those which focus on learning (documenting lessons learnt) and those which focus on accountability (reporting to others what has been achieved. There are numerous types of evaluations that can be used, depending on the need and the context, (e.g. a Real time evaluation during the implantation of the programme). Evaluations could be conducted internally or by an external team. Depending on the context and size of the programme, there may be an evaluation of only the WASH programme or it might be an evaluation of the wider programme.

Key criteria that are generally used for evaluation humanitarian action are[[8]](#footnote-8):

* Relevance/appropriateness
* Effectiveness
* Connectedness
* Coherence
* Coverage
* Efficiency
* Impact

The logframe will form the basis of the evaluation, considering the inputs (whether the resources were used), the activities (what was done), the outputs (what was delivered), outcomes (what was achieved), and impact (the long-term changes).

Both quantitative and qualitative data should be gathered as part of the final evaluation. As described in Step 5, a Baseline Survey should be conducted at the beginning of the programme. Using the same methodology and the same questions, an endline survey should be done as part of the evaluation, to assess changes. If a baseline survey is not conducted and there is no proper monitoring framework, impact can become very difficult to prove and measure.

The evaluation should be document, with a short, clear report and shared with all the stakeholders, and most importantly, it must be used.

**FAQ:**

**Q: How can I involve the community it monitoring?**

**A:** We are accountable to the affected population, it is their programme, so it is important we listen to their views. Monitoring the programme, the processes, and outcomes aims to understand what effect the programme has had on those affected, as they themselves see it. The community knows best what has happened and why, and by involving them they are empowered to have more control over the programme. However, it may be difficult for the community to be objective and they may lack skills and knowledge to carry out monitoring. But, there are several ways to get the different sectors of the community involved (men, women and children); such as observations, feedback on results and interpretation in community meeting, keeping simple tally sheets, pocket chart voting, mapping, water testing etc. The community level volunteers, who come from the affected community can play a key role in monitoring.

## **STEP 8: REVIEW, RE-ADJUST**



The process is iterative, as in every project cycle where you will go back to your initial assumption and strategy to re-steer your intervention to make it more effective and efficient.

Remember to ensure the hygiene promotion programme is relevant to the needs. Emergency situations are often complex, with frequent changes in the situation. Continuous assessment, re-planning and re-adjustment of activities are essential. Look around! Are there other WASH problems in the affected community that have not been addressed? Has the problem changed? Have new problems arisen? If so, go back to Step 1 and begin again. [Annex 1.3 IFRC Guidelines to Hygiene Promotion in Emergencies quick fix](#_1.3_IFRC_Guidelines) provides a Step by Step guide to the HP in emergencies with main activities involved and links for additional information.

**Documentation and Handing over**

It is important that the response includes ERUs, it is done in collaboration with the NS (e.g. in large emergency with RDRT and ERU teams, they should all work with the NS, helping to strengthen their capacity as needed); all the work should be documented and shared with the NS, IFRC and other RDRTs and ERUs working in the disaster response. This will help to avoid duplication of work and the planning of the follow-up work. The lessons learnt should be documented and shared as part of the handover. The documentation does not have to be reports alone, it can be pictures or short video clips. The process carried out in implementing the hygiene promotion activities and the lesson learnt in various forms (report, photos and video) should be included in the handover.

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# Annexes

## **Rapid Assessment Tools**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hygiene Behaviour Check** |  | | | | | | | | | | | | | | | | | | | | **Possible Collection methods** |
| **Community Structure** |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Where do the community live? |  | | | | | | | | | | | | | | | | | | | | G, OE |
| 1. What is the population | No. of People | | | | | | | | | | | | | No. of Households/Tents | | | | | | | G, HW, CR, OE, WC |
| Men | | Women | | | | | | | | Boys | | Girls |
| 1. According to them what are the priority problems order? | Food shortage | Security | | | | | | Water  Availability | | | | | Shelter | Health | | | | | | Other | HW, CL, HI, OTW, OE, WC |
| 1. Has there been any change in the priority problems order? What is the change? |  | | | | | | | | | | | | | | | | | | | | HW, CL, HI, OTW, OE, WC |
| 1. Do people have adequate shelter, fuel, food and security? | Yes | | | | | | | | | | | | | No | | | | | | | OE, CL, OTW |
| 1. Is the any change to the effective communication channels? | Yes / No | | | | | | | | | | | | | | | | | | | | HW, CL, OTW, CI |
| **Public Health Situation** |  | | | | | | | | | | | | | | | | | | | |  |
| 1. What are the main public health problems or risks? |  | | | | | | | | | | | | | | | | | | | | G. OE, CL, CR, HERU |
| 1. Is there any change in spread of diseases in the community? | Yes / No  If yes, what diseases and change? | | | | | | | | | | | | | | | | | | | | G. OE, CL, CR, HERU |
| 1. What is the water and sanitation related morbidity and mortality? |  | | | | | | | | | | | | | | | | | | | | G. OE, CL, CR, HERU |
| 1. What changes will have the greatest impact on public health? |  | | | | | | | | | | | | | | | | | | | | G. OE, CL, CR, HERU |
| **Safe drinking water** |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Is there any change in water sources people use? |  | | | | | | | | | | | | | | | | | | | | HW, CL, OTW, CI, M |
| 1. Are the water sources protected? |  | | | | | | | | | | | | | | | | | | | |
| 1. Is there any change in why people use this water source? | Only source | | | | | | | | | Like the taste | | | | | | Best pure water | | | | | HW, CL, OTW, CI, M, FGD |
| 1. Is the water available continuously? | Yes / No | | | | | | | | | | | | | | | | | | | | HW, CL, OTW, CI, M, FGD |
| 1. For what purpose do they use the water? | Drinking | | | | | Cooking | | | | | | | Bathing | | Washing dishes | | | | | | CL, OTW, CI, M |
| 1. Is the drinking water likely to be contaminated? Why do you think so? | Yes /No | | | | | | | | | | | | | | | | | | | | CL, CI, M, FWT |
| 1. Who mainly goes to collect water for the family? | women | | | | | | | | | men | | | | | | children | | | | | CL, CI, FGD, HI |
| 1. How long people have to queue for water? | 30 mins | | | 1 hour | | | | | | | | More than an hour | | | | | | | | | CL, CI, FGD, HI |
| 1. Is there adequate drainage around the water points? | Yes/No | | | | | | | | | | | | | | | | | | | | CL, CI, M, OTW |
| 1. Are drinking water containers clean and sufficient in number? | Yes / No | | | | | | | | | | | | | | | | | | | | CL, CI, FGD |
| 1. Do they use any treatment method before using water? | Boiling | | | Chlorination | | | | | | | | Solar | | | | | Other | | | | CL, CI, FGD, HI, HW |
| 1. What do people use to store drinking water in? | Jerrycan | | | Buckets with lid | | | | | | | | Open containers | | | | | Other | | | | CL, CI, FGD, HI, HW |
| **Safe excreta disposal** |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Where do people defecate? | Communal Latrines | | | | Shitting field | | | | | | | | Open defecation | | | | | Trench pit latrines | | | CL, CI, FGD, HI, OTW, PC |
| 1. Has there been a change in the percentage of people using latrines? |  | | | | | | | |  | | | |  | | | | | | | | CL, CI, FGD, HI, OTW, PC |
| 1. Is there change in evidence of open defecation around the community location? Is it better or worse? | Yes / No  Better / Worse | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, OTW |
| 1. How many latrines are there? Is this more than before? |  | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, OTW, M |
| 1. Do children use latrines? | Yes /No | | | | | | | | | | | | | | | | | | | | CI, FGD, OTW, HI, HV |
| 1. Who cleans the latrines? Has there been any change in the responsibilities of latrine cleaning? |  | | | | | | | | | | | | | | | | | | | | CI, FGD, HI |
| Handwashing |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Which key times do people wash their hands? | After latrine use | Before eating | | | | | Before preparing food | | | | | | After handling baby’s faeces | | | | | | Other (specify) | | HW, CI, FGD, HI, PC |
| 1. What is the estimated percentage of people who wash their hands in key times? |  | | | | | | | |  | | | |  | | | | |  | | | HW, CI, FGD, HI, PC |
| 1. What is used for handwashing? | Soap | | | | | | | | Ash | | | | Only water | | | | | Other | | | HW, CI, FGD, HI, PC |
| 1. Do they still have sufficient number of soap? | Yes / No | | | | | | | | | | | | | | | | | | | | CI, FGD, HI, HV |
| Hygiene Practices |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Is there any change in number of households who cover their food? | Yes / No | | | | | | | | | | | | | | | | | | | | CI, FGD, HI, HV |
| 1. Is there any change in the available garbage cans? | Yes / No | | | | | | | | | | | | | | | | | | | | CI, FGD, HI, HV |
| 1. Is the surrounding of the community cleaner than before? |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Is there proper animal management? |  | | | | | | | | | | | | | | | | | | | |  |
| Hygiene Practices |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Is there a communal garbage pit? And how is it managed? | Yes / No | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, HI, M, OTW |
| 1. Is there problems of rats, mosquitoes and lice? | Yes / No | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, HI, OTW |
| 1. Is there a lot of flies around? | Yes / No | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, HI, OTW |
| 1. Is there proper drainage for waste water? | Yes / No | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, HI, OTW, M |
| 1. Is there a need for non-food items to improve hygiene and dignity of community members | Yes / No | | | | | | | | | | | | | | | | | | | | CL, CI, FGD, HI, OTW, M |
| Menstrual Hygiene |  | | | | | | | | | | | | | | | | | | | |  |
| 1. What do women use during menstruation? Any change in the percentage of usage of items? | Clothe | | | | | | | | Sanitary Pads | | | | others | | | | | | | | FGD women, HI, HW |
| 1. Are the latrines with enough privacy for women? Any changes made in the latrine design and usage? | Yes / No | | | | | | | | | | | | | | | | | | | | FGD women, HI, HW |
| 1. Is there washing and handwashing facilities? | Yes / No | | | | | | | | | | | | | | | | | | | | FGD women, HI, HW |
| Priority and Vulnerable groups |  | | | | | | | | | | | | | | | | | | | |  |
| 1. Is there any change in the number of people in the community with disabilities or injuries? | Yes / No  Estimated number: | | | | | | | | | | | | | | | | | | | | HW, CR, CL, FGD, HV, HERU |
| 1. Are the latrines easily accessible for these people? Any changes made on accessibility? | Yes / No | | | | | | | | | | | | | | | | | | | | HW, CR, CL, FGD, HV, HERU |

Key for Possible collection methods

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| Discussions/Meeting with Government- G | Mapping- M | Health ERU- HERU |
| Discussion/Meeting with Health workers- HW | Pocket Chart exercise- PC | WASH Cluster- WC |
| Discussion/Meeting with Community or Camp leaders- CL | Focus Group Discussions – FGD | Other ERUs- OE |
| Observation from Transect Walk – OTW | Household Interviews - HI | Field Water Test- FWT |
| Community members Interviews – CI | Clinic records - CR | House Visit- HV |

Table 1: Assessment tools

Ta

: Summary of health findings to be linked to different groups

## **Example of Monitoring Framework**

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| **Indicator** | **Means of verification** | **Frequency** |
| Environment free from all faecal matter | Transect walks | Daily or every two days |
| Users take responsibility for the management and maintenance of sanitation facilities | Observing communal toilets | Daily or every two days |
| % of the population wash their hands with soap or ash at least after contact with faecal matter | Observing hand washing points |  |
| % of the population wash their hands with soap or ash at least before handling food |  |  |
| Clean water used for drinking | Spot checks at water points |  |
| Water is stored safely in the home (clean, covered container) | Spot-check of households |  |
| Women are enabled to deal with menstrual hygiene issues in privacy and with dignity - | FGD | Monthly |
| Water points and sanitation facilities are accessed by all sections of the community | Observing water points and facilities | Daily or every two days |
| FGD | Monthly |
| Hygiene Promoters trained and effective | Staff feedback on quality and use of training | One week and one month after training |
| Community feedback routes are in place and feedback is acted on | Record forms, team meetings | Weekly |
| All sections of the community, including vulnerable groups, are consulted and represented at all stages of the project | FGD | Monthly |

Table

3:

Example Monitoring

## **1.3 SUMMARY of IFRC Guideline to Hygiene Promotion in** **Emergencies**

***WHAT IS IN THIS DOCUMENT?***

This document provides a summary of how to implement Hygiene Promotion in Emergencies in a Red Cross Red Crescent (RCRC) context. It encourages those RCRC managers who plan and implement hygiene promotion interventions to follow a clear pathway (using a step-by-step process), without taking shortcuts and rushing into delivering ‘hygiene messages’. It also provides National Societies (NS) with a standard approach for quality assurance since it offers an opportunity for more effective training and monitoring. These steps (which are important for our unique status and role in the disaster response) are expanded in “IFRC Guidelines to Hygiene Promotion in Emergencies”

**WHO IS THIS DOCUMENT FOR?**

The main target audience for this document is RCRC staff and volunteers who are responsible for planning, implementing and monitoring hygiene promotion (including training community-based volunteers), as part of an emergency response; e.g. members of emergency response teams such as ERU modules, RDRT, NDRT members or RCRC staff and volunteers in IFRC and National Societies.

***WHY IS THIS DOCUMENT IMPORTANT?***

It is important to include an effective hygiene promotion programme as part of all WASH (Water, Sanitation and Hygiene) interventions in an emergency response.

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| rcrc dEFIINTION OF HYGIENE PROMOTION IN EMERGENCY |
| Hygiene promotion (HP) in Emergencies in the Red Cross is defined as ‘a planned, systematic approach delivered by RCRC community based volunteers to enable people to take action to prevent water, sanitation and hygiene-related diseases by drawing on the affected population’s knowledge and resources and supporting their mobilisation and engagement.’ |

Hygiene promotion activities ensure the affected population are aware of key public health risks and are enabled to adopt safe hygiene practices and make the best use of WASH facilities and services (including their operation and maintenance).

[Key components of Hygiene Promotion are:](http://unicefinemergencies.com/downloads/eresource/docs/WASH/WASH%20Hygiene%20Promotion%20in%20Emergencies.pdf)

* Community participation
* Use and maintenance of facilities
* Selection and distribution of hygiene items
* Community and individual action
* Communication with WASH stakeholders
* Monitoring

During an emergency response, the RCRC has generally used the 'campaign' approach for hygiene promotion, with the emphasis on giving messages; however, community engagement needs to be included to make the response more effective. Due to the pressure of responding to an emergency, the NS and RCRC disaster management teams (RDRT or ERUs, etc.) have often rushed into the production of Information, Education and Communication (IEC) materials without undertaking a proper analysis of the context, understanding the risk behaviours and identifying accurately the needs of the affected population. More thought needs to be given to identify the community’s capacity and barriers to practice safer hygiene. Community participation is needed to ensure that the communication materials produced brings the relevant and desired behavioural outcomes.

RCRC staff and volunteers involved in hygiene promotion as part of an emergency response need to have a greater understanding about the attitudes and beliefs that influence behaviour of the affected population. People may have internalized certain practices before the emergency that are done automatically (for example washing hands before eating) but after the disaster these practices may only be possible if the means (e.g. water and soap) are not available. RCRC staff and volunteers may need more in-depth knowledge and information about what influences what people think and do when they face the adversity of a disaster (e.g. people may believe that diarrhoea is part of the normal process of a child growing, so they may not take any action to prevent or treat it). It is essential to talk with the affected people, ensuring they are engaged in all stages of the programme.

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| ACCOUNTABILITY |
| It is important to acknowledge that our fundamental accountability must be to those we seek to assist. All RCRC WASH activities must emphasize: providing information, active listening to those affected, respectful attitude and empathy to those who we assist.  Remember:   * Are we being open and transparent? * Are we listening to the community? * Are they participating? * How are the views of the community being considered? * Is there an effective feedback mechanism? * Does the community have adequate information on the response? * Does the staff recruited have the proper skills and attitudes?   All RCRC Staff and volunteers involved in hygiene promotion activities need to be familiar and adhere to humanitarian principles and standards, including:   * The Red Cross fundamental principles * The Red Cross Movement and NGO Code of Conduct * The standards in the Sphere handbook * The Core Humanitarian Standard * IFRC Minimum standard commitments to gender and diversity in emergency * Accountability to beneficiaries   The NS should include this in the trainings for new volunteers and staff involved in the response; but those managing hygiene promotion programmes need to ensure that the staff and volunteers are familiar with these standards and principles and that they are considered and adhered to at all stages of the programme. |

**8 STEPS FOR HYGIENE PROMOTION IN EMERGENCY**

In summary, there are 8 steps for hygiene promotion in emergencies for the RCRC.

1. Identifying the problem
2. Analysing barriers and motivators for behaviour change
3. Identifying target groups
4. Formulating hygiene behaviour change objectives
5. Planning
6. Implementation
7. Monitoring and evaluation
8. Review, re-adjust

**STEP 1: IDENTIFYING THE PROBLEM**

The team establishes through assessment activities information about the current hygiene behaviours and the impact of the emergency on the community. Key points to consider are:

* Impact of the disaster,
* Risks to health,
* Current hygiene behaviours and how they have changed as a result of the disaster, and which ones can be potentially harmful
* What the community knows, does, understands and wants about water, sanitation and hygiene
* Water and sanitation related morbidity and mortality
* Access to water and sanitation facilities

The HP team works with the affected community, the engineers, government and other RCRC teams (e.g. RDRT, ERUs etc.) to complete an assessment. They should use interactive participatory methods with all sectors of the community: men, women and children, (not forgetting marginalized, less visible vulnerable groups, including the disabled), to gather information, and engage with the community, working with them to identify the problem to help them find a solution.

**STEP 2: ANALYSING BARRIERS AND MOTIVATORS FOR BEHAVIOUR CHANGE**

The team gathers information about the different motivators that can trigger change in the affected population. For example, nurturing feelings in mothers of young children or the social status aspiration in men can be very appealing.

The information gathered through the assessment needs to provide evidence of what stops people taking action themselves:

* Is it the lack of knowledge (e.g. they may not be familiar with malaria, if they are displaced and come from a non-malaria region)?
* Is it a different understanding (e.g. the word diarrhoea might be translated with different meanings)?
* Is it different beliefs (e.g. they may think the baby’s faeces are not dangerous)?
* Is it the lack of resources (lack of water, soap, clean latrines, etc.)?

The analysis of the factors that prevent the uptake of safe practices should be done with community members and other relevant stakeholders.

The assessment should include participatory activities (focus group discussion, mapping, voting, ranking activities, etc.). These might not be so easily conducted in the very early stages of the response; but engaging with the community is important, and useful information can be gathered by using a variety of inter-active techniques; these activities can be expanded as soon as the situation stabilizes. Include questions about barriers and motivators as part of the initial assessment, in a way that acknowledges people’s situation and starts an open discussion.

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| **BEHAVIOUR CHANGE COMMUNICATION** |
| Remember that those factors stopping people to behave safely are not always related to a lack of knowledge about the theory of germs or disease transmission paths. More often those barriers are related to socio-cultural factors (e.g. in some communities women cannot share a toilet with their father-in-law), religious (e.g. specific siting of facilities) or physical (e.g. absence of facilities or no access to them). Do not make assumptions that people do not have the knowledge - they may understand differently! It is the task of the hygiene promoter to discuss with the communities and analyse how people think, in conjunction with what they know. |

**STEP 3: IDENTIFYING TARGET GROUPS**

The team identifies which target groups need to be prioritised. Important considerations when selecting target groups are:

* Who are most at-risk?
* Who are the influencers in the community? E.g. community or religious leaders
* Ensure all sections of the affected community are included (e.g. children, older people, people with disabilities) and other stakeholders.
* Special emphasis on the needs of babies and young children (as they need different WASH facilities)

People’s decision-making depends on the information they have, their ability to participate and engage in the programme. This might not be achieved at the onset of the emergency, especially in those disasters with high level of destruction, human loss and trauma, but at least some basic level of consultation and information needs to be established from the beginning of the operation. As soon as the situation becomes more stable, the affected groups need to be part of the planning process, including the selection of behaviour change objectives.

**STEP 4: FORMULATING HYGIENE BEHAVIOUR OBJECTIVES**

The team and key stakeholders, including the community, set the objectives for each of the risks identified during the assessment phase.

Objectives can be related to hygiene behaviour (e.g. increasing hand washing practices at key times) or enabling factors (e.g. hand washing facilities with soap are available).

Specific Operation & Maintenance (O&M) objectives should be included in the planning (e.g. engaging the affected population in maintenance of toilets and water systems).

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| Stating obJectives with others |
| To complete this task, the team needs to set up the objectives with the community and other key stakeholders (e.g. Government). By enabling all key stakeholders to be involved in the planning and decision-making, ensures that the objectives are relevant to the needs and context.  The involvement of RCRC Engineers (and Government technical staff) in charge of WASH construction activities is essential in setting objectives, as the facilities are key elements for enabling behaviour change. All the team, i.e. hygiene promoters and engineers, should do this step together. |

**STEP 5: PLANNING**

The team implementing the hygiene promotion activities during an emergency response needs a working plan stating the problem, the objectives, the activities with methods and tools, the resources needed (both financial and human) and a monitoring and evaluation plan.

This plan is more effective when it is done with others (engineers, affected community, local government, other agencies, NS staff, etc.) and not made in isolation by the hygiene promotion team.

It is essential that the approach focuses on ‘enabling the community’, helping them to agree on community actions and facilitating the implementation of the actions; rather than simply ‘we are doing hygiene promotion’ which often translates into teams of hygiene promoters telling communities what to do, or educating others with standard messages, acting as though they know better; this approach is rarely effective.Methods for hygiene promotion need to respond to the hygiene behaviour objectives and be relevant to the target group identified.

The working plan should include a combination of methods that use different type of communication tools that can be used for different purposes (share knowledge, influence & inspire others, make decisions, etc.).

Not all methods for hygiene promotion require the use of ‘hygiene messages’. Participatory techniques, e.g. three-pile sorting, are focused on creating debate rather than simply passing on a message. The aim is to identify problems and agree on potential solutions that require community action. All methods and IEC materials should be pre-tested and piloted to ensure they are understood and are appropriate to the context.

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| RecRuitment and Training of HP Team |
| Recruitment, training and retention of RCRC volunteers are important aspects of the hygiene promotion programme. The job description for all RCRC volunteers responding as hygiene promoters should be agreed with all key stakeholders, and importantly the NS managers in an emergency response. It can be challenging to get the ideal qualified staff and volunteers from the NS local branches, so when selecting staff and volunteers for HP team, emphasis must be given on those who can easily engage with the affected community (good communication skills, respected by community members, etc.). RCRC volunteers are instrumental for the implementation of hygiene promotion plans. Acknowledge and build on existing skills:   * Volunteers working in long term WASH programmes may have strong mobilization and engaging skills. They are often familiar with NS HP methods; e.g. PHAST[[9]](#footnote-9)[[10]](#footnote-10) * Volunteers trained in emergency response (NDRT members for example) may have the quick and flexible approach required for a rapid and appropriate response. |

**STEP 6: IMPLEMENTATION**

Key points to consider when implementing hygiene promotion plans include coordination and communication with all key stakeholders:

* The affected community may have resources available to support the activities.
* The NS may have resources available – e.g. do they have a HP box, IEC materials or toolkits?
* The Government might also have its own standards (e.g. National Polices may state a specific approach to use).
* The hygiene promotion sub-groups within the WASH cluster may provide the links to other partners working in the sector and may also set up technical recommendations that will need to be considered.
* Other agencies responding with hygiene promotion activities may also share resources and ideas. Coordinating with them is essential to avoid duplication: coordinate, share and learn!

**WORKING WITH ENGINEERS** The Red Cross WASH engineers involved in the construction and maintenance of WASH facilities (e.g. toilets, water systems, hand washing facilities) should be involved in all stages of the HP programme, and especially the assessment and planning stages; the construction and promotional activities need to be connected; e.g. there is no point in constructing a latrine that is technically sound but in the views of the population inappropriate for their use – perhaps in an unsafe location or not the type of toilet they are accustomed to. Hygiene promoters are responsible for consulting and forwarding the people’s preferences, desires and aspirations related to the design and siting of WASH facilities to the engineers. Hygiene promoters might also be involved in the household water treatment, supporting the RCRC Engineers in conducting training and following up on the use of treatment products. These activities can be coupled with hygiene promotion activities at household and community level.

**The Relief teams do RELIEF DISTRIBUTION in RCRC Emergency Response**. Hygiene promoters do not conduct massive distribution of hygiene related items (hygiene kits, soap, buckets, etc.), but they might get involved in small-scale distribution as part of training, demonstration or promotional activities. If gaps are identified in terms of access to essential items (soap and buckets), this needs to be reported to the Relief Teams operating within the NS and / or IFRC Operation.

Hygiene Promoters have an important role to play in ensuring that all members of the community (men, women & children) have access to hygiene items that are appropriate for their needs; they should be helping with the critical link between listening to the community and the communication with the Relief teams; including providing feedback from the community distribution of hygiene items.

Menstrual hygiene management should not be forgotten. The role of the hygiene promoter is to discuss with the women to find out what common practices exist, their preferences and current resources and constraints for menstrual hygiene; and use that information to influence the design of family kits (also called dignity kits, menstruation kits, women kits, etc.).

**STEP 7: MONITORING AND EVALUATION**

A baseline survey needs to be completed at the beginning of a programme. Sophisticated statistical tools are not needed, but standard sampling methods need to be used. It needs to be quick and simple, designed for capturing major changes in the situation and the behaviour. Qualitative data (such as from focus group discussions, pocket chart voting) should be recorded alongside the quantitative baseline information.

The team needs to monitor the progress and impact of the hygiene promotion programme; including Identifying trends, e.g. latrine usage, Monitoring is not simply about numbers; but also, asking questions such as - are people benefitting from the programme, why people (including children) might not be using the WASH facilities, is their feedback heard and acted upon?

The team establishes the monitoring system setting indicators (linking with hygiene behaviour and the context), detailing the methods and frequency (depends on the context).

All the information should feed into the planning process (Step 5) and should be used for re-adapting the activities and approaches.

An evaluation should be done (either as a Real-time evaluation and/or at the end of the programme, to document the achievements, challenges and lessons learnt. An endline survey (using the same questions as in the baseline) should be done as part of evaluation, to assess changes.

**STEP 8: REVIEW, RE-ADJUST**

Remember to ensure the hygiene promotion programme is relevant to the needs. Emergency situations are often complex, with frequent changes in the situation. Continuous assessment, re-planning and re-adjustment of activities are essential. Look around! Are there other WASH problems in the affected community that have not been addressed? Has the problem changed? Have new problems arisen? If so, go back to Step 1 and begin again.

And the monitoring and evaluation documentations, photos and videos produced should be shared with the NS counterparts and IFRC WASH Unit to identify and continue support (if needed) to the communities and to capture the lessons learnt.

## **1.4 IFRC Guidelines to Hygiene Promotion- Quick fix**

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| **Hygiene Promotion** **(HP) in Emergencies** in the Red Cross is defined as ‘a planned, systematic approach delivered by RCRC community based volunteers to enable people to take action to prevent water, sanitation and hygiene-related diseases by drawing on the affected population’s knowledge and resources and supporting their mobilisation and engagement.’ | | | | |
| **HYGIENE PROMOTION IN EMERGENCIES** | | | | |
| **Step** | **Includes** | | **Actors** | **Information sources (All documents available** at <http://watsanmissionassistant.wikispaces.com/EHP>[watsanmissionassistant - Software hygiene promotion](http://watsanmissionassistant.wikispaces.com/Software+hygiene+promotion#IFRC Guidelines to Hygiene Promotion in Emergencies (EHP)) |
| https://encrypted-tbn2.gstatic.com/images?q=tbn:ANd9GcSiQUMRCENik3NXXANhYnEF0RldVngJWEPL1WDkldFYDKSOzOnr**STEP 1:** **IDENTIFYING THE PROBLEM** | Gathering quantitative and qualitative information to understand; what the community knows, does, and understands, what are their needs, risks, practices and community structures and the impact of the disaster, by using: | | WASH hardware engineers, community, other sectors working in the same communities, Government institutions and other NGOs | * IFRC Guidelines for Emergency Assessment in [English](http://watsanmissionassistant.wikispaces.com/file/view/1%29%20IFRC-guidelines-assessments.pdf/353862396/1%29%20IFRC-guidelines-assessments.pdf), [French](http://watsanmissionassistant.wikispaces.com/file/view/2%29%2071607-Guidelines-fr.pdf/353862410/2%29%2071607-Guidelines-fr.pdf), [Spanish](http://watsanmissionassistant.wikispaces.com/file/view/3%29%2071600-guidelines-sp.pdf/353862430/3%29%2071600-guidelines-sp.pdf), [Arabic](http://watsanmissionassistant.wikispaces.com/file/view/4%29%2039622-Guidelines%20for%20emergcy-A_LR.pdf/353862442/4%29%2039622-Guidelines%20for%20emergcy-A_LR.pdf) * Sphere Project Water and Sanitation Initial Need Assessment Checklist * [Transect Walk](http://watsanmissionassistant.wikispaces.com/file/view/Transect%20Walk%20and%20Observation%20Guide%20%28IFRC%29.pdf/355674208/Transect%20Walk%20and%20Observation%20Guide%20%28IFRC%29.pdf) * Working with communities: a Toolbox |
| - Existing Secondary data  - Mapping  - FGD with community group (3 pile sorting and pocket chart activity) | - Observations and Transect walks  - Interviews local authorities, other agencies, WASH cluster, RCRC staff and volunteers |
| http://www.aha-soft.com/free-icons/aha-soft-logistics-icons/icons/open-barrier.png**STEP 2: ANALYSING BARRIERS AND MOTIVATORS FOR BEHAVIOUR CHANGE** | Gathering information on different motivators and barriers to trigger behaviour change and eliminate/reduce barriers.  And assessing any reactions, triggers and cultural compatibility and making changes according to the observations and feedbacks. | | WASH hardware people, beneficiaries, Health department staff, Government and other NGOs | * [Transmission route](http://watsanmissionassistant.wikispaces.com/file/view/Transmission%20routes%20for%20diarrhoeal%20diseases%20-%20Chart.ppt/353325546/Transmission%20routes%20for%20diarrhoeal%20diseases%20-%20Chart.ppt) * [Good and Bad behaviours](http://watsanmissionassistant.wikispaces.com/file/view/Pakistan_PHAST_Activity%203_Good%20and%20bad%20behaviours.pdf/354396926/Pakistan_PHAST_Activity%203_Good%20and%20bad%20behaviours.pdf) |
| **D:\Users\Mariyam.Asifa\Pictures\Target%20group.jpgSTEP 3: IDENTIFYING TARGET GROUPS** | Identify the target groups together with the community. The target groups must include: who is most at risk, the influencers in the community, all sections of community (children, older people and people with disabilities) and special emphasis groups (e.g.: babies/ young children) with different requirements. | | Community leaders and Health workers, WASH Hardware people, other agencies working in the area | * [Target group selection](http://watsanmissionassistant.wikispaces.com/file/view/fs_target_group.pdf) * [Gender checklist for WASH](http://watsanmissionassistant.wikispaces.com/file/view/Gender+checklist+for+watsan+programming+(IFRC).pdf) |
| D:\Users\Mariyam.Asifa\Pictures\goals-icon.jpg**STEP 4: FORMULATING HYGIENE BEHVIOUR CHANGE OBJECTIVES** | Setting objectives for each of the risks identified which can be related to hygiene behaviour change or enabling factors. | | Community leaders and Health workers, Trained HP staff and volunteers, Community group selected for pre-testing. | * [IFRC PoA Template – Indicators](file:///D:\Users\Mariyam.Asifa\Documents\EHP\EHP%20Pack\123\STEP%204%20Formulating%20the%20behaviour%20change%20objectives\IFRC%20WASH%20PoA%20Template.pdf) * [Outcomes, Output and Activities View](file:///D:\Users\Mariyam.Asifa\Documents\EHP\EHP%20Pack\123\STEP%204%20Formulating%20the%20behaviour%20change%20objectives\WatSan%20PoA%20Template%20(Outcomes,%20Outputs%20and%20Activities)%20FINAL.pdf) |
| **STEP 5: PLANNING** | Working with hardware engineers and others to make a work plan from the identified objectives and choosing output and indicators using a snapshot (survey and other methods) of the situation. And it also includes:   * Choosing a method or approach and communication channels to target different groups * Preparing materials for HP activities (make use of the HP Box) * Choosing volunteers for HP interventions * Pilot and Pre-test the methods and activities by trying out it on a small group of people * Make changes and start implementation * Preparing monitoring and reporting plan for the activities * Schedule and conduct the hygiene promotion activities | | Trained HP staff and volunteers, Community focal points and hardware engineers | * [Volunteer Management Toolkit](http://watsanmissionassistant.wikispaces.com/file/view/Volunteer%20Management%20%28IFRC%20Toolbox%29.pdf/356652642/Volunteer%20Management%20%28IFRC%20Toolbox%29.pdf) * [PHAST](http://watsanmissionassistant.wikispaces.com/file/view/PHAST+(1).pdf) * [CLTS](http://watsanmissionassistant.wikispaces.com/file/view/CLTS+in+Red+Cross+-+Discussion+paper+-+final.pdf) * [Sampling](http://watsanmissionassistant.wikispaces.com/Software+hygiene+promotion) |
| Image result for Icon Implementatio**STEP 6: IMPLEMENTATION** | Following the plan and implementing the activities. The key activities are:   * Working with hardware engineers and others to establish the needed behaviour change communication which goes along with the WASH facilities * Recruiting and Training the volunteers and staff * Working together with Relief Teams to give feedback from/to communities on distribution of HP items | | Trained HP staff and volunteers, Community focal points | * [WatSan & Health NFI Guidelines](http://watsanmissionassistant.wikispaces.com/file/view/WatSan%20and%20Health%20NFI%20Guidelines.docx/356033150/WatSan%20and%20Health%20NFI%20Guidelines.docx) * IFRC Guidelines to Hygiene Promotion in Emergencies Trainer’s Manual * [WASH Cluster Training Material](http://washcluster.net/topics/wash-trainings) * [IEC Materials](http://watsanmissionassistant.wikispaces.com/Software+hygiene+promotion) |
| D:\Users\Mariyam.Asifa\Pictures\report_icon.gif**STEP 7: MONITORING AND EVALUATION** | * Use the HP monitoring forms prepared on Step 5 * Collect data again after 3 months compare with the initial baseline data from Step 1 and evaluate. * Make changes to HP work plan to address the hygiene behaviour objectives of the new scenario | | Trained HP staff and volunteers, Community focal points | * [Monitoring](http://watsanmissionassistant.wikispaces.com/file/view/6%29%20Planning%20for%20Monitoring%20and%20Evaluating.doc/353323110/6%29%20Planning%20for%20Monitoring%20and%20Evaluating.doc) and Evaluation |
| Image result for Icon Review and readjust**STEP 8: REVIEW, RE-ADJUST** | Follow the changes to the situation and re-plan and re-adjust to address the current problems. | | Trained HP staff and volunteers, Community focal points and hardware engineers |  |

1. Centers for Disease Control and Prevention, (2016) Global water, sanitation and hygiene: <https://www.cdc.gov/healthywater/global/wash_statistics.html> (accessed on 8.2.16) [↑](#footnote-ref-1)
2. NOTE: The Sphere handbook is currently under revision [↑](#footnote-ref-2)
3. UNHCR (2017, forthcoming) Hygiene Promotion Guidelines [↑](#footnote-ref-3)
4. ICRC, IFRC (2008) Guidelines for assessments in emergencies. [↑](#footnote-ref-4)
5. British Red Cross, (2016), Mass Sanitation Module (MSM) Handbook, a general reference for MSM deployments. [↑](#footnote-ref-5)
6. IFRC, 2015, Minimum standard commitments to gender and diversity in emergency programming, pilot version [↑](#footnote-ref-6)
7. WASH Cluster, 2008, Hygiene promotion in Emergencies, A briefing paper [↑](#footnote-ref-7)
8. OECD, DAC criteria [↑](#footnote-ref-8)
9. [↑](#footnote-ref-9)
10. 1 PHAST: Participatory Hygiene and Sanitation Transformation, which has a focus on community behavior change using community participation. [↑](#footnote-ref-10)