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|  |  | | **Summary of IFRC Guidelines to Hygiene Promotion in Emergencies** | |
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|  | | 26 | MARCH 2017.DRAFT |

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

This document provides a summary of the “IFRC Guidelines to Hygiene promotion in Emergencies” for 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 “Guidelines to Hygiene Promotion in Emergencies”

**WHO IS THIS DOCUMENT FOR?**

The main target audience for this document is RCRC NS 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 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 emphasise: 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 might 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

The HP team works with the affected community, the engineers, government and other RCRC (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 in 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[[1]](#footnote-1)[[2]](#footnote-2) * 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. [↑](#footnote-ref-1)
2. 1 PHAST: Participatory Hygiene and Sanitation Transformation, which has a focus on community behavior change using community participation. [↑](#footnote-ref-2)