



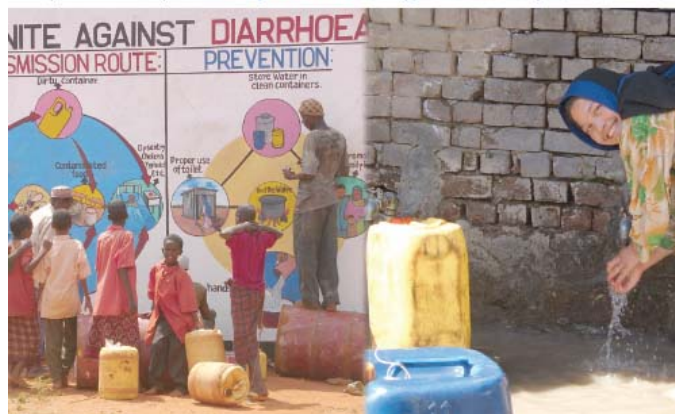
## Introduction to Hygiene Promotion: Tools and Approaches

Promotion de l'Hygiène Promoción de la Higiene Hygiene Promotion

### Introduction to Hygiene Promotion: Tools and Approaches

Multilingual resources for generalists involved in facilitating hygiene improvement in an acute emergency context

Best practice materials produced through the WASH Cluster Hygiene Promotion Project, 2007 c/o UNICEF



#### Introduction to Hygiene Promotion

Training for Community Mobilizers

Training for Hygiene Promoters and HP Coordinators

- Part 1 Essential To Know
- Part 2 Useful To Know
- Part 3 Additional Training for HP Coordinators

This manual contains training materials and handouts to enable facilitators to rapidly prepare training for different levels of hygiene promoters.

It can also serve as a resource for self directed learning by both hygiene promoters and others involved in supporting or managing WASH interventions.

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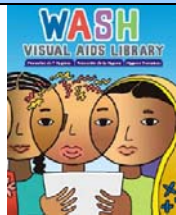
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September 2009

# WASH Cluster Hygiene Promotion Resources

<i>HP Training and Resources CD</i>	
<p><b>1. Introduction to HP Tools and Approaches</b></p> <ul style="list-style-type: none"> <li>Briefing paper on the essentials of Hygiene Promotion,</li> <li>Indicators for Hygiene Promotion</li> <li>Advice on Hygiene Promotion-related Non Food Items selection and delivery</li> <li>Example Job Descriptions for Hygiene Promotion Coordinators, Hygiene Promoters and Community Mobilisers</li> <li>Equipment lists for Hygiene Promotion Communication</li> <li>Annotated Bibliography of resources for Hygiene Promotion</li> <li>Terminology, definitions and glossary</li> </ul> <p>A 4-hour orientation workshop/training package aimed at providing a general overview of hygiene promotion</p> <ul style="list-style-type: none"> <li>Session plans</li> <li>Handouts</li> <li>Facilitators resources</li> <li>PowerPoint</li> </ul> <p><b>English, French &amp; Spanish</b></p>	
<p><b>2. Training for Community Mobilisers</b></p> <ul style="list-style-type: none"> <li>Training sessions for community members in hygiene promotion. This training is aimed at community members who may have limited literacy skills and relies mainly on interactive exercises using picture sets, role-plays and demonstrations etc. It does not include handouts or power-point slides.</li> </ul> <p><b>English, French &amp; Spanish</b></p>	
<p><b>3. Training for Hygiene Promoters &amp; Hygiene Promotion Co-ordinators</b></p> <p><b>Part 1: Essential To Know Training for Hygiene Promoters</b></p> <ul style="list-style-type: none"> <li>Session Plans</li> <li>Handouts</li> <li>PowerPoint</li> </ul> <p><b>Part 2: Useful To Know Training for Hygiene Promoters</b></p> <ul style="list-style-type: none"> <li>Session Plans</li> <li>Handouts</li> <li>PowerPoint</li> </ul> <p><b>Part 3: Additional Training for Hygiene Promotion Coordinators</b></p> <ul style="list-style-type: none"> <li>Session Plans</li> <li>Handouts</li> <li>PowerPoint</li> <li></li> </ul> <p><b>English, French &amp; Spanish</b></p>	
<i>Complementary Resource: Visual Aids Library DVD</i>	
<p>Drawings, picture sets, photos and promotional resources (videos, radio spots, flip charts, leaflets and posters) for use in hygiene promotion programmes. Includes instructions for games and interactive picture sets.</p> <p><b>English, French &amp; Spanish</b></p>	

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# HYGIENE PROMOTION IN EMERGENCIES

## A BRIEFING PAPER

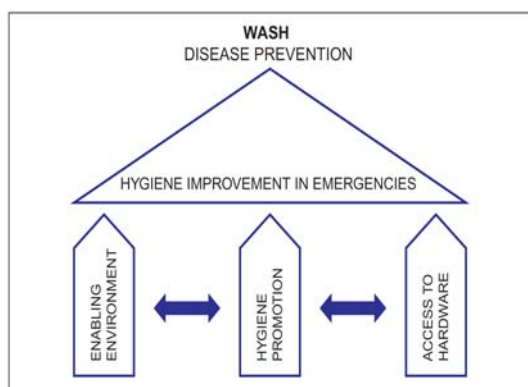
This briefing paper is aimed at all those involved in facilitating hygiene improvement in an acute emergency context, especially WASH co-ordinators and programme managers. It aims to provide an overview of the focus and content of Hygiene Promotion interventions and why they must be integrated with hardware provision. More information on how to do Hygiene Promotion can be found in the resource documents listed in the appendix.

Water and Sanitation related diseases cause significant deaths and sickness in emergencies. Even without the disruption of an emergency, diarrhoea kills over 30,000 children per week worldwide. During protracted war and conflict in particular, simple diarrhoeal diseases can often kill more people than the fighting itself.

Hygiene Promotion is pivotal to a successful WASH intervention. Effective Hygiene Promotion is based on dialogue and interaction with affected communities; working in partnership with them forms the basis of accountable programming<sup>1</sup>.

## What is Hygiene Promotion?

**Hygiene Promotion is the planned, systematic attempt to enable people to take action to prevent or mitigate water, sanitation, and hygiene related diseases and provides a practical way to facilitate community participation and accountability in emergencies.**

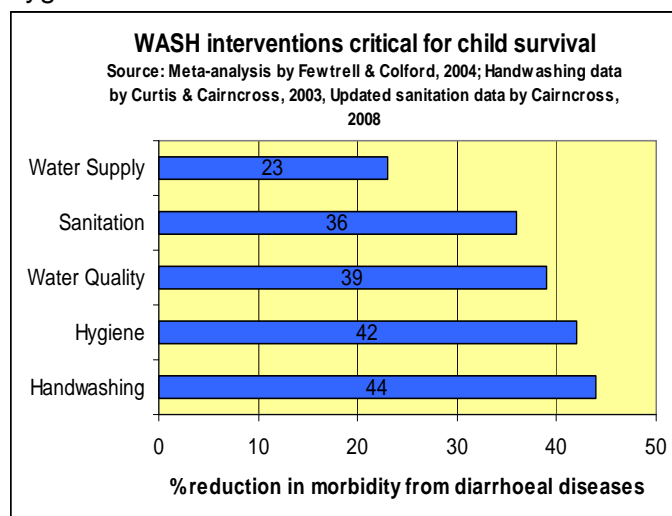


**Hygiene Promotion also involves ensuring that optimal use is made of the water, sanitation and hygiene enabling facilities that are provided. Previous experience has shown that facilities are frequently not used in an effective and sustainable manner unless Hygiene Promotion is carried out. Access to hardware combined with an enabling environment AND Hygiene Promotion make for hygiene improvement as shown in the model of the Hygiene Improvement Framework for Emergencies (see below left). The overall aim of hygiene improvement is to prevent or mitigate WASH related diseases. Examples of each box in the HIF are given in the appendix.**

The priority focus of Hygiene Promotion in an emergency is the prevention of diarrhoea through:

- Safe disposal of excreta
- Effective handwashing.
- Reducing the contamination of household drinking water<sup>2</sup>

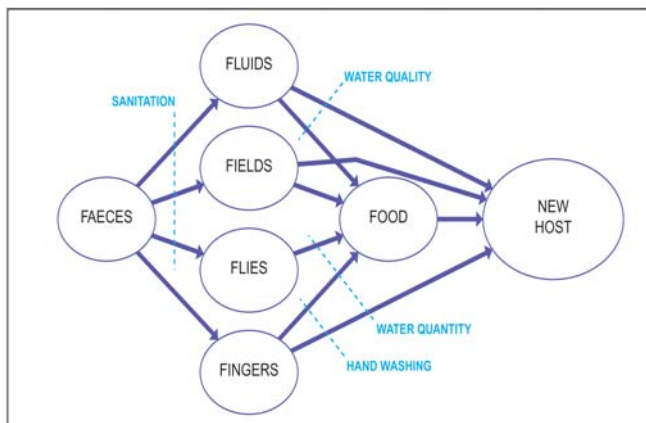
The diagram below shows the relative importance of different WASH interventions and the need for Hygiene Promotion.



<sup>1</sup> See Sphere Standards

<sup>2</sup> Example indicators for these objectives can be found in the List of Indicators





The 'F' diagram (left) illustrates the transmission routes of most diarrhoeal

diseases and how the transmission routes can be interrupted. Although the main focus of Hygiene Promotion should be the prevention or reduction of diarrhoea, the methods employed may also be used to address other public health issues such as malaria or other water and sanitation related diseases.

Depending on the context, it may be more appropriate to focus on an environmental clean up, where the key priorities are already well managed.

## Components of Hygiene Promotion

The diagram below represents the different components of Hygiene Promotion in an emergency situation and examples of the specific activities related to each component are then provided.

### Community Participation e.g.:

- Consult with affected men, women, and children on design of facilities, hygiene kits, and outreach system
- Identify and respond to vulnerability e.g. the elderly or those with disabilities
- Support and collaborate with existing community organisations, organisers, and communicators

### Use and Maintenance of facilities e.g.:

- Feedback to engineers on design and acceptability of facilities
- Establish a voluntary system of cleaning and maintenance
  - Encourage a sense of ownership and responsibility
- Lay the foundations for longer term maintenance by identification, organisation and training of water and sanitation committees

### Selection and distribution of hygiene items e.g.:

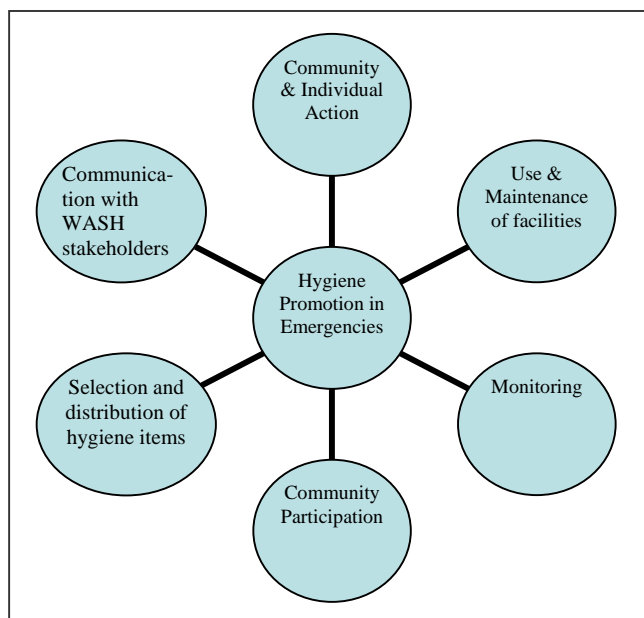
- Decide on content and acceptability of items for hygiene kits
  - Ensure the optimal use of hygiene items (including insecticide-treated bed nets where used)

### Community and Individual Action e.g.:

- Apply principles of Behaviour Change Communication and Social Mobilisation
- Train outreach system of hygiene promoters to conduct home visits
- Organise community dramas and group activities with adults and children
- Use available mass media e.g. radio to provide information on hygiene

### Communication with WASH stakeholders e.g.:

- Collaborate with and/or orientate government workers
- Train women's groups/co-operatives and national NGOs



## Monitoring:

### Collect, analyse and use data on:

- Appropriate use of hygiene items
- Optimal use of facilities
- Community satisfaction with facilities

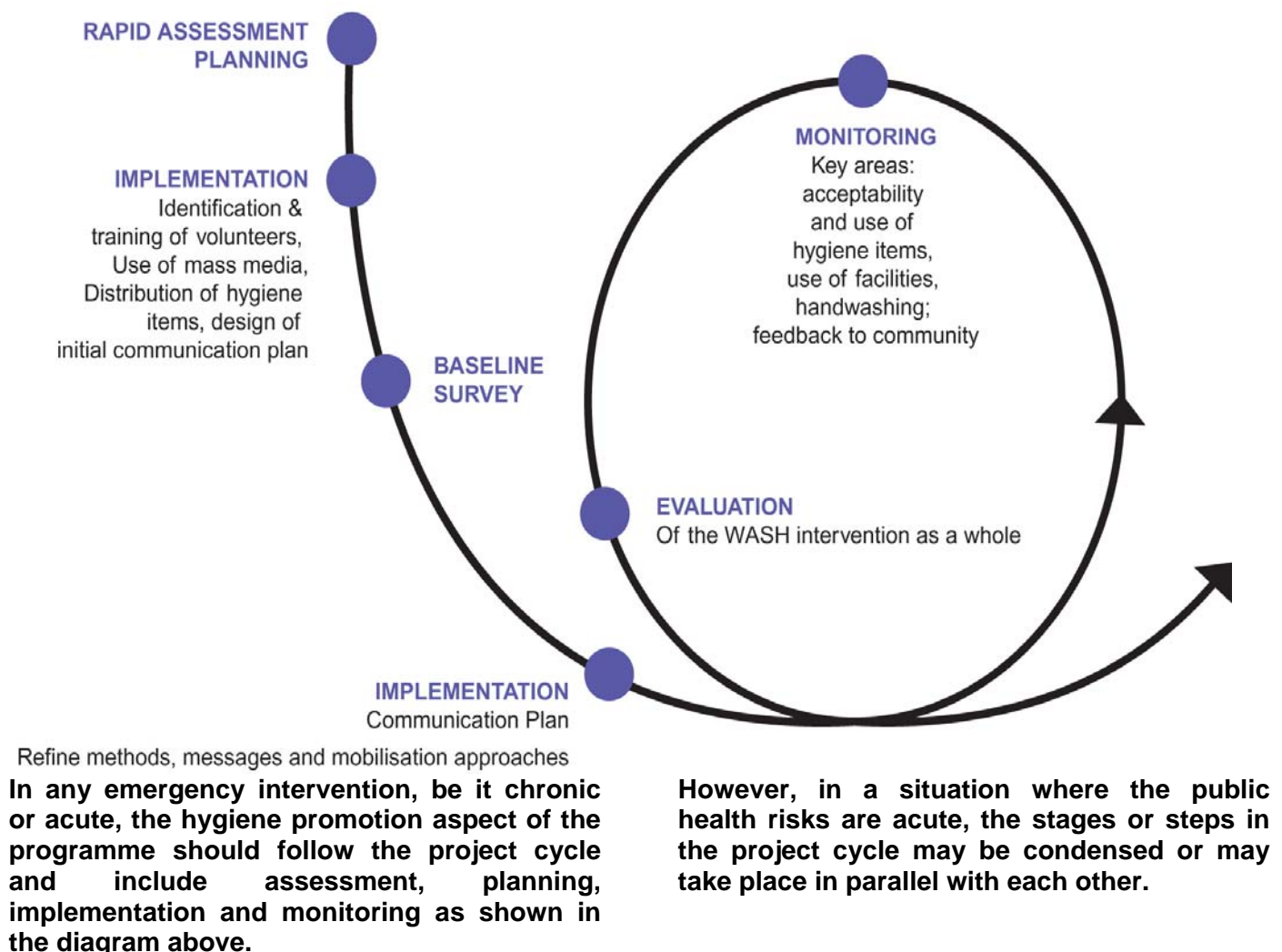
## Action & Information

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

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 (Rosenstock, Strecher and Becker, 1994)

## How do you do Hygiene Promotion in an emergency?

### A simplified model of the Project Cycle





# Hygiene Promotion in different phases and contexts of an emergency

Emergency contexts are very varied and the specific approach to Hygiene Promotion will depend on the existing situation and what is feasible in terms of population customs, culture, and resources. The key difference between Hygiene Promotion interventions in different phases of the emergency or different contexts will usually relate to the intensity and scale of the intervention, which is dependent on the level of public health risk. In general, the early stages of the emergency will be characterised by the need to at least provide information to the affected population but as soon as possible a more interactive approach should be used. At all times

the emphasis should be on mobilising people to take action.

## Team Integration

**Water and Sanitation personnel, be they engineers, technicians or hygiene promoters, need to work together to achieve an impact on public health and every intervention needs to address both 'hardware' and 'software' requirements. Joint work planning, field visits, and training as well as shared monitoring and reporting mechanisms will help with this.**

## Hygiene Promotion steps

Step	Collaboration required	Key issues/activities	WASH resources (ensure use of government resources also)
<b>Step 1 Assessment</b> Conduct rapid assessment to identify risk practices and get an initial idea of what the community knows, does, and understands about water, sanitation, and hygiene.	Government WASH team	Which specific practices allow diarrhoeal microbes/other diseases to be transmitted?  Which practices are the most harmful?	See <i>Information Management Guidelines (WASH Cluster 2008)</i>
<b>Step 2</b> Consult women, men, and children on contents of hygiene kit	Logisticians	What specific hygiene needs do men, women, and children have e.g. sanitary towels, razors, potties?	See <a href="#">WASH-related Non Food Items Briefing Paper</a>
<b>Step 3 Planning</b> Select practice(s) and hardware for intervention (define objectives and indicators)	All WASH team	Which risk practices are most widespread? Which will have the biggest impact on public health? Which risk practices are alterable? What can be done <b>to enable</b> change of risky practice?	See <a href="#">List of Indicators</a>
<b>Step 4</b> Define target audiences (this may be all the affected community with priority focus on those who care for young children) and stakeholders		Who employs these practices?  Who influences the people who employ these practices? E.g. teachers, community leaders, Traditional Birth Attendants etc.	See <a href="#">Annotated Bibliography</a>
<b>Step 5</b> Define initial mode of intervention  Determine initial key messages and channels of communication  Determine advocacy and training needs for stakeholders		What mass media methods are available? E.g. 60% of people have radios but they are often used only by men What methods do the target audiences trust? E.g. traditional healer, discussions at women's group meetings Where/how can men and women be accessed? E.g. distribution queue, water point	See <a href="#">Annotated Bibliography</a>

<b>Step 6</b> Recruit/identify and start to train fieldworkers and outreach system	Government System/national NGOs	What capacity (systems, skills, and approaches) already exists in government/national NGOs?	<i>See Training Modules for Fieldworkers and Mobilisers(2008)</i> <i>See WASH HP Visual Aids Library (planned 2008)</i>
<b>Step 7 Implementation</b> Begin implementation and continue assessing situation	Logisticians Government Engineers	Distribute hygiene kits Emphasis initially on providing information and use of mass media e.g. radio spots, campaigns, and home visits by volunteers Organise group meetings/interviews and discussions with key informants and stakeholders to initiate a more interactive approach.	<i>See <a href="#">Annotated Bibliography</a></i>  <b><u>See WASH HP Visual Aids Library (planned 2008)</u></b>
<b>Step 8 Ongoing assessment</b> Develop baseline  Understand motivational factors/ refine key messages	Engineers	Obtain quantitative data where feasible. Carry out systematic collection of qualitative data using participatory methods (co-ordinate with others and be careful not to overwhelm communities with over questioning) What motivates those who currently use safe practices? What are the advantages of the safe practices?	<i>See Information Management Guidelines (WASH Cluster 2008)</i>
<b>Step 9 Monitor</b>	Engineers	Are hygiene kits being used/are people satisfied with them? Are toilets being used/are people satisfied with them? Do men and women feel safe when accessing facilities? Are people washing their hands? Is drinking water in the home free from contamination?	<i>See <a href="#">List of Indicators</a></i>  <i>See Sphere (summary in WASH HP Orientation Workshop Supplementary Materials or <a href="http://www.sphereproject.org">www.sphereproject.org</a>)</i>
<b>Step 10 Implementation</b> Refine communication plan Rapidly adapt intervention according to outcome of monitoring Continue training Continue monitoring	WASH team	Emphasis more on interactive methods e.g. group discussions using mapping, three pile sorting etc. Identify and train (with engineers) longer term structures e.g. committees	

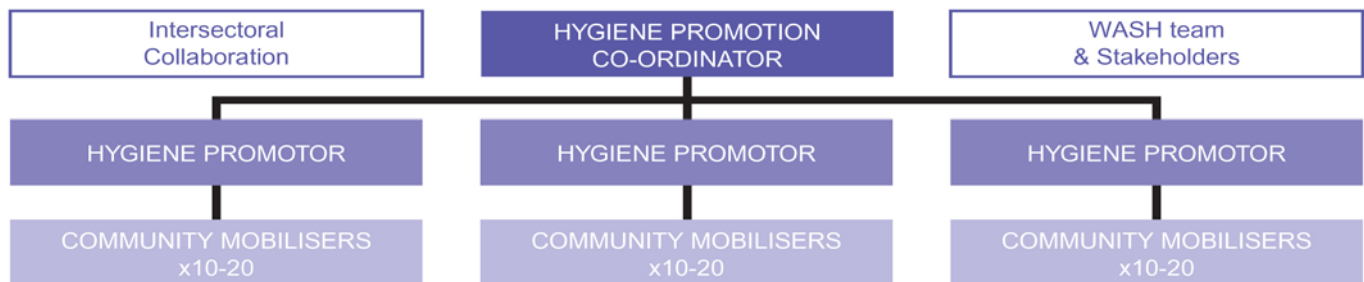
\* Adapted from Guidance Manual on Water Supply and Sanitation: LSHTM/WEDC 1998

# Hygiene Promotion approaches and methods

The most commonly used approach to access the population in emergencies is that of identifying and training community outreach workers (volunteers/mobilisers/animators). If the health risks are very acute e.g. high risk of a cholera outbreak, it may be unrealistic to ask people to work for long hours for little remuneration. Payment in kind e.g. bicycle, tee shirts, hygiene items etc. may be an option but some agencies e.g. the government may not have the resources to provide financial or other incentives and unilateral decisions by incoming agencies may undermine efforts to ensure future sustainability. The issue is complex and needs to be addressed through the co-ordination mechanism. (See summary of advantages and disadvantages of paying volunteers in '[Generic job descriptions](#)' paper.)

A cascade system, where outreach workers (at least 1:500 per population or more if intensive work is required or if populations are spread out)<sup>3</sup>, are supervised by trained hygiene promoters who are supported by skilled professionals, is the most common model used, but others are possible. A network of peer educators might also be established e.g. teenagers or young mothers. Hygiene clubs could also be established in each affected area. A key aspect of the initial Hygiene Promotion assessment is to identify existing local capacity and skills.

## Cascade Outreach System



**It is recommended that both the available mass media (e.g. radio or leaflets) AND other more interactive methods are employed (see orientation workshop). Even in an acute emergency some initial discussions with individuals and community groups can take place and as the emergency evolves more widespread use of methods that foster discussion should be encouraged.**

Participatory methods that focus on interaction with the affected community are often the most successful in achieving changes in practice. However, there is a trade off between 'reach' and effectiveness and the more participatory approaches are often time consuming and labour intensive whereas the dissemination of messages via the mass media will reach more people more quickly, but may be less effective in achieving the desired outcomes.

Among the most useful participatory methods are 'community mapping' exercises, focus group discussions, exercises using visual aids to stimulate discussion and mobilisation activities such as three pile sorting, chain of contamination, and pocket chart voting. An assessment of the existing resources available for hygiene promotion is important as this will help to ensure that culturally appropriate methods and tools are employed.

It is important to note that health benefits are not always the main motivating factor for changes in behaviour. The need for privacy and safety, convenience, social status, and esteem may sometimes be stronger driving forces than health arguments.

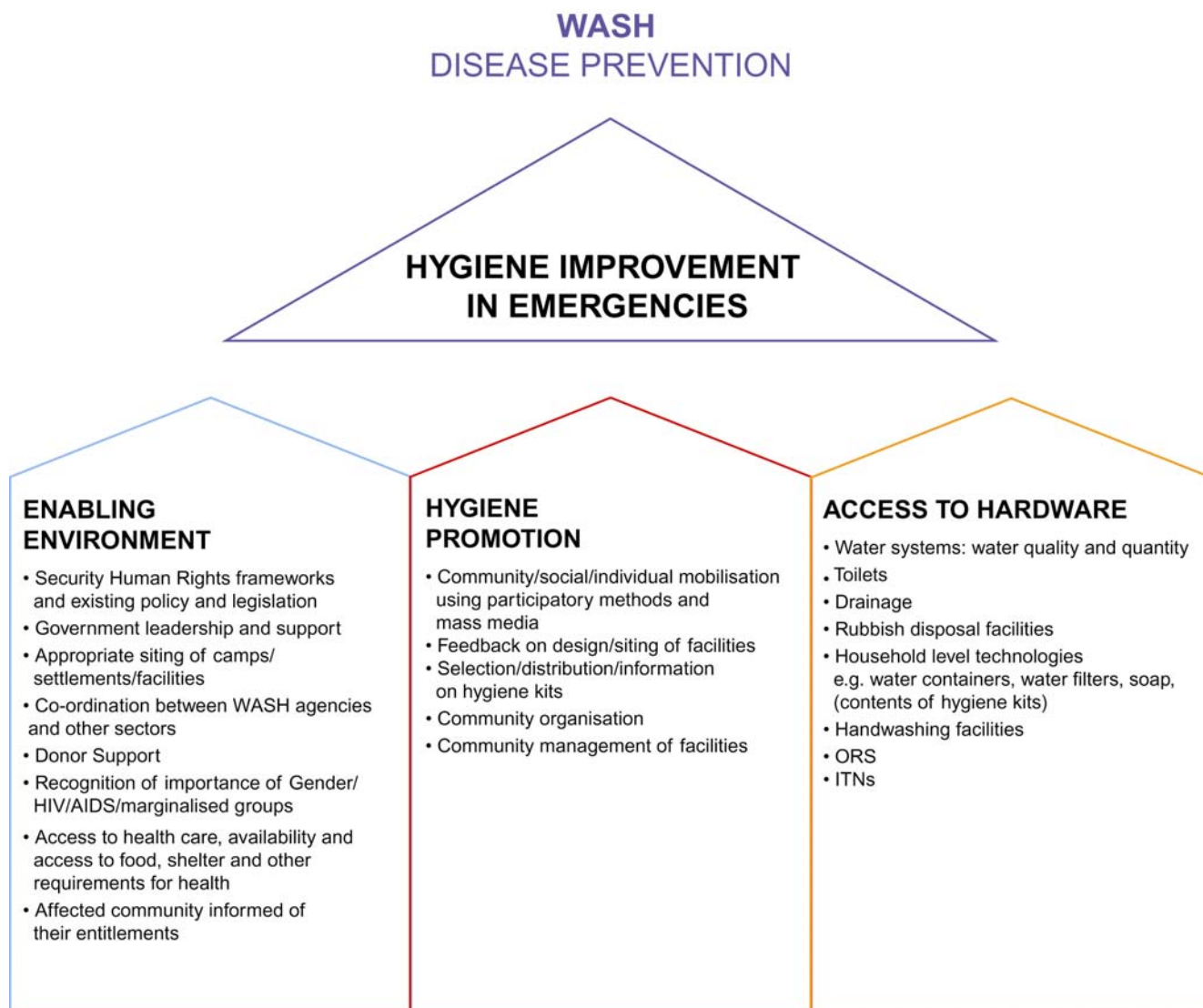
<sup>3</sup> The ratio of 1:500 people is suggested as the minimum level of intervention by Sphere

## Appendix 1: Supporting materials

- **A rapid staff orientation package** focusing on how to engage women, men, and children in WASH interventions, with materials for individual or group inductions and an outline for the content of a half-day workshop for managers, health promoters, and engineers. These materials aim to create awareness and commitment to WASH interventions. This includes an outline, handouts, facilitator's resources and a powerpoint.
- **Menu of indicators** for monitoring hygiene promotion, for use by field practitioners and promoted by WASH coordinators.
- **Annotated Bibliography** A list of hygiene promotion tools and resources, (books, manuals, training modules, audio visual materials) as reference materials for WASH coordinators and others.
- **List of Essential Hygiene Promotion Equipment for Communication** to inform WASH coordinators and guide field implementing agencies.
- **Hygiene related Non-Food Items Briefing Paper** A briefing paper that aims to ensure that the distribution of hygiene related non-food items (NFIs) achieves maximum impact.
- **Generic job descriptions and overview** for field hygiene promoters and community level mobilisers that aim to inform and guide WASH coordinators and implementing agencies to encourage consistency and minimum standards.

## Appendix 2: Example Hygiene Improvement Framework for emergencies

Below is an example of how the Hygiene Improvement Framework might look in an emergency context. As with any model it is not perfect and is open to interpretation. However, it provides a useful overall framework that can help to set the hygiene promotion work within the context of the integrated WASH intervention.



\*NB In some agencies, different sectors will take primary responsibility for the provision of Oral Rehydration Sachets (ORS) and Insecticide-treated Nets (ITNs).

December 2008 (amended graph)



# Indicators for monitoring Hygiene Promotion in Emergencies

## Introduction

During emergencies it is important to monitor the impact of hygiene promotion including the change in community hygiene practices which can contribute to the reduction of WASH related diseases. Information provided by monitoring can usefully feedback into future evaluation and planning of hygiene promotion projects so the objectives can be adjusted where necessary. It is important that data collection is not just seen as an exercise, but that the results of data analysis can be used to identify the projects strengths and weaknesses and ultimately influence decision-making.

During the initial stages of hygiene promotion programme planning, objectives are set and accompanying indicators of achievement defined. A logical framework can be used as an active tool to guide monitoring. Monitoring can include measuring **impact** and assessing whether the project purpose has been achieved and significant change has occurred. This includes reviewing the projects appropriateness, outcomes and outputs (facilities provided or systems set in place) and activities (toilets or water points constructed)<sup>4</sup>. It is also important to monitor participation of communities and whether all those affected are adequately represented e.g. women, men, the poorest and disabled people. Monitoring can be used to measure progress against the baseline data gathered during the initial stages of an emergency, as well as faults in project design and unrealistic objectives.<sup>5</sup>

**Process** monitoring can include how the project is being developed and for identifying and solving problems.<sup>6</sup>

There is a balance to be achieved in the process of collecting data for monitoring, too much data may be difficult to analyse given the time constraints in an emergency.

## Indicators

Indicators are identified in order to be able to monitor and evaluate. Indicators are how you measure whether you have achieved your objective and how this has been done. Indicators can be qualitative or quantitative and are identified when the project plan is initially written. They are either impact indicators or process indicators. Process indicators are found in the Logical Framework at (activity & result level), compared to impact indicators which are found at (purpose or specific objective level).<sup>7</sup> It is also important to measure participation of people and gather health clinic data where possible.

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<sup>4</sup> Oxfam (2001). Guidelines for Public Health Promotion in Emergencies.

<sup>5</sup> Ferron, S., Morgan, J., O'Reilly, M. Hygiene Promotion. A Practical Manual for Relief & Development

<sup>6</sup> Oxfam (2007) Revised Guidelines for Public Health Promotion in Emergencies.

<sup>7</sup> Oxfam (2007) Revised Guidelines for Public Health Promotion in Emergencies.

Hygiene promotion can be difficult to measure and this process is helped if indicators are simple, few in number and suitable for use at community level where possible.

### **Direct and Proxy (indirect or substitute) Indicators**

Direct indicators can be easily measured e.g. numbers of toilets.

Whilst the ultimate aim of hygiene promotion projects is to reduce the mortality and morbidity of WASH related diseases, it is widely recognised that it can be difficult to establish a direct relationship as the incidence of disease is affected by many factors. This is partly due to the difficulty of obtaining accurate data, especially in an emergency situation. For this reason indirect or 'proxy' indicators are considered an acceptable alternative to monitor project impact e.g. hand washing with soap has been proven to have a significant impact on the reduction of diarrhoeal diseases.

### **Indicators to use in an emergency**

A short list of essential indicators is included here which should always be included in any situation.

A list of more general priority indicators which can be used in emergencies is included in the table below with indicators for excreta disposal, water supply, hygiene practices and the environment.

The table provides a comprehensive list of indicators that may all require monitoring at some point during most WASH programmes. However, the particular indicators chosen for monitoring in any given situation, and the frequency with which those indicators are measured, should reflect specific priorities identified during assessment and planning and the practicalities of collecting and managing the data required to measure them.

It is important, where possible to adhere to national monitoring guidelines.

There should be coordination on indicators used across the WASH cluster, so that hygiene promotion is included and prominent in the main key WASH cluster indicators.

## **Essential indicators for monitoring Hygiene Promotion in emergencies**

The five essential indicators which should always be monitored as a priority include:

- X% of the population uses safe water for drinking
- environment free from all faecal matter
- X% of the population wash their hands with soap or ash at least after contact with faecal matter and before handling food
- Women are enabled to deal with menstrual hygiene issues in privacy and with dignity
- All sectors of the community, including vulnerable groups, are enabled to practise the target hygiene behaviours

(X% = depends on the situation)

## **Example Proxy Indicators for Monitoring the Effectiveness of Hygiene Promotion Interventions in Emergencies**

<b>Hygiene Behaviour</b>	<b>Indicators</b>
<b>Safe drinking water</b>	<ul style="list-style-type: none"> <li>adequate water handling practices to minimize contamination practised by x% of the population</li> </ul>
<b>Safe excreta disposal</b>	<ul style="list-style-type: none"> <li>x% of children's and babies' faeces are safely disposed of</li> <li>toilets are used by the majority of men, women and children</li> </ul>
<b>Hygiene Practices</b>	<ul style="list-style-type: none"> <li>soap or ash for hand washing is available in all households</li> <li>hand washing facilities are available at 100 % of communal latrines or in the majority of homes and in use</li> </ul>
<b>Women's privacy and dignity around menstrual hygiene</b>	<ul style="list-style-type: none"> <li>appropriate sanitary materials and underwear for all women and girls are available</li> </ul>
<b>Community participation &amp; representation</b>	<ul style="list-style-type: none"> <li>all sections of the community, including vulnerable groups, are consulted and represented at all stages of the project</li> <li>the majority of community members are satisfied<sup>8</sup> with the provision of facilities</li> <li>users take responsibility for the management and maintenance of water supply and sanitation facilities</li> </ul>

The following are suggestions of ways to monitor some of the essential indicators:

<b>Indicator</b>	<b>Means of monitoring</b>
<b>Safe Drinking Water</b>	Water testing at source and household level Inspection of water containers at water points Household visits to look at water storage containers for signs of possible contamination e.g. not covered, open necked, hands come in contact with water etc.
<b>Safe excreta disposal</b>	Exploratory walks to look for signs of open defecation Observation of maintenance and use of toilets/potties provided Reports from members of affected community expressing use and satisfaction with toilets provided
<b>Hygiene practices</b>	Observation of soap at household level Observation of hand washing at communal latrines Self reported increase in hand washing by affected community
<b>Menstrual hygiene</b>	Reports of satisfaction with provision of menstrual materials from women
<b>Community participation</b>	Observation and discussion with community committees Observation and reports of response to vulnerable groups e.g. latrine provision for disabled people Reports from men, women and children of satisfaction with facilities and improvements in hygiene

### **Adapted from:**

\* International Rescue Committee (2005). Environmental Health Field Guide

\* Walden, V., Nixon Achieng, O., Shirlaw, L., Malile, M. (2007). Minimum standards for public health promotion monitoring during the first three months of a rapid-onset emergency. A guide for field staff.

### **Note:**

- The Sphere minimum standards for disaster response include indicators for water and sanitation (see WASH Cluster Hygiene Promotion Bibliography) [www.sphereproject.org](http://www.sphereproject.org) see Chapter 2 (available in English, French and Spanish)
- Indicators common to all WASH cluster activities should also be considered.

<sup>8</sup> Satisfaction will need to be defined in terms of access, safety, privacy, systems for cleaning etc.

## **Annex 1: Indicators for monitoring Hygiene Promotion in emergencies and relevant sphere indicators**

The table below details the suggested priority WASH indicators alongside the relevant Sphere Indicators. The WASH indicators focus on providing a proxy (substitute) indicator for impact whereas the Sphere indicators also include many process indicators detailing what may be required in order to achieve that impact.

<b>Hygiene Behaviour</b>	<b>Indicators</b>	<b>Relevant Sphere Indicators</b>
<b>Safe drinking water</b>	adequate water handling practices to minimize contamination practised by x% of the population	Each household has at least two clean water collecting containers of 10-20 litres, plus enough clean water storage containers to ensure there is always water in the household Water collection and storage containers have narrow necks and/or covers, or other safe means of storage, drawing and handling, and are demonstrably used
<b>Safe excreta disposal</b>	x% of children's and babies' faeces are safely disposed of  toilets are used by the majority of men, women and children	Use of toilets is arranged by household(s) and/or segregated by sex Toilets are designed, built and located with the following features: <ul style="list-style-type: none"> <li>- used by all sections of the population</li> <li>- sited to minimise threats to users, especially women</li> <li>- sufficiently easy to keep clean</li> </ul> to provide a degree of privacy Users (especially women) have been consulted and approve of the siting and design of the toilet Separate toilets for women and men are available in public places (markets, distribution centres, health centres, etc.) Shared or public toilets are cleaned and maintained in such a way that they are used by all intended users Toilets are used in the most hygienic way and children's faeces are disposed of immediately and hygienically Infants and children up to two years old have 12 washable nappies or diapers where these are typically used. People are provided with tools and materials for constructing, maintaining and cleaning their own toilets if appropriate
<b>Hygiene Practices</b>	Soap or ash for hand washing is available in all households  Hand washing facilities are	People wash their hands after defecation and before eating and food preparation There is at least 250g of soap

	available at 100 % of communal latrines or in the majority of homes and in use	available for personal hygiene per person per month. Each person has access to 200g of laundry soap per month Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day (water quantity)
<b>Women's privacy and dignity around menstrual hygiene</b>	Appropriate sanitary materials and underwear for all women and girls are available	Women and girls have sanitary materials for menstruation
<b>Community participation &amp; Representation</b>	<p>All sections of the community, including vulnerable groups, are consulted and represented at all stages of the project</p> <p>The majority of community members are satisfied<sup>9</sup> with the provision of facilities</p> <p>Users take responsibility for the management and maintenance of water supply and sanitation facilities</p>	<p>Women and men of all ages from the disaster-affected and wider local populations, including vulnerable groups, receive information about the assistance programme, and are given the opportunity to comment to the assistance agency during all stages of the project cycle</p> <p>Written assistance programme objectives and plans should reflect the needs, concerns and values of disaster-affected people, particularly those belonging to vulnerable groups, and contribute to their protection.</p> <p>Programming is designed to maximise the use of local skills and capacities.</p>

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<sup>9</sup> Satisfaction will need to be defined in terms of access, safety, privacy, systems for cleaning etc.



## WASH related non-food items

A briefing paper

### Maximising the benefits of the distribution of hygiene items

Non-food items (NFI) such as cooking sets, soap, buckets, jerry cans and sanitary towels will often be required during an emergency. They have an important role to play in preventing disease outbreaks and help those affected by conflict or disaster to carry out everyday requirements such as cooking and collecting water. Some items are life saving, such as jerry cans for collecting water, blankets in cold weather or soap for maintaining hygiene. Other items may simply contribute to people's sense of dignity in difficult circumstances e.g. underwear, razors and toothbrushes. Most NFIs are used for their intended purpose but some may be sold to raise money to pay for other needed items. While people are at liberty to make their own decisions about the use of such items, an important opportunity to enable better health and hygiene may be lost if people are not given sufficient information about the health benefits of the items distributed. The provision of hygiene items by hygiene promoters can also act as an incentive to become involved in Hygiene Promotion activities.

Encouraging women, men and children to make the best use of hygiene items is often the remit of hygiene promoters but items are often selected and distributed by relief teams headed by logisticians. It is recommended that Hygiene Promoters and Logisticians work together to ensure an effective and efficient system is put in place. Large-scale distributions may need

- It is critical to involve hygiene promoters in the selection and distribution of hygiene items, especially where items may not be used for their intended purpose
- Cluster co-ordinators, hygiene promoters, and logisticians must work together to ensure the efficient distribution and maximum impact of NFIs



to rely on the expertise of logisticians but smaller distributions of tools or cleaning

materials could be carried out with the help of community mobilisers.

Not only is it important that good use is made of hygiene kits but it is also vital that the distributed items do not have a negative effect on other areas of the intervention e.g. empty water bottles may be used for anal cleansing and may cause latrines to fill up very quickly. Disposable nappies and/or sanitary

towels for women may also block latrines or be disposed of inappropriately. Chlorine solution and ORS may be harmful if not used correctly.

The packaging used for hygiene kits can in itself present an additional problem of disposal when items are distributed in large quantities. It may be possible to recycle some packaging materials if people have no need for it.

Improved co-ordination between WASH Hygiene Promotion teams and those who might be distributing non-food items could maximise the health benefits of the distribution and ensure that money and resources are used in the most cost effective way possible.

**An evaluation of the hygiene kit distribution in Pakistan following the earthquake in 2006 identified several problems. Underwear for women was distributed only in small and medium sizes and often was not used. Women were also not familiar with disposable sanitary towels and both underwear and sanitary towels should have been packaged separately in the family hygiene kits. Men in the area tended to have beards and razor blades were unnecessary. Some people felt that razor blades were imposed by western people to try to change their culture and religion. Greater community consultation in the selection of hygiene items was recommended. IFRC 2006**

### Selection of hygiene items

Discussions with affected men and women should form the basis of the selection of hygiene items and while it may not be possible to consult extensively in an acute emergency, there is always some space for dialogue with the affected population. As Sphere suggests:

*'existing cultural practices and familiar products should be assessed in specifying the items supplied. Care should be taken to avoid specifying products that would not be used – due to lack of familiarity – or that could be misused (e.g. being mistaken for foodstuffs).'*

In areas where there are cyclical emergencies, it is easier to have such discussions as part of the emergency preparedness measures.

Many women in Aceh lost all their belongings during the tsunami. They told hygiene promoters that they had received clothes as part of the relief distributions but they lacked underwear. Arrangements were made for local traders to purchase underwear in a variety of sizes and colours and this was delivered at a pre-arranged time to a secluded area of the camp where the women were able to select what they needed in privacy. A similar arrangement was made for the men at a later date. Oxfam 2005



**The following hygiene items might be provided to affected populations but the exact contents of any hygiene kit will depend on specific circumstances.**

### **Personal Hygiene**

- Soap for laundry and personal hygiene (Sphere recommends 250gms bathing soap per person per month and 200gms laundry soap per person per month)
- Water collection AND storage containers (Sphere specifies at least 2 water collecting containers of 10-20 litres plus 'enough water storage containers to ensure there is always water in the house')
- Washable/disposable sanitary towels for women
- Underwear for women and men (and children where appropriate)
- Washable nappies for babies
- Potties for young children
- Bedpans/urinals for those with disabilities
- Anal cleansing containers
- Razor blades, nail clippers, combs, shampoo
- Toothbrushes and toothpaste
- Insecticide Treated Nets
- ORS sachets

### **Communal Hygiene**

- Tools and equipment for digging and/or cleaning latrines or digging drainage (e.g. shovels, picks, wheelbarrows, buckets, boots etc.)<sup>10</sup>

**A phased approach to distribution is recommended. An example of this is given below:**

#### **1<sup>st</sup> PHASE**

2 water containers (1 collection & 1 storage)

Soap for laundry and personal hygiene for 2 weeks (225gms)

Depending on the specific situation other items may also be distributed in the first phase e.g. anal cleansing containers, ITN's or Water treatment agents (where people have some familiarity with these).

#### **2<sup>nd</sup> PHASE**

Additional water container (see water treatment agent in the next column)

Soap for one month (see Sphere)

Cloth (ideally for menstrual hygiene but could be used for other purposes, 1x3m either dark or light cotton cloth per woman)

Water treatment agent for household usage for 15-30 days minimum – including instructions on use and water treatment and storage container (can be provided in 1<sup>st</sup> Phase if people are already familiar with this )

Potties for young children

#### **3<sup>rd</sup> PHASE**

Locally defined and purchased hygiene items

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<sup>10</sup> Each situation must be judged according to accepted norms and considerations of health and safety. Discussion with the engineers will also be important in deciding what items to provide for these activities

## Catalogues from other agencies

UNICEF Emergency Relief Items: Compendium of Generic Specifications (2 volumes)  
1999-2000 [www.ungm.org/Pages/Information/Documents/erc\\_vol1.pdf](http://www.ungm.org/Pages/Information/Documents/erc_vol1.pdf)

UNICEF [www.supply.unicef.dk/catalogue](http://www.supply.unicef.dk/catalogue)

ICRC – Emergency Items Catalogue 2004 [www.icrc.org/emergency-items](http://www.icrc.org/emergency-items)

Oxfam GB Catalogue – section on Health & Hygiene – CD only

IRC – Emergency Hygiene Promotion Kit – CD only

ACF catalogue – CD only

**It is important to consider quality as well as cost – the cheapest items do not always last very long. In Chad angry refugees returned tools they had been given for cleaning up the camps when the tools broke after a few days.**

### Distribution

It may be possible to organise a mass distribution of some pre-stocked priority items, such as soap or water containers, in the very early stages of a large emergency but with other items there must be an assessment of what people need and what is culturally appropriate.

It is recommended that only items that are not culturally sensitive, such as soap (for laundry and personal hygiene) and water containers, be stockpiled for mass distribution in the first few days of an emergency. For other more culturally sensitive items (e.g. sanitary pads and underwear) pre-assessment is critical.

It is beneficial to procure some items locally, where possible, to ensure that they are acceptable.

It may also be possible to organise the provision of cash or vouchers to enable people to make their own decisions about the purchase of hygiene items especially for items such as underwear or sanitary material, thus enhancing people's dignity and ensuring appropriateness.

Some of the above items e.g. soap and disposable sanitary towels may need a repeat distribution every few months to replenish supplies, depending on people's capacity to meet their own needs.

Monitoring of the acceptance and use of the hygiene kits should take place as soon as possible after the distribution, and modifications made, as necessary, prior to the next distribution.

If distribution is done through an intermediary e.g. community leaders or partner NGO, follow up is also vital. Support may be needed to ensure adequate and systematic monitoring and follow up.

In areas of high literacy it may also be possible to provide a written leaflet to accompany the materials distributed. This should clearly explain the contents of the kit, their use, and, where necessary, warnings about misuse. It should also explain people's rights in relation to the distribution.

### **Tips for improving the distribution of hygiene items** **Before distribution**

- Participatory identification and prioritisation of appropriate hygiene items should be done with the community if possible during the rapid assessment. The emphasis is on providing items that people are familiar with, especially where these may be important for cultural or religious reasons e.g. containers for anal cleansing.
- Where possible provide people with samples of items so that they can choose according to preference e.g. materials for women's menstrual protection or items available on the local market.
- A clear, detailed description of the item is required when ordering, along with an indication of the item's priority.
- NFIs should be packaged for ease of handling and transportation by beneficiaries, and securely enough to prevent leakage of liquids.
- A registration list of beneficiaries' households is required (indicating male, female, anyone with a disability or special needs, children, elderly people, and any other vulnerable group (e.g. female or child headed household) and the total number of household population/occupants).
- Ideally, use existing registration lists e.g. those for food distribution, or identify respectable leaders or volunteers within each area to do the registration. This can be cross-checked by random visits to some of the registered households to verify information given by leaders.
- A record of what was distributed needs to be kept – ideally by both the agency and each beneficiary. (In Malawi people were given a card to keep, that provided the details from the registration form and, on the back, listed their specific rights in relation to NFI distribution processes.)
- An NFI distribution team should be identified for each location and should include a distribution officer, beneficiary leader(s), and volunteers.
- A plan for distribution management, task allocation to various teams, flow management, recording, and security will also need to be drawn up. A distribution venue must be identified. Other requirements may include: ink for thumb prints, pens for signatures, and tables and chairs for distribution committee members.
- A distribution schedule detailing dates/times, distribution sites, targeted beneficiaries, items needed, and the responsible persons for every site must be prepared. The list should be shared with the logistics team/warehouse to enable them to prepare transport and support if required.



- Information about the time, place, and nature of the distribution must also be communicated to the affected population via their leaders, notices, community health workers etc. If the distribution is targeted, the beneficiary selection criteria should also be made known.
- If necessary, organise and train separate teams to carry out demonstrations or provide information on assembly and use of items distributed e.g. water filters, chlorine solution and ORS

### **During distribution**

- Ensure that beneficiaries understand the criteria for beneficiary selection, NFI content and use, in order to encourage transparency. They will also need to be made aware of their rights in regard to distribution (specifically that the distribution is free) and the complaints procedure, should the need arise.
- Try to address queries or complaints as they arise and ensure that disruptions to the distribution are dealt with quickly and effectively.
- Where possible, ensure that the materials distributed are intact and functioning e.g. that buckets have lids and taps, and that water filters have all the component parts.

### **After distribution**

- Monitor beneficiary satisfaction with the distribution process and the hygiene items, and observe the use of the items provided. This can be done by randomly selecting a percentage of households for interviews and/or through focus group discussions (a monitoring checklist is contained in the data collection guidance manual and toolkit).
- Monitoring may also highlight where items have been sold in order to purchase items that are considered more important e.g. food or medicines, and may thus highlight other unmet needs.
- Compile distribution reports of items distributed, the number of people receiving items and their level of satisfaction with the items received.
- Reconcile stock levels with broken or defective items etc. Document emerging issues and lessons learnt.
- Ensure that lessons learnt feed into subsequent distributions.

## **Suggestions for improving co-ordination**

- Expertise in setting up distribution mechanisms is required for effective distribution to large populations and may be best managed by logistics teams.
- Hygiene Promotion teams should include an assessment of the hygiene kit requirements of women, men, and children in the initial rapid assessment and ensure that feedback is provided to the Shelter/NFI cluster leads.
- Hygiene Promotion co-ordinators/WASH programme managers should attend the NFI coordination meetings and explain their remit and what they can offer in terms of maximising the benefits of hygiene NFIs e.g.:
  - *selection of appropriate items*
  - *content of relevant information that should be provided with hygiene items*
  - *information/hygiene activities during or soon after distributions*
  - *monitoring of use and acceptability of distributed items*
- Shelter/NFI cluster leads should ask each agency to provide a plan of when distributions will take place and what items will be distributed so that they can be shared with Hygiene Promotion teams.
- Shelter/NFI cluster leads should recommend that each agency that will distribute hygiene items should consult with the WASH agency operating in their area to discuss the best way to provide supporting information and how the distribution will be monitored.

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## ***WASH cluster generic job descriptions for Hygiene Promotion staff and volunteers***

### **Background note**

#### **1. Outline of job descriptions**

This document presents generic job descriptions for the following:

- Hygiene Promotion Coordinator
- Hygiene Promoter
- Hygiene Promotion Community Mobilisers

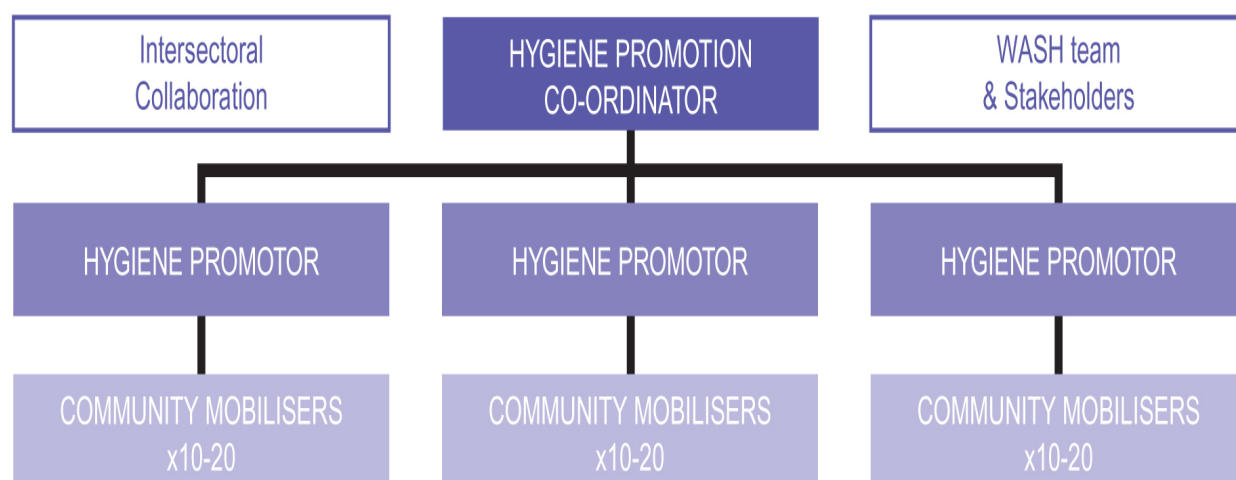
The generic job descriptions are intended to inform Cluster Coordinators and guide implementing agencies (which may include international and national organisations). They outline key activities and competencies and promote minimum standards for the rapid recruitment of Hygiene Promotion staff and volunteers. They are based on a number of generic and specific job descriptions used by agencies in recent years.

**Hygiene Promotion Coordinators** are primarily responsible for the Hygiene Promotion outcomes of operational agencies' WASH programmes. They work by establishing and managing a network of Hygiene Promoters and Community Mobilisers who carry out activities at community level. They coordinate at programme level with other actors in the WASH cluster (other WASH programme staff, other Hygiene Promotion Coordinators, WASH cluster lead etc.) and other related clusters (Health, Nutrition, Protection etc.).

**Hygiene Promoters** are primarily responsible for Hygiene Promotion outputs of an operational agency's WASH response. They manage the day-to-day Hygiene Promotion activities, with each Hygiene Promoter working with a group of Community Mobilisers in a specific location or sector of the disaster-affected population.

**Hygiene Promotion Community Mobilisers** carry out the day-to-day Hygiene Promotion activities of an operational agency's WASH response at community level. They work by establishing a relationship with community members that allows them to be the interface between the disaster-affected community and the WASH response. They may be volunteers or paid staff, depending on the circumstances (see Section 3). The phrase 'job description' used here does not imply paid employment.

The job descriptions correspond to the staffing structure shown below. This reflects the way in which implementing agencies commonly manage Hygiene Promotion activities, although different circumstances may require a different staffing structure and organisation of activities, and job titles may vary. For instance, on small programmes and where resources are limited, there may just be two tiers in the structure, with the Hygiene Promotion Coordinator managing a team of Community Mobilisers directly.



## 2. Adapting the generic job descriptions to specific circumstances

The generic job descriptions should be adapted to suit available human resources, the scale and nature of the emergency, and implementing agencies' operational requirements. The following paragraphs illustrate some of the factors that may be considered.

The way in which responsibilities are divided between the Hygiene Promotion Coordinator, Hygiene Promoters, and Community Mobilisers will depend on their level of skills and experience. In most circumstances the Hygiene Promoters are likely to carry out the day-to-day implementation and monitoring activities suggested here. But in many cases the Hygiene Promoters will be able to hand over a growing number of activities to Community Mobilisers as their skills and confidence develop. In some circumstances the Community Mobilisers will not be able to take as much responsibility for implementation and monitoring as is suggested here and some tasks, such as managing community meetings, will be carried out by the Hygiene Promoters. But in many cases the Community Mobilisers will be able to gain necessary skills and confidence as the programme develops and so take on more responsibility.

Where the disaster-affected population is in scattered settlements that are not easy to visit regularly, the Hygiene Promoters may be required to work with greater autonomy than in concentrated settlements, and so their level of skills and experience may need to be greater. Alternatively, several Hygiene Promotion Coordinators may work on the same programme, to be able to provide support to colleagues scattered in the field, with a strong focus on capacity building to enable Hygiene Promoters and Mobilisers to be able to work effectively with minimum supervision.

In many cases the Hygiene Promotion Coordinator would be part of a WASH team managed by a WASH Programme Manager. Some agencies prefer to have the WASH Programme Manager directly managing a team of Hygiene Promoters and a team of Water and Sanitation Technicians. In this case the key tasks and responsibilities of the Hygiene Promotion Coordinator would be incorporated into this person's role, on a smaller scale, and there would be less need for internal coordination. On the other hand, some agencies may choose to focus entirely on Hygiene Promotion in certain contexts. In this case the Hygiene Promotion Coordinator would need to make special efforts to ensure effective coordination with the agency providing water and sanitation services.

The WASH Cluster Coordinator would normally facilitate the coordination of all aspects of the WASH cluster response. However, in very large emergencies there may be a WASH Cluster Hygiene Promotion Coordinator who would have specific oversight of Hygiene Promotion activities across implementing agencies' programmes. This would have some implications for the role of implementing agencies' Hygiene Promotion Coordinators.

### **3. Human resources planning, recruitment, and management**

#### **3.1 Planning**

A useful way to plan for human resources needs for Hygiene Promotion is to start by estimating the number of Community Mobilisers required. At least two Mobilisers per 1,000 affected people should be allowed for. More Mobilisers will be required for scattered populations or for carrying out particularly intensive Hygiene Promotion activities. If possible, the work should be arranged so that the Mobilisers work in pairs i.e. one man and one woman per 1,000 people. There should be no more than about seven Community Mobilisers per Hygiene Promoter, to ensure adequate supervision. A population of 20,000 affected people would therefore typically require 40 Community Mobilisers and six Hygiene Promoters.

If a Child-to-Child approach is being used, a similar ratio of children's Mobilisers should be planned for, i.e. two Mobilisers per 1,000 children.

It may be useful to plan for a core of Hygiene Promotion staff to start the programme and build up to full strength over a period of a few weeks, using the experience and understanding of the context and challenges gained to refine human resources plans.

Specific job descriptions or (task descriptions) should be developed for the various positions that need to be filled for the Hygiene Promotion programme. The generic job descriptions can be used as a model. The person specification for each role will help in the recruitment process.

#### **3.2 Recruitment**

##### ***Hygiene Promoters***

People who are likely to have the skills required to be Hygiene Promoters include individuals with training and experience in healthcare, health promotion, community development, social work, education, extension work etc. They require strong people management skills and an ability to relate effectively to the affected community. Such people may have key roles in the public, commercial, and non-governmental sectors in normal times and care should be taken to avoid undermining the capacity of these sectors when recruiting Hygiene Promoters. It may be possible to negotiate secondment arrangements with long-term employers for the duration of the emergency, whereby staff return to their normal posts after an agreed period.

Hygiene Promoter posts may be advertised by word of mouth or by written advertisements on flyers or in local newspapers. Advertisements should specify exactly how applications should be made and what documents should be produced in support of the application. Whatever method is chosen, there is often a very large number of applicants, and arrangements should be made to inform unsuccessful applicants. Short-listed candidates should be interviewed by a panel of at least two people, including the Hygiene Promotion Coordinator and another staff member who knows the context well.



## **Community Mobilisers**

Community Mobilisers should be recruited from among the affected community if possible. However, it may be necessary, for speed or other reasons, to recruit Mobilisers from outside the affected community. For example, Red Cross/Red Crescent volunteers may work as Community Mobilisers with a refugee population. Suitable candidates include people with experience in community health, education, or development. Again, care should be taken not to take essential staff and volunteers away from other essential activities. This particularly concerns community health workers and teachers. Reasonable efforts should be made to have a gender balance and representative mix of people from different social and ethnic groups in diverse populations.

Community Mobiliser positions may be advertised by word of mouth or by posting information at public places such as healthcare facilities, distribution points etc. Again, many applications should be expected and a system should be in place to short-list promising applicants and inform unsuccessful ones. Short interviews should be carried out by the Hygiene Promotion Coordinator and at least one Hygiene Promoter. During the interview the candidates should be given clear information about the reward/incentive system that will be used, to avoid disappointment and loss of motivation later on.

## **3.3 Management**

Hygiene Promoters should be managed according to the normal policies and procedures of the implementing organisation. There is likely to be a lot of training during the first days and weeks of the emergency programme<sup>11</sup> and, thereafter, a programme of regular team meetings for planning and reporting on activities and issues arising. Job descriptions should be reviewed early in the work period to ensure they are fully understood and that they provide adequate guidance for staff.

Most Hygiene Promoters will have a geographic area of responsibility, managing a team of Community Mobilisers who work in a specific area, and some may have particular sectoral responsibilities, such as liaising with schools or working with local media.

Community Mobilisers will be assigned to specific sections of the affected community. The most practical arrangement is for them to work in the area in which they live, but this may not always be possible.

Community Mobilisers will require intensive training at the start of the programme<sup>12</sup>. Thereafter, day-to-day supervision and on-the-job training should be provided by the Hygiene Promoters. This will commonly involve a daily meeting at community level and then the Hygiene Promoters may accompany Community Mobilisers in turn as they do their work. As for Hygiene Promoters, it is important that Community Mobilisers fully understand and are comfortable with their job (or task) descriptions.

From time to time it is useful to bring all the Hygiene Promoters and Community Mobilisers together for modular training (for instance, a half-day session on diarrhoea management or adult learning), review of activities, and experience or planning. These meetings are important for developing and maintaining team cohesion and a common understanding of the programme.

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<sup>11</sup> Reference here to ToR 9

<sup>12</sup> Reference here to ToR 9

### **3.4 Compensation**

Hygiene Promoters are normally employed as full-time professional staff and in most cases will be given a contract of paid employment appropriate to their responsibilities and in accordance with national legislation.

In some cases Community Mobilisers may be employed according to national legislation, as daily workers or with a more long-term contract appropriate to the nature of the tasks involved and the duration of the programme. In many other cases they will have volunteer status, without a formal contract, though national legislation regarding volunteers should be respected.

Volunteers may be rewarded, compensated and encouraged for their work in many ways, including the following:

- payment of per diems or daily allowances to cover costs incurred during their work;
- provision of a meal on working days;
- provision of materials and equipment that can be used outside the programme (e.g. a bicycle or wet-weather clothing);
- training courses with refreshments and certificates, particularly if training courses fit into a recognised national or organisational system of qualifications;
- the opportunity to learn and progress within an organisation, potentially to secure paid employment in a more formal role.

Whatever arrangement is chosen (paid or volunteer status), it must be discussed clearly among implementing organisations and across clusters to avoid creating tensions between organisations and disrupting established systems.

All staff and volunteers must be provided with a written agreement that lays out the expectation and obligations of the implementing agency and the person concerned. Systems must be put in place to manage stress, health and safety, and personal security, and provision of insurance for injury and loss must be clearly discussed and agreed.

#### 4. Advantages and disadvantages of working with paid Community Mobilisers

Advantages
In situations where intensive Hygiene Promotion activities are required (to deal rapidly with a hygiene-related epidemic, for example), paid staff may work full time, and can be compensated accordingly
It may be easier to plan and manage the work of paid staff because, by receiving regular payment, they have a contractual obligation, a strong incentive to perform, and are able to focus on their work if their material concerns are lessened by receiving a wage.
Payment provides status and is a sign of respect for the work done. This is an additional form of motivation and can increase the ability of Community Mobilisers to work effectively.
Many potential Community Mobilisers can only afford to work, even part time, if they are paid for their time.
In disaster-affected communities, payments made to Community Mobilisers are a valuable contribution to livelihoods and the local economy.
Administering money payments is usually simpler and less time-consuming than providing in-kind incentives.
Disadvantages
Where Community Mobilisers from the affected community are paid a wage they may be seen as working for the implementing agency rather than the community, and this could weaken the links with the community.
Communities may be less inclined to participate in collective activities voluntarily if they know that Community Mobilisers receive payment for their time.
When one or more agencies pay Community Mobilisers for their work this may create problems for established systems that carry out similar kinds of work on a volunteer basis (Red Cross/Red Crescent volunteer systems, Ministry of Health Community Health Worker systems etc.).
When attractive payments are made to Community Mobilisers in resource-poor settings, particularly where public services are disrupted, employees may be pulled away from their normal roles in essential service provision.
Paying regular wages to a large number of Community Mobilisers can be expensive and may divert funds from other essential activities.
It is likely to be more difficult to achieve sustainability after the emergency phase if it costs a lot to employ workers essential to the ongoing programme.

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## WASH cluster generic job description: Hygiene Promotion Coordinator

<b>Job title:</b>	<b>Hygiene Promotion Coordinator</b>
<b>Reports to:</b>	WASH Team Leader
<b>Manages:</b>	Hygiene Promoters and Community Mobilisers

### **Purpose:**

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As part of the WASH intervention, to safeguard and improve the public health of the affected population by:

- promoting safe WASH practices, including appropriate use and maintenance of WASH facilities and services;
- ensuring appropriate community involvement in the design and delivery of essential WASH services and facilities;
- ensuring effective coordination and integration of Hygiene Promotion activities with the delivery of water and sanitation services and facilities.

### **Key tasks and responsibilities:**

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#### **Information management**

- In collaboration with other members of the WASH team, design and manage assessments and baseline studies in order to identify WASH-related health risks and priorities.
- In cooperation with other WASH staff, design and plan activities to reduce these risks, with reference to both physical and behavioural aspects.
- Design and manage a plan to monitor activities, outputs and impact and adapt the programme as needed.
- Design and manage periodic studies to measure progress and the health impact of the WASH intervention.
- Provide regular and reliable narrative and financial reports.
- Work together with other WASH team members to ensure that the various aspects of the WASH response are integrated, and that they form part of a coherent public health response.
- Coordinate assessments, plans, and activities with other agencies (governmental and non-governmental), as necessary. Participate in cluster coordination meetings as appropriate.

## **Implementation**

Ensure and oversee the following activities:

- Identification of key hygiene practices to be addressed and sectors of the population with whom to engage and develop an appropriate communications strategy to promote safe practices.
- Identification, or facilitation, of community structures through which the WASH activities can be implemented.
- Mobilisation of the disaster-affected communities as appropriate for participation in planning, construction, operation, and maintenance of WASH facilities and services.
- Creation of channels for dialogue between the WASH response and the affected population, to ensure appropriate technical interventions and allow the agency to be held to account for the quality of the WASH programme.
- Design, implementation, and monitoring of WASH activities that are appropriate to specific sectors of the community, e.g. children, youths, women, and men.
- Identification of any need for the distribution of non-food items related to public health, such as containers, soap, hygiene kits, etc., and participation in the choice of items, targeting strategy, promotion of effective use, and post-distribution monitoring.

## **Resources management**

- Recruit, train, and manage Hygiene Promoters and Community Mobilisers.
- Plan and manage the Hygiene Promotion budget, and control/authorise expenditure.
- Manage day-to-day logistics, administration, and personnel activities (including any local, contracted personnel/daily labour) in accordance with national law and organisational guidelines.

## **Programme approach**

- Ensure that Hygiene Promotion activities are in line with relevant standards, codes of conduct, and humanitarian principles.
- Use participatory approaches as far as possible throughout the programme cycle, in training, and in the use of tool kits and other materials.
- Ensure that Hygiene Promotion activities and resources are implemented and handed over or ended in a way that promotes local capacities and sustainable operations.
- Ensure that gender, protection, HIV, the environment, and other important cross-cutting concerns are taken into account in programme design, implementation, and reporting; ensure that activities reflect the needs of specific groups and individuals e.g. elderly people, children, and people with disabilities.

**Person specification:**

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1. Knowledge of public health and one or more other relevant area (e.g. health promotion, community development, education, community water supply).
2. At least two years of practical experience in developing countries in appropriate community health programmes in different contexts. Some of this time should have been in emergency relief programmes.
3. Good knowledge and experience of working with local partner agencies with a capacity to provide formal and informal training.
4. Experience and understanding of Hygiene Promotion and community mobilisation in relation to water and sanitation activities.
5. Understanding of international health and development and relief issues.
6. Sensitivity to the needs and priorities of disaster-affected populations.
7. Demonstrated experience of integrating gender and diversity issues into public health promotion.
8. Assessment, analytical, and planning skills.
9. Good oral and written reporting skills.
10. Diplomacy, tact, and negotiating skills.
11. Training/counterpart development skills.
12. Personnel management skills.
13. Good communication skills and ability to work well in a team.
14. Ability to work well under pressure and in response to changing needs.
15. Ability to travel at short notice and to work in difficult circumstances.
16. Good written and spoken skills in the language of the humanitarian operation.

**Other information:**

Specific job descriptions to be completed with brief background on context, humanitarian response, and organisation's role, reporting lines, terms and conditions etc.

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## WASH cluster generic job description: Hygiene Promoter

<b>Job title:</b>	<b>Hygiene Promoter</b>
<b>Reports to:</b>	Hygiene Promotion Coordinator
<b>Manages:</b>	Community Mobilisers

**Purpose:**

As part of the WASH intervention, to safeguard and improve the public health of the affected population by:

- promoting safe WASH practices, including appropriate use and maintenance of WASH facilities and services;
- ensuring appropriate community involvement in the design and delivery of essential WASH services and facilities.

**Key tasks and responsibilities:****Information management**

- Help plan and carry out needs assessments, baseline studies and periodic studies, and feed back findings to stakeholders.
- Help plan activities to reduce WASH-related risks.
- Collate data from Community Mobilisers and prepare regular reports on activities and WASH conditions for monitoring.
- Coordinate with water supply and sanitation field staff to ensure that the various aspects of the WASH response are integrated.
- Liaise with community leaders and other sectors and agencies working locally in order to coordinate within the WASH sector and between sectors such as health and shelter.
- Keep proper records of field expenditures and report on these to the Hygiene Promotion Coordinator.

**Implementation**

- Promote safe WASH practices, including appropriate use and maintenance of WASH facilities and services.
- Ensure that action is taken to mitigate priority water and sanitation related health risks.
- Facilitate appropriate community involvement in the design and delivery of essential WASH services and facilities.



- Enable effective dialogue with the affected community to allow the agency to be held to account for the quality of the WASH programme.
- Help identify needs for non-food items relevant to hygiene, participate in the choice of items, targeting strategy, promotion of effective use, and post-distribution monitoring.

### **Resources management**

- Recruit, train, and manage Community Mobilisers or other hygiene outreach workers.
- Organise day-to-day logistics, administration, and personnel activities together with the Hygiene Promotion Coordinator.

### **Programme approach**

- Supervise Hygiene Promotion activities in line with relevant standards, codes of conduct, and humanitarian principles.
- Use participatory approaches as far as possible throughout the programme cycle, in training, and in the use of tool kits and other materials.
- Supervise Hygiene Promotion activities and resources so that they are implemented and handed over or ended in a way that promotes local capacities and sustainable operations.
- Take account of gender, protection, HIV, the environment, and other important cross-cutting concerns in programme design, implementation, and reporting; carry out activities in a way that reflects the needs of specific groups and individuals e.g. elderly people, children, and people with disabilities.

### **Person specification:**

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1. Knowledge of one or more of the following: public health, health or Hygiene Promotion, community development, education, or community water supply and sanitation.
2. At least two years of practical experience in the country concerned, in relevant community development, health, WASH, or similar programmes.
3. Good knowledge and experience of working with local partner agencies.
4. Experience and understanding of Hygiene Promotion and community mobilisation in relation to water and sanitation activities.
5. Sensitivity to the needs and priorities of different sectors of a community.
6. Familiarity with the culture of the affected population, ability to develop respect from a wide range of people and strong ability to communicate effectively on hygiene matters.
7. Fluency in the language of the affected population and the international language used in the humanitarian operation.
8. Assessment, analytical, and planning skills.

9. Good oral and written reporting skills.
10. Diplomacy, tact, and negotiating skills.
11. Training/counterpart development skills.
12. Personnel management skills.
13. Ability to work well in a team in difficult circumstances.

**Other information:**

Specific job descriptions to be completed with brief background on context, humanitarian response and organisation's role, reporting lines, terms and conditions etc.

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## WASH cluster generic job description: Hygiene Promotion Community Mobiliser

<b>Job title:</b>	<b>Hygiene Promotion Community Mobiliser</b>
<b>Reports to:</b>	Hygiene Promoter

### Purpose:

As part of the WASH intervention, to safeguard and improve the public health of the affected population by:

- promoting safe WASH practices, including appropriate use and maintenance of WASH facilities and services;
- ensuring appropriate community involvement in the design and delivery of essential WASH services and facilities.

### Key tasks and responsibilities:

#### Information management

- Gather data during needs assessments, baseline studies, and periodic studies, and help feed back findings to stakeholders.
- Help plan activities to reduce WASH-related risks.
- Record data on routine activities and WASH conditions and forward it to the Hygiene Promoters.
- Liaise with water supply and sanitation field staff.
- Liaise with community leaders and other sectors and agencies working locally.

#### Implementation

- Help identify key hygiene practices to be addressed and carry out appropriate activities to promote safe practices. These activities may include the following:
  - communication activities such as community meetings, drama, information campaigns, use of educational materials etc.;
  - support to water-point committees, hygiene committees, latrine attendants etc.
- Mobilise disaster-affected communities as appropriate.
- Act as the link between the WASH response and the affected population at community level.
- Help identify needs for non-food items relevant to hygiene, participate in the choice of items, targeting strategy, promotion of effective use, and post-distribution monitoring.

#### Resources management

- Use programme resources effectively and with care.

**Programme approach**

- Carry out Hygiene Promotion activities in line with relevant standards, codes of conduct, and humanitarian principles.
- Encourage the participation of community members throughout the programme.
- Act in a way that is sensitive to gender, protection, HIV, the environment, and other important cross-cutting concerns.

**Person specification:**

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1. Some prior knowledge of health, hygiene, teaching, or community development.
2. Strong communication skills.
3. Good listening skills.
4. Sensitivity to the needs and priorities of different sectors of the community.
5. Trust and wide acceptance by the community.
6. Diplomacy, tact, and negotiating skills.
7. Literacy, numeracy, and record keeping skills are desirable but may not be essential.

**Other information:**

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Specific job descriptions to be completed with brief background on context, humanitarian response and organisation's role, reporting lines, terms and conditions etc.

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## List of essential Hygiene Promotion equipment for communication

Included below is a list of basic Hygiene Promotion materials essential for use during an emergency (some of which may be purchased locally), in addition to a list of optional materials which are more high tech and expensive. The number relates to that recommended for a beneficiary population of 5,000 with 10 Hygiene Promoters.

### List of basic Hygiene Promotion materials

5 x Megaphones with batteries (ideally minimum 20 watt with clear sound projection to 700m and rechargeable batteries)

22 x T-shirts and hats/caps with 'Hygiene Promoter' printed on them (it might be appropriate to have long-sleeved T-shirts or shirts for some countries)

5 x Banners (plain, which can be written on)

5 x Flip charts with illustrations of generic hygiene practices for different regions

10 x Flip chart pads – plain paper

5 x Training & Visual Aids Kit: A4 size plain paper, coloured paper, A4/A3 size card, pencils, markers (permanent and non permanent), paints and brushes, balloons, assorted fabric (approximately 2-3 metres, felt, wool – for making puppets and props for drama activities), sewing kit (scissors, needles, thread), glue, craft knife, plastic backing, *blu-tack*, exercise books or notepads, biros, plastic/card folders, and evaluation sheets<sup>13</sup>

50 x Notebook and pen

10 x Plastic sheets: useful to sit on, to construct shelters for Hygiene Promotion sessions, as well as for drawing games e.g. giant snakes and ladders

10 x Hardcopy of the WASH *Hygiene Promotion Guidelines* (short-term outputs produced by this project) and 4 key books:

- *Facts for life 1 & 2*, UNICEF 2002
- *A practical manual for relief and development*, by Ferron et al 2007
- *Where there is no artist*, by Rohr-Rouendaal, 2007
- *Behaviour change communication in emergencies*, UNICEF 2006

1 x Office tent

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<sup>13</sup> Oxfam (2001) *Guidelines for Public Health Promotion in Emergencies*. Training & Visual Aids Kit.

### 3 x Tables

1 x Laminator (for A4 and A3 size paper, portable) and the plastic for sealing (10 packets of Lamination pouches in A4, A3 and ID sizes, packets of 10 pouches each)

It is a useful item for producing Hygiene Promotion materials (digital photos, flash cards, posters, PRA materials etc) for training and distribution in target communities. Pictures for Hygiene Promotion discussions can be photocopied, coloured, and laminated for use in the communities. Additionally it can be used to process ID cards for programme and field staff. This item must be purchased with Laminator pouches, without which it won't be possible to laminate materials.

1 x Computer (and CD Rom with useful visuals) and printer (for colour printing)

Computer with sufficient capacity and compatible with digital camera and printer.

Portable inkjet printer that can produce coloured prints, lightweight, durable, with wireless port. Coloured cartridges for the printer, universal plug adapted for the printer, and kitbag for computer and printer.

1x Digital camera

The purchase of a digital camera, portable printer, and laminator enables field practitioners to take photos, print them immediately, laminate them and use locally for Information, Education and Communication (IEC). Laminating them makes them more durable.

Local purchasing advice: The digital camera should be capable of carrying out basic functions, easy to use (ie field workers can easily be taught to use them and produce photos and materials for IEC), lightweight and durable. Ideally it should not be very expensive. The USB cable must be compatible with the printer.

1 x A waterproof plastic trunk to store all above equipment.

### **List of optional equipment for Hygiene Promotion communication**

1 x Video/DVD player

10 x Musical instruments such as drums, tambourine, rattles (could purchase locally)

1 x Digital projector and spare parts

1 x Portable screen

1 x Camcorder

10 x Cassette recorder for recording Hygiene Promotion songs.

10 x Hand-held digital recorder or digital voice recorder (to download to computer)

1 x Generator and electrical equipment

## Catalogues from other agencies

UNICEF Emergency Relief Items: Compendium of Generic Specifications (2 volumes) 1999-2000 [www.ungm.org/Pages/Information/Documents/erc\\_vol1.pdf](http://www.ungm.org/Pages/Information/Documents/erc_vol1.pdf)

UNICEF [www.supply.unicef.dk/catalogue](http://www.supply.unicef.dk/catalogue)

ICRC – Emergency Items Catalogue 2004 [www.icrc.org/emergency-items](http://www.icrc.org/emergency-items)

Oxfam GB Catalogue – section on Health & Hygiene – CD only

IRC – Emergency Hygiene Promotion Kit – CD only

ACF catalogue – CD only

### *Note:*

- Some materials would need to be prepared and gathered beforehand including generic pictures of hygiene practices tailored for different regions.
- We recommend stockpiling the items on the basic list within agencies and that agencies cooperate in pooling available resources for a major emergency.

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## Annotated bibliography for Hygiene Promotion in emergencies

This bibliography is comprised of: key Hygiene Promotion documents for emergencies, other Hygiene Promotion documents, CD Roms, videos, a table of the sources and a list of useful websites.

### Key documents

The following key documents focus on Hygiene Promotion in emergencies.

**Sphere Project (2004) *Humanitarian charter & minimum standards in disaster response*. Geneva: The Sphere Project.**

The aim of the Sphere Project is to improve the effectiveness and accountability of disaster response during emergencies. The key tool developed by the project is the Sphere Handbook which sets out minimum standards during disasters including water, sanitation, and hygiene. Indicators and guidance notes are included. Many members of the international community collaborated during the production of this handbook, and made a commitment to adhere to these standards. The 2004 edition of the handbook has recently been reviewed and updated.

**UNICEF and other agencies (WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP, and The World Bank) (2002). *Facts for life 1 & 2*. (Updated version). New York: UNICEF.**

Aims to provide parents and other care givers with information they need to save and improve children's lives. This resource contains a series of messages on a range of issues relating to child health including diarrhoea and hygiene which are presented in a non-technical language. It is intended for health workers and family members and the messages are clear, brief, and practical.

*Material is in English, French, and Spanish.*

**UNICEF (2006) *Behaviour change communication in emergencies. A tool kit*. Unicef, Regional Office for South Asia: (UNICEF, ROSA)**

This resource is suitable for those working in emergencies caused by natural disasters, and was produced in South Asia. It is designed to help personnel to prepare, plan, implement, and monitor behaviour change communication initiatives supporting health, hygiene, and child protection efforts in emergencies. The section on Hygiene Promotion outlines the role of Hygiene Promotion in emergencies and the development of behavioural objectives, key messages, and communication actions for Hygiene Promotion. It sets out methodologies to use during the first six to eight weeks of an emergency, as well as beyond the initial response. It includes many practical tools for use in planning and implementation.

**Ferron, S., Morgan, J., and O'Reilly, M. (2007) *A practical manual for relief & development*. (Updated version). London: IT Publications on behalf of CARE International.**

This is a comprehensive and practical manual to help field workers develop a Hygiene Promotion programme in both relief and development settings. It is also helpful for those trying to achieve better programme integration of water, sanitation, and Hygiene Promotion/community management. Capacity building and participation is central to the manual, in particular working collaboratively, so that people have significant input into the design, implementation, and management of water and sanitation programmes.

Participatory learning during emergencies is emphasised, and the Hygiene Promotion approaches which are useful in different phases of the emergency project cycle. The final appendices provide details of the methodologies used as well as pictures which can be adapted and used. Examples of job descriptions and training schedules are also included.

**Harvey, P. (2007) *Excreta disposal in emergencies. A field manual*. An interagency publication (International Federation of Red Cross/Red Crescent, Oxfam, UNHCR, UNICEF and WEDC). Loughborough: WEDC, Loughborough University.**

This manual has been written in recognition of the need for more emphasis on excreta disposal during emergencies, in particular as inadequate sanitation facilities and poor hygiene practices give rise to many of the common diseases. It is aimed at field-based technicians, engineers, and non-technical staff working on sanitation in emergencies, including natural disasters, complex emergencies, relief for refugees and internally displaced people, and with a focus on rural and peri-urban areas. The aim of this manual is to provide practical guidance on assessment, planning, design, and construction of appropriate excreta disposal systems, as well as how to maintain and promote their use.

**Oxfam (2001) *Guidelines for public health promotion in emergencies*. Oxford: Oxfam.**

These practical guidelines are for field workers who wish to design and implement public health promotion projects in emergencies, with a particular focus on the control of diarrhoeal diseases. Central is the importance of community involvement in reducing public health risks. The guidelines recognise that different emergency scenarios require different interventions and distinguish the high-risk, acute stage of emergencies from that of the medium-risk situation. The use of different methodologies for base-line collection and monitoring is clearly presented. A final section on resources is included with checklists for assessment of hygiene practices, household observation, reporting formats, and an example of a programme log frame.

**Action Contre La Faim (2005) *Water, sanitation and hygiene for populations at risk*. Paris: Hermann. Available in English, and French.**

These emergency guidelines include a chapter on Hygiene Promotion and community management including programme planning. Contains details of tools which can be used during information gathering for a base-line survey, including three-pile sorting and community mapping. A list of items which can be usefully included in hygiene kits is also given.

**ECHO (2005) *Model guidelines for mainstreaming water and sanitation in emergencies, protracted crises, linking relief, rehabilitation & development and disaster preparedness operations*. European Commission.**

The introduction to these guidelines outline ECHO's strategic approach for water and sanitation in emergencies. Water, sanitation, and hygiene interventions are categorised and tailored for acute emergencies and chronic emergencies, and further within these

categories for natural disasters, conflict induced disasters, and disasters resulting from population displacement. Interventions and good practices for Hygiene Promotion are included for each situation. Crosscutting issues are also addressed including participation, gender, the environment, targeting the most vulnerable and linking relief and rehabilitation to development. A guide of standards and indicators is also included.

**International Rescue Committee (2005) *Environmental health field guide. Guideline summaries, technical references, standard designs, blank forms, field tools and software*. New York: International Rescue Committee.**

This guide is designed to assist field staff implementing environmental health projects through all phases of the cycle during emergencies. The Hygiene Promotion section outlines the steps of programme implementation including the key hygiene practices to target, the key messages, training methodologies, and suggestions for how to integrate water and sanitation to other field programmes. Also included is the Hygiene Improvement Framework linking hardware to software. Includes a comprehensive collection of documents, technical designs, and forms which have been field tested and are in use. An extensive annotated bibliography for Hygiene Promotion and community participation materials is available but mainly focuses on development work.

**Morgan, J. (2001) *Environmental Health Promotion capacity building. A training guide based on CARE's Hygiene Promotion manual*. Well Task 515.**

**Loughborough: WELL. London School of Hygiene & Tropical Medicine/Water Engineering Development Centre (WEDC)**

This training guide was written with the aim of disseminating the contents of the manual, *Hygiene Promotion. A Practical Guide for Relief and Development* for those working on Hygiene Promotion in the field. Its objectives are to help people analyse the causes of environmental health, prioritise activities which will improve conditions, identify and measure changes in practices, and plan for interventions which are sustainable. Participation is at the heart of the methodology. The guide is aimed at those managing both urban and rural environmental health services and development projects at all levels.

**Turatbekova, M. (Ed.) (2005) *PHAST for an emergency*. UNICEF, Pakistan.**

This manual was produced and used during the Pakistan earthquake. PHAST (Participatory Hygiene & Sanitation Transformation) is mostly used in a development context, but this guide has adapted the PHAST methodology for use in training PHAST trainers working in the refugee camps. The PHAST stages which have been selected include those of problem identification, problem analysis, and selecting options for solutions.

**International Federation of Red Cross/Red Crescent (2006). *Emergency Response Unit: Mass Sanitation Module (Revised)*. Geneva: IFRC, Water & Sanitation Unit, Health & Care Department.**

The International Federation of Red Cross/Red Crescent recently updated their Emergency Response Unit Mass Sanitation Module which delivers essential sanitation and Hygiene Promotion services to populations in emergency situations. This module has a capacity to provide services to 20,000 people in a small area, with options for adding resources for serving larger or more scattered groups, and is intended to be deployed for up to four months and with a staff of three persons including a hygiene promoter. Its principle activities include the planning of sanitation and Hygiene Promotion activities and the construction of emergency latrines and development of community-based latrine programmes. A training programme has been produced for training personnel of the Emergency Response Unit before their deployment to an emergency situation.

**Rohr-Rouendaal, P. (2007) *Where there is no artist – development drawings and how to use them*. 2<sup>nd</sup> Edition. London: Practical Action Publishing. (Includes CD ROM).**

This book contains over 1,200 drawings related to a wide range of health and educational issues, in addition to guidelines for copying, enlarging, and adapting them in a simple manner. It is envisaged that the drawings can be used to help stimulate learning. This 2<sup>nd</sup> edition has a CD-ROM attached.

## **Other Hygiene Promotion documents**

The following documents are relevant for Hygiene Promotion in a development context. Listed in alphabetical order by author.

**Adam, G. and Harford, N. (1998) *Health on air. A guide to creative radio for development*. London: Health Unlimited.**

This practical handbook has been developed for those in developing countries planning to use radio to influence attitudes and change health behaviour. In particular it is for radio practitioners (managers, editors, reporters, and producers) involved in health education media campaigns and others in health organisations and NGOs. It gives guidelines on how to: assess need when using radio for health education; select information; pre-test; devise programme formats; schedule; plan campaigns make radio interactive; and monitor and evaluate. Examples are included which illustrate techniques, approaches, and issues which are based on the experiences of health education projects and radio stations worldwide.

**Almedon, A. (1997) *Hygiene evaluation procedures: Approaches & methods for assessment for water & sanitation-related practices*. Boston: International Foundation for Developing Countries. Distributed by IT Publications, London**

This handbook provides practical guidelines for field personnel who want to design and conduct an evaluation of water and sanitation related hygiene practices. In particular it focuses on helping practitioners with little previous experience of gathering and interpreting qualitative data, by exploring a variety of relevant methods and tools, and describing how they can be usefully chosen and combined. Qualitative data gathering is a useful way of gathering information on socio-cultural aspects of behaviour, which offers an alternative to the limitations of quantitative data measurement. Also included are examples from field experience of common mistakes and pitfalls.

**Appleton, B. and Sijbesma, C. (2005) *Hygiene Promotion. Thematic overview paper 1*. Delft, The Netherlands: IRC, International Water & Sanitation Centre.**

This paper aims to help readers to familiarise themselves with current thinking about Hygiene Promotion. Chapters include the importance of Hygiene Promotion and why it matters, learning from experiences and research, and making Hygiene Promotion more effective. Also included are case studies, resources, web sites, contacts, courses, and a Hygiene Promotion quiz. The large number of appendices include material related to Hygiene Promotion including participatory tools and techniques and PHAST. This paper is one of a series on water, sanitation, and health.

**Bockhorn-Vonderbank, M. (2004) *Children's Hygiene & Sanitation Training (CHAST). A practical guide*. Caritas Luxembourg/Caritas Switzerland (Swiss Group).**

This guide outlines the full CHAST methodology which has been adapted from the PHAST approach to suit the needs of young children in Somaliland. It aims to help children make the links between personal hygiene and health and includes step-by-step instructions for CHAST facilitators. An accompanying CD includes the CHAST tools with illustrations,

posters, exercises, and games for children between the ages of five and 12 years. CHAST uses a 'child to child' approach where children participate together in discussions and role plays to share their experiences.

**Connolly, M.A. Ed. (2005) *Communicable disease control in emergencies. A field manual*. Geneva. WHO.**

This field manual covers the control of all communicable diseases which may occur during an emergency. Of particular interest is the section on control and prevention of diseases caused by poor water and sanitation including diarrhoeal diseases, cholera, and shigellosis and scabies. This serves as a technical reference resource in which basic medical facts are included and information is organised under clinical features, diagnosis, and case management, although there is very little reference to hygiene or health promotion per se.

**Curtis, V. (1999) *Hygiene Promotion. Well Technical Brief*. Loughborough: Water Engineering Development Centre (WEDC), Loughborough University.**

This short, three-page technical brief explains why hygiene education has in the past failed, including a number of key fallacies which are taken for granted. In particular it challenges the myth that "adults are clean slates" on which to write new ideas. Key principles to improve hygiene education are outlined, including: target a small number of risk practices; target specific audiences; identify the motives for changed behaviour; hygiene messages need to be positive; identify appropriate channels of communication; decide on a cost-effective mixture of channels; and Hygiene Promotion needs to be carefully planned, executed, and evaluated.

**Curtis, V., Cairncross, S., and Youli, R. (2000) 'Domestic hygiene & diarrhoea. Pinpointing the problem.' *Tropical Medicine & International Health*. Vol 5. No 1. pp 22-32. January 2000.**

This journal paper discusses how domestic practices can help to reduce diarrhoeal diseases. The authors suggest that successful Hygiene Promotion depends on the need to identify and target the few hygiene practices which are a major source of risk. Also that safe stool disposal, a primary barrier to transmission, may be more important in preventing diarrhoea than the secondary barrier of handwashing before eating. The authors maintain that the epidemiological evidence for the effect of primary and secondary behaviours supports their conclusion. They conclude by suggesting that Hygiene Promotion programmes should give priority to the safe disposal of faecal material and the adequate washing of hands after contact with adult and child stools.

**Curtis, V. and Kanki, B. (1998) *Hygienic, happy and healthy, How to set up a Hygiene Promotion programme (Volumes 1, 2, 3 and 4)*. New York: UNICEF.**

Guidelines are provided for use in a development context on how to use research to set up a Hygiene Promotion programme, using social mobilisation techniques to encourage the adoption of safer hygiene practices. Four short manuals in the series cover how to plan a hygiene programme, how to set up a hygiene programme, motivating behaviour change, and designing a hygiene communication programme.

**Fewtrell, L. and Colford J. (2004) *Water, sanitation & hygiene: interventions and diarrhoea. A systematic review and meta-analysis*. Health, Nutrition & Population Discussion Paper. Washington DC: The World Bank.**

This is a formal review and meta-analysis examining the evidence of a large number of studies reporting the results of interventions intended to reduce illness through improvements in drinking water, sanitation facilities, and hygiene practices. It was found

that in developing countries diarrhoeal diseases were reduced by individual interventions including improved water quality (specifically point-of-use treatment), water supply interventions (mainly the provision of household connections and use of water without household storage), and hygiene interventions (especially those promoting handwashing). Multifactorial interventions consisting of water supply, sanitation, and hygiene education reduced diarrhoea, but were not more effective than individual interventions.

**Flavin, M., Naimoll, G., Sherburne, L. (2004) *Improving health through behaviour change. A process guide on Hygiene Promotion*. Arlington, USA: Environmental Health Project (with PAHO, Plan & USAID). Joint publication 7.**

Central to this guide for planning and management of Hygiene Promotion is the use of behaviour-centred methodology. It can be used both as a whole guide for Hygiene Promotion programme development, implementation, and evaluation, as well as for developing training sessions on behaviour change. The guide has a section on the Hygiene Improvement Framework. The focus is mainly on longer term Hygiene Promotion.

**GOAL (2007) *GOAL technical guidelines on water & sanitation – Draft*.**

These guidelines have been written for GOAL personnel and are useful for both development and emergencies. They cover aspects of water and sanitation, with a short chapter on Hygiene Promotion. The sections are thoroughly and well referenced with an innovative colour coding reference system, to technical briefs produced by WEDC and WELL, with documents accessed on the web (and available on an accompanying CD produced by GOAL), and recommended texts for programme activities and useful websites.

**Hope and Timmel (1984) *Training for transformation*. London: Intermediate Technology Publications, Zimbabwe: Mambo Press.**

The well known *Training for Transformation* series of three manuals has been widely used and valued by many organisations worldwide. They serve as an introduction to participatory development with training exercises, case studies, and practical ideas.

**Howard-Grabman, L. and Snetro, G. (No date) *How to mobilise communities for health and social change. A field guide*. Health Communication Partnership. [PUBL?]**

This field guide gives the general principles and methods of community mobilisation working with disadvantaged or marginalised groups in developing countries. It contains examples and lessons learned from different countries worldwide. The guide is aimed at health programme managers of community-based programmes who are considering promoting or improving community mobilisation at all levels.

**International Federation of Red Cross/Red Crescent (2007) *Software tools for water & sanitation programming*. IFRC, Water & Sanitation Unit, Health & Care Department.**

This guide to implementing a software programme is aimed at Red Cross/Red Crescent workers currently working in water and sanitation projects, with examples from different RC National Societies. This guide has an accompanying CD-Rom which includes a number of useful tools. It clearly defines Hygiene Promotion and behaviour change and gives an overview of community participation and management. It looks at PHAST (Participatory Hygiene & Sanitation Transformation) in some detail, outlining its seven steps and benefits and constraints of Red Cross programmes, and provides a useful outline for PHAST training including details of training at different levels and planning for

training. Additional PHAST tools are included including for gender and for monitoring and evaluation (including a base-line survey and quarterly monitoring tools). There is a chapter on the use of PHAST in emergencies in refugee or displaced-persons camps, along with suggestions for shortening PHAST in the acute phase, as well as in-country outbreaks of diseases such as cholera.

**O'Sullivan, G.A., Yonkler, J.A., Morgan, W., Merritt, A.P. (2003) *Field guide for designing a health communication strategy. A resource for health communication professionals*. Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programmes.**

The aim of this field guide is to provide practical guidance on designing, implementing or supporting a strategic health communication effort, which takes a long-term approach and is appropriate for audience needs. It is based on the premise that strategic communication should be collaborative and participatory. A set of practical tools is included as well as worksheets, examples, and tips to help the reader apply the concepts described. The guide is intended for programme managers implementing health programmes in developing countries and communication specialists.

**Linney, B. (1995) *Pictures, people and power*. Hong Kong: Macmillan.**

This book shows how pictures can be used to promote learning and help to empower people, by drawing on local knowledge. It covers issues such as visual literacy which the author thinks can be easily learned if presented in an empowering way. In addition, it emphasises the importance of people producing their own visual materials and how pictures can be more effective than just the use of message-based posters for learning.

**Narayan, D. (1993) *Participatory evaluation: Tools for managing change in water & sanitation*. World Bank Technical Paper No. 207. Washington DC: The World Bank.**

This classic publication remains an excellent and useful guide to participatory evaluation in the water and sanitation sector drawing on experiences from projects worldwide. It promotes the importance of setting targets and indicators with the community, including for hygiene behaviours, in order to evaluate specific interventions effectively.

**Pretty, J., Guijt, I., Thompson, J. and Scoones, I. (1995) *Participatory learning & action: A trainer's guide*. London: IIED.**

This useful guide is intended for trainers who are training others in the use of participatory methods and has a style which is easy to read. It gives a comprehensive overview of the theory and practice of participatory learning and action, and focuses on the complexities of training in a real-world setting and how to deal with them. One section has details of 101 games and practical exercises for use in workshop and classroom settings as well as in the field. These are useful for energising participants, improving group interactions, enhancing interviewing skills, encouraging analysis of local livelihoods and conditions, and evaluating various exercises and training events.

**UNICEF (1998) *Towards better programming. A manual on school sanitation and hygiene*. Water, Environment and Sanitation Technical Guidelines Series No. 5. New York: UNICEF.**

This manual is one in a series of guidelines on water, the environment, and sanitation. It outlines both the hardware and software components of a school sanitation hygiene programme and gives a broad overview of the state of knowledge and experience of such programmes at that time, including case studies. It makes suggestions for how to create an enabling environment for school sanitation programmes at the national, school, and community level including assessment, planning, implementation, construction, and



maintenance of school facilities and monitoring programme implementation. It has been written by UNICEF in collaboration with the IRC.

**UNICEF (1999) *Towards better programming. A manual on communication for water supply and environmental sanitation programmes*. Water, Environment and Sanitation Technical Guidelines Series No. 7. New York: UNICEF.**

This manual is one in a series of guidelines on water, the environment, and sanitation. It gives an overview of programming for behaviour development and includes guidance on incorporating communication and behaviour change approaches in water and environmental sanitation programmes. Communication for development, on which it is based, operates through three main strategies which include advocacy, social mobilisation, and programme mobilisation.

**UNICEF and London School of Hygiene and Tropical Medicine (1999) *Towards better programming. A manual on Hygiene Promotion*. Water, Environment and Sanitation Technical Guidelines Series No. 6. New York: UNICEF.**

This manual is part of a guideline series produced by UNICEF on water, the environment, and sanitation, and is based on the experiences of a UNICEF-supported project in West Africa. It describes a method of bottom-up programme planning for Hygiene Promotion working with people to design safe alternatives to risk practices. It describes how to identify what motivates people to carry out safe hygiene practices. This manual is simply presented with black and white line drawings, making it easy to reproduce for local use.

**USAID (2004) *Strategic report 8. Assessing hygiene improvement. Guidelines for household and community levels*. Arlington, USA: Environmental Health Project.**

These guidelines present appropriate indicators and data collection instruments to evaluate water supply, sanitation, and hygiene interventions. They include 66 indicators and 360 model survey questions which can be used to measure hygiene improvement and which represent best practice. The indicators are classified into 'priority' and 'supporting' and relate to the areas of improving access to hardware, promoting proper hygiene, and strengthening the enabling environment. Detailed information about each indicator is given. The Hygiene Improvement Framework (HIF) is introduced as an approach to prevent childhood diarrhoea.

**Werner, D. and Bower B. (1982) *Helping health workers learn*. USA: Hesperian Foundation.**

This is an invaluable resource for training village health workers and educators working at community level. Its core is people-centred and it promotes a participatory approach to helping people to analyse and address their problems. It includes well illustrated activities for mothers and children, ways of producing low-cost teaching aids, suggestions for using theatre for education, and ways to build on community experiences and strengths.

**WHO (2004) *Cholera outbreak. Assessing the outbreak response and improving preparedness*. Geneva: WHO.**

These WHO guidelines offer a framework for assessing and responding to a cholera outbreak and are intended for use by health professionals. The response proposed is broader than just a medical one. Guidelines also aim to improve preparedness for the response and future outbreaks. Topics covered include outbreak detection and confirmation, organisation of response, management of information, case management treatment, reduction of mortality, hygiene measures in health care facilities, community, water, food, sanitation, funerals, surveillance, and partner organisations.

**WHO (2005) *Malaria control in complex emergencies. An inter-agency field handbook.* Geneva: WHO.**

This inter-agency handbook, developed by the Roll Back Malaria Technical Support Network on Complex Emergencies, is the first to include comprehensive guidelines on malaria control in emergencies. It focuses on the acute phase of an emergency and provides practical guidance for planners on effective malaria control responses including designing and implementing measures to reduce malaria morbidity and mortality.

**WHO Technical Note for Emergencies (2005) *Essential hygiene messages in post-disaster emergencies.* Revised. Technical Notes for Emergencies. Geneva: WHO.**

This fact sheet outlines some of the key activities in dealing with Hygiene Promotion in post-disaster emergencies.

**Wood, S., Sawyer, R., and Simpson-Herbert, M. (1998) *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal diseases.* WHO. Available in English, French & Spanish.**

The PHAST guide (Participatory Hygiene & Sanitation Transformation) has seven steps, of which the first five take the community through the development of a plan to prevent diarrhoeal diseases by improving water supply, hygiene behaviours, and sanitation. When it was first produced in 1998, this guide presented a new model to empower communities to improve hygiene behaviour and to improve, manage, and promote ownership of water and sanitation facilities. PHAST aims to demonstrate the relationship between sanitation and health status, and increase the self-esteem of community members. The steps aim to help community members to work out what they want to do and how it should be implemented and sustained in the future. Each of the seven steps has activities which are clearly set out and are accompanied by tool kits. The steps include problem identification, problem analysis, planning for solutions, selecting options, planning for new facilities and behaviour change, and monitoring and evaluation. Part III of this guide shows how to make a tool kit for each of the activities including a pocket chart and three-pile sorting.

**World Bank. (No date) *A guide for developing a Hygiene Promotion programme to increase handwashing with soap.* Washington DC: Health Communication Partnership.**

This practical handbook focuses on handwashing which it considers may be more effective than any single hygiene behaviour, and promotes stand-alone handwashing with soap programmes. It lays out the experiences of the Global Public-Private Partnership for handwashing with Soap which has promoted mass handwashing programmes and large-scale promotion in Ghana, Peru, Senegal, and Nepal. Issues covered are facilitating the foundation for a national handwashing programme, understanding the consumer, and programme implementation and organisation. Case studies and tools are included.

## **CD-ROMS**

**Action Contre La Faim:**

***Hygiene Promotion: a learning experience.***

This contains Hygiene Promotion materials from a number of different ACF supported projects including Cambodia, Honduras, Liberia, Myanmar, Nicaragua, Philippines, and Timor. *Material is in French, English and Spanish.*

***Hygiene Promotion Self Training Module (Draft). (June 2006)***

This self-training module is clear and easy to navigate and guides the reader through the stages of hygiene programme planning. It is well illustrated and includes examples of IEC materials.

***Water and sanitation e-library (2007).***

This CD contains a wide range of materials on the hardware and software of water and sanitation, including Hygiene Promotion. Tools are included from different countries and the different stages of programme planning including workshop reports, examples of monitoring and assessment formats (including base-line indicators), school health, PHAST, and a bibliography. Useful publications from other organisations are also included. The e-library also has a section on public health materials.

**International Federation of Red Cross/Red Crescent:  
*Water & Sanitation Mission Assistant. (Updated July 2002)***

This contains a range of International Federation of RC/RC materials including those which are water and sanitation related. They include project reports, policy, and details of emergency response units. A few useful texts from other organisations are also included.

***Water & Sanitation IEC material database.***

This CD contains examples of practical IEC materials from Red Cross programmes which can be used in an emergency, including fact sheets, drawings, posters, and photos. The fact sheets include information on the prevention of malaria and cholera. A few posters included are on household water treatment and hygiene practices, and have been produced by different agencies. Photos are of people undertaking water and sanitation activities and hygiene practices in different parts of the world.

Also included are a number of very useful drawings by Rod Shaw which are generic outline sketches of people undertaking water and sanitation activities (e.g. carrying a bucket of water) in low-income countries, and which can be adapted for use in any country. (Shaw, R. (2005), *Drawing Water*. WEDC)

***IFRC water and sanitation software 2007.***

A range of very useful materials are included produced by the Red Cross and other organisations. They are organised according to the Hygiene Promotion project cycle, including tools for assessment, planning, implementation, and monitoring and evaluation. General materials are also included on WASH-related diseases, gender, the environment, water and sanitation and vulnerable groups, community participation, sustainability, community management, and international public health training. Materials from other organisations include manuals and guidelines.

***International Rescue Committee:***

CD rom of 150+ electronic technical documents on Hygiene Promotion

**Video:*****Prescription for Health. IDRD, Canada***

A short video on water, sanitation and hygiene in the development context.

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## Annotated Bibliography: list of sources

Title	Author	Date	Type of material	Source (but these do change)
A guide for developing a Hygiene Promotion programme to increase handwashing with soap	World Bank	No date	Guide	<a href="http://www.globalhandwashing.org/Publications/Handwashing_Handbook.pdf">www.globalhandwashing.org/Publications/Handwashing_Handbook.pdf</a>
Behaviour change communication in emergencies. A tool kit	UNICEF	2006	Tool kit	<a href="http://www.unicef.org/ceecis/BC_C_full_pdf.pdf">www.unicef.org/ceecis/BC_C_full_pdf.pdf</a>
CHAST. A practical guide	Bockhorn-Vonderbank, M.	2004	Guide	Available on WASH Cluster Hygiene Promotion CD, UNICEF.
Cholera outbreak. Assessing the outbreak response & improving preparedness	WHO	2004	Guidelines	<a href="http://whqlibdoc.who.int/hq/2004/WHO_CDS_CPE_ZFk_2004.4_eng.pdf">whqlibdoc.who.int/hq/2004/WHO_CDS_CPE_ZFk_2004.4_eng.pdf</a>
Communicable disease control in emergencies. A field manual	Connolly, M.A.	2005	Manual	<a href="http://www.who.int/infectious-disease-news/IDdocs/whocds200527/ISBN_9241546166.pdf">www.who.int/infectious-disease-news/IDdocs/whocds200527/ISBN_9241546166.pdf</a>
Domestic hygiene & diarrhoea. Pinpointing the problem	Curtis, V., Cairncross, S., Youli, R.	2000	Journal Paper	<a href="http://www.blackwell-synergy.com/doi/pdf/10.1046/j.1365-3156.2000.00512.x">www.blackwell-synergy.com/doi/pdf/10.1046/j.1365-3156.2000.00512.x</a>
Emergency response unit: mass sanitation module	International Federation of RC/RC	2006	Module Guidelines	Available from WASH Cluster Hygiene Promotion CD, UNICEF.
Environmental health field guide	International Rescue Committee	2005	Guide	<a href="http://www.irc-eh-field-guide.com/EH_PORTABLE_LIBRARY/Home.htm">http://www.irc-eh-field-guide.com/EH_PORTABLE_LIBRARY/Home.htm</a>
Environmental health promotion capacity building	Morgan, J.	2001	Guide	<a href="http://www.lboro.ac.uk/well/resources/well-studies/full-reports-pdf/task0515.pdf">www.lboro.ac.uk/well/resources/well-studies/full-reports-pdf/task0515.pdf</a>
Essential hygiene messages in post-disaster emergencies	WHO	2005	Factsheet	<a href="http://wedc.lboro.ac.uk/WHO-Technical Notes-for-Emergencies/">http://wedc.lboro.ac.uk/WHO-Technical Notes-for-Emergencies/</a>
Excreta disposal in emergencies	Harvey, P.	2007	Manual	Hard copies available from WEDC, UK:- <a href="http://wedc.lboro.ac.uk/projects/new_projects3.php?id=152">http://wedc.lboro.ac.uk/projects/new_projects3.php?id=152</a>

Facts for life	UNICEF & other agencies	2002	Factsheets	<a href="http://www.unicef.org/publications/index-4387.htm">http://www.unicef.org/publications/index-4387.htm</a>
Field guide for designing a health communication strategy	Johns Hopkins Bloomberg School	2003	Guide	<a href="http://www.jhuccp.org/pubs/fg/02">www.jhuccp.org/pubs/fg/02</a>
GOAL Technical Guidelines on Water & Sanitation -Draft	GOAL	2007	Guidelines	Currently available from GOAL Best Practice Website (see below for instructions to log-in)
Guidelines for public health promotion in emergencies	Oxfam	2001	Guidelines	<a href="http://publications.oxfam.org.uk">http://publications.oxfam.org.uk</a>
Health on air. A guide to creative radio for development	Adam, G., Harford, N	1998	Handbook	Hardcopies available from TALC, UK:- <a href="http://www.talcuk.org">www.talcuk.org</a>
Helping health workers learn	Werner, D, Bower B.	1982	Manual	Hardcopies available from Hesperian Foundation:- <a href="http://www.hesperian.org/mm5/merchant.mvc?Store_Code=HB&amp;Screen=CTGY&amp;Category_Code=ENG">www.hesperian.org/mm5/merchant.mvc?Store_Code=HB&amp;Screen=CTGY&amp;Category_Code=ENG</a>
How to mobilise communities for health & social change.	Howard-Grabman, L., Snetro, G	No date	Guide	<a href="http://www.hcpartnership.org/Publications/Field_Guides/Mobilize/pdf/">www.hcpartnership.org/Publications/Field_Guides/Mobilize/pdf/</a>
Humanitarian Charter & minimum standards in disaster response	Sphere Project	2004	Guidelines	<a href="http://www.sphereproject.org/handbook">www.sphereproject.org/handbook</a>
Hygiene evaluation procedures: approaches & methods for assessment for water & sanitation-related practices	Almedon, A.	1997	Handbook	<a href="http://www.unu.edu/unupress/food2/UIN11E/uin11e00.htm">www.unu.edu/unupress/food2/UIN11E/uin11e00.htm</a>
Hygiene Promotion.	Curtis, V	1999	Technical Brief	<a href="http://www.lboro.ac.uk/well/resources/fact-sheets/fact-sheets-hm/hp.htm">www.lboro.ac.uk/well/resources/fact-sheets/fact-sheets-hm/hp.htm</a>
Hygiene Promotion: A practical manual for relief & development	Ferron, S., Morgan, J., & O'Reilly, M.	2007	Manual	Hard copies available from: Stylus Publishing, USA:- <a href="http://styluspub.com/books/BookDetail.aspx?productID=138936">http://styluspub.com/books/BookDetail.aspx?productID=138936</a> and TALC, UK:-

				<a href="http://www.talcuk.org/books/hygiene-promotion-practical-manual-for-relief-and-development.htm">http://www.talcuk.org/books/hygiene-promotion-practical-manual-for-relief-and-development.htm</a>
Hygiene Promotion. Thematic overview paper	Appleton, B., Sijbesma, C.	2005	Paper	<a href="http://www.irc.nl/content/download/23457/267837/file/TOP1_HygPromo_05.pdf">www.irc.nl/content/download/23457/267837/file/TOP1_HygPromo_05.pdf</a>
Hygienic, happy & healthy: how to set up a Hygiene Promotion programme	Curtis, V., Kanki, B.	1998	Guidelines	<a href="http://www.sanicon.net/titles/title.php3?titleno=110">http://www.sanicon.net/titles/title.php3?titleno=110</a>
Improving health through behaviour change. A process guide on Hygiene Promotion	EHP, PAHO, Plan, USAID	2004	Guide	<a href="http://ehproject.org/PDF/Joint_Publications/JP007-CIMCIPProcessGuideWeb.pdf">ehproject.org/PDF/Joint_Publications/JP007-CIMCIPProcessGuideWeb.pdf</a>
Malaria control in complex emergencies. An inter-agency handbook	WHO	2005	Handbook	<a href="http://www.who.int/malaria/docs/ce_interagencyfhbook.pdf">www.who.int/malaria/docs/ce_interagencyfhbook.pdf</a>
Model guidelines for mainstreaming water & sanitation in emergencies	ECHO	2005	Guidelines	Currently available from ECHO <a href="http://ec.europa.eu/echo/">http://ec.europa.eu/echo/</a>
Participatory evaluation: Tools for managing change in water and sanitation	Narayan, D	1993	Guide	Hardcopies available from World Bank Publications:- <a href="http://publications.worldbank.org/howtoorder">http://publications.worldbank.org/howtoorder</a>
Participatory learning & action: a trainer's guide	Pretty, J., Guijt, I.	1995	Guide	Hardcopies available from Earthprint, UK:- <a href="http://www.earthprint.com/Product.aspx?n=6021IIED">http://www.earthprint.com/Product.aspx?n=6021IIED</a>
PHAST for an emergency	Turatbekova, M. (ed)	2005	Manual	Available from WASH Cluster Hygiene Promotion CD, UNICEF.
PHAST step-by-step guide: a participatory approach for the control of diarrhoeal diseases	Wood, S., Sawyer, R., Simpson-Herbert, M.	1998	Guide	<a href="http://www.who.int/water_sanitation_health/hygiene/envsan/phastep/en/index.html">www.who.int/water_sanitation_health/hygiene/envsan/phastep/en/index.html</a>
Pictures, people and power	Linney, B.	1995	Book	Hardcopies available from TALC, UK:-

				<a href="http://www.talcuk.org/books/pictures-people-and-power.htm">http://www.talcuk.org/books/pictures-people-and-power.htm</a>
Software tools for water & sanitation programming	International Federation of RC/RC	2007	Guide	<a href="http://www.ifrc.org">www.ifrc.org</a>
Strategic report 8. Assessing hygiene improvement.	USAID	2004	Guidelines	<a href="http://www.ehproject.org/PDF/Strategic_papers/SR-8-HISGPaperVersion.pdf">www.ehproject.org/PDF/Strategic_papers/SR-8-HISGPaperVersion.pdf</a>
Towards better programming - a manual on communication for water supply & environmental sanitation programmes	UNICEF	1999	Manual	<a href="http://www.unicef.org/wes/files/communication_e.pdf">www.unicef.org/wes/files/communication_e.pdf</a>
Towards better programming - a manual on Hygiene Promotion	UNICEF & LSHTM	1999	Manual	<a href="http://www.unicef.org/wes/hman.pdf">www.unicef.org/wes/hman.pdf</a>
Towards better programming - a manual on school sanitation & hygiene	UNICEF	1998	Manual	<a href="http://www.unicef.org/wes/files/School_e.pdf">www.unicef.org/wes/files/School_e.pdf</a>
Training for transformation	Hope, A. and Timmel, S.	1995	3 Manuals	Hardcopies available from TALC, UK:- <a href="http://www.talcuk.org/books/community-health-b.htm">http://www.talcuk.org/books/community-health-b.htm</a>
Water, sanitation and hygiene for populations at risk.	Action Contre La Faim	2005	Guidelines	Hard copies available from: <a href="http://www.amazon.fr">www.amazon.fr</a>
Water, sanitation & hygiene: interventions and diarrhoea. A systematic review and meta-analysis	Fewtrell, L., Colford, J.	2004	Discussion Paper	<a href="http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Fewtrell&amp;ColfordJuly2004.pdf">http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Fewtrell&amp;ColfordJuly2004.pdf</a>
Where there is no artist - development drawings & how to use them	Rohr-Rouendaal, P.	2007	Book	Hardcopies available from Stylus Publishing, USA:- <a href="http://www.styluspub.com/Books/Features.aspx?productID=46772">www.styluspub.com/Books/Features.aspx?productID=46772</a> or Practical Action Publishing



				<a href="http://developmentbookshop.com/product_info.php?products_id=724">http://developmentbookshop.com/product_info.php?products_id=724</a>
<b>CD ROMS</b>				
Hygiene Promotion self training module (draft)	ACF	2006		
Hygiene Promotion: a learning experience	ACF			
IFRC water & sanitation software	IFRC	2007		
Water & sanitation e-library	ACF	2007		
Water & sanitation IEC material database	IFRC			
Water & sanitation mission assistant	IFRC	July 2002		
<i>CD ROM of 150+ electronic technical documents on Hygiene Promotion</i>	IRC			
<b>Video</b>				
Prescription for health	IDRD, Canada			

#### *Abbreviations*

ACF: Action Contre La Faim

IFRC: International Federation of Red Cross/Red Crescent

IRC: International Rescue Committee

PAHO: Regional Office for the Americas of WHO

#### Note:

1) Accessing the GOAL Best Practice Website:

This website can be used by those working in the humanitarian sector who can use the resources for their own use on a non-profit basis. The website can be accessed as follows:-

- Log onto the following address: <http://www.goalireland.net>
- The username is goalie and the password is Dublin, anyone should be able to log on.
- On the site, go into the Technical reference materials folder to access the various technical materials
- Any comments/feedback or new ideas on the site content are welcome however these should be posted on the GOAL Discussion Forum if possible.

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## List of useful websites on environmental health

- <http://www.paho.org>

PAHO is the Regional Office for the Americas of WHO. Their water mitigation information is on: <http://www.disaster-info.net/watermitigation/e/introduction/htm>

The Spanish website is:

<http://www.paho.org/defaultl.Spa.htm>

- <http://www.lboro.ac.uk/departments/cv/wedc/>

The Water, Engineering and Development Centre (WEDC) at Loughborough University provides education, training, research, and consultancy for improved planning, provision and management of physical infrastructure and services for development in low and middle-income countries. It focuses on the needs and demands of poor people.

WEDC has initiated a new link on their website. The address is:

- [http://www.lboro.ac.uk/wedc/image\\_library/](http://www.lboro.ac.uk/wedc/image_library/)

There are quite a few digital images for Hygiene Promotion which can be downloaded.

- <http://www.lboro.ac.uk/well/>

WELL is a resource centre network providing services and resources in water, sanitation and environmental health for the Department for International Development (DFID) of the British government and partner organisations.

- <http://www.irc.nl/>

IRC (International Water and Reference Centre) provides news and information, advice, research and training on low-cost water supply and sanitation in developing countries. It is based in the Netherlands.

- <http://www.ehproject.org/>

The Environmental Health Project. Funded by USAID, EHP is primarily a technical resource for environmental health practitioners and programmes. A main area of expertise is reducing morbidity and mortality in children under five by improving environmental conditions or reducing exposure to disease agents, with infectious diseases of major public health importance.

- [http://www.accessexcellence.org/AE/AEC/CC/hand\\_background.html/](http://www.accessexcellence.org/AE/AEC/CC/hand_background.html/)

The US National Museum's Access Excellence project provides a history of handwashing and its role in helping to prevent infectious diseases.

- <http://www.wrc.org.za/>

Water Research Commission (WRC)

The WRC promotes coordination, communication, and cooperation in the field of water research: establishes water research needs and priorities; funds research on a priority basis; and promotes the effective transfer of information and technology.

- <http://www.lib.utexas.edu/maps/index.html>

University of Texas electronic map collection. Provides geographical, political, and health-related maps for a wide range of countries and areas.

- <http://www.wsp.org/>

Water and Sanitation Programme (WSP). The WSP is an international partnership of the world's leading development agencies concerned with water and sanitation services for poor people. Its mission is to alleviate poverty by helping poor people gain sustained access to improved water and

sanitation services. It is managed through a head office in Washington, D.C. and four regional offices in South Asia, East Asia and the Pacific, Africa, and the Andean Region.

- <http://www.helid.desastres.net/cgi-bin/library.exe>

World Health Organisation electronic Health Library for Disasters. Provides links to resources on a wide variety of health topics and addresses health in disaster settings. Resources available in French, English and Spanish.

- <http://www.irc.nl/products/publications/list.php?list=online>

(IRC) International Water and Sanitation Centre.

IRC facilitates the sharing, production and use of knowledge so that governments, professionals, and organisations can better support people in developing countries to obtain water and sanitation services they will use and maintain. The IRC provides links to, and disseminates materials and builds the capacity of, water and sanitation resource centres in developing countries.

- <http://www.aidworkers.net/>

Aid Workers Network links relief and development field staff to share support, ideas, and best practice. The website is being developed to provide a comprehensive resource for busy field workers needing practical advice and proven resources. Information available in French and Spanish.

- <http://www.odihpn-org/>

Humanitarian Practice Network. Its objectives are to provide relevant analysis and guidance for humanitarian practice, as well as summary information on relevant policy and institutional developments in the humanitarian sector. Information available in French and Spanish.

- <http://www.ehjournal.net/start-asp>

The online version of Environmental Health: A Global Access Science Source journal.

**[http://www.projetqualite.org/compas/outil/uk/index\\_uk.html](http://www.projetqualite.org/compas/outil/uk/index_uk.html)**

French information about quality standards.

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Best practice materials produced through the WASH Cluster HP project, c/o UNICEF 2007

## Terminology and definitions<sup>14</sup>

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

**Health Promotion** is the process of enabling people to increase control over, and to improve, their health. The Ottawa Charter<sup>15</sup> (1986) defined five key principles of health promotion:

- To build healthy public policy
- To create supportive environments
- To strengthen community action
- To develop personal skills
- To reorient health services

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

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

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

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<sup>14</sup> Adapted from Oxfam’s Public Health Promotion Guidelines for Emergencies and IFRC ERU-MSM Guidelines and training package

<sup>15</sup> The Ottawa Charter was the outcome of a the first meeting of health promotion professionals held in Ottawa in 1986 held as a response to growing expectations for a new Public Health Movement. It built on the progress made by the Declaration of Primary Health Care made in Alma Ata. A subsequent key meeting was held in Jakarta in 1997.

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

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

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

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

**Behaviour change communication (BCC)** is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education, and communication (IEC) programmes to promote more tailored messages, greater dialogue, and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programmes to ensure sustainable change in attitudes and behaviour.<sup>16</sup>

**Community** is a group of people who:

- are interdependent of each other and limited by geographical boundaries
- share common natural resources
- share a common culture
- experience the same problems

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

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<sup>16</sup> Behaviour Change Communication Toolkit for the Workplace, ILO-FHI HIV/AIDS

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

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

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

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

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

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

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

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

**Health** is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. It is a fundamental human right and attainment of the

highest possible level of health is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector. (World Health Organisation – WHO)

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

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

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

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

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

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## Hygiene Promotion orientation package

The package is aimed primarily at WASH team members who need to know how Hygiene Promotion fits into the WASH intervention. More detailed training packages are available for those carrying out Hygiene Promotion in the field.

### What's in it?

<b>Overview</b> - overall objectives, background information, layout for the whole session	<b>Powerpoint</b> to assist with running the session	<b>Handouts</b> <ul style="list-style-type: none"> <li>- Terminology definitions</li> <li>- Frequently asked questions (FAQs)</li> <li>- Gender checklist</li> <li>- HP quiz</li> </ul>	<b>Facilitator's Resources</b> <ul style="list-style-type: none"> <li>- PHAST overview</li> <li>- Social marketing overview</li> <li>- Child to child overview</li> <li>- Communication</li> <li>- SPHERE</li> <li>- Avian and pandemic influenza</li> <li>- HIV/AIDS</li> <li>- Humanitarian accountability</li> </ul>
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### What does it cover?

<b>What is hygiene promotion?</b>		<b>The Hygiene Improvement Framework</b>	
	<b>How do you do Hygiene Promotion? – the project cycle</b>		<b>Facilitating participation and accountability – practical methods and enable participation</b>
<b>Familiarization with supporting tools</b>		<b>Final questions to clarify issues and provide information for future orientations</b>	

## **Overall Objectives:**

To provide a rapid orientation to Hygiene Promotion in emergencies in order to:

- Create awareness about the importance of Hygiene Promotion in all WASH interventions
- To facilitate community involvement and accountability in WASH interventions
- To improve co-ordination and communication between and within WASH teams

## **Background Information**

The following issues should be borne in mind when carrying out this training:

- This is designed as a rapid, general briefing for WASH implementing agencies and is suitable for co-ordinators, managers, and implementers (engineers, technicians, and hygiene promoters).
- When introducing the course it should be stressed that in the time available it is only possible to provide a rapid orientation to the subject rather than an in-depth training.
- It is preferable that the training is carried out prior to an emergency but it can be carried out in a shortened form during an emergency using slides 1-28 only. The interactive exercises can also be shortened or left out but time for discussion on the content of the slides must be included in the orientation and the slides are NOT intended to be delivered simply as a lecture. The interactive exercises could, for example, be carried out in plenary only and the small group work omitted.
- The sessions are designed for small groups of 15 – 20 people. More time will be necessary for discussion if the group is larger than this.
- The package is not meant to provide detailed information on how to do Hygiene Promotion (other training modules are provided for this purpose).
- Although the package can be used as a stand alone tool, it is preferable if it is facilitated by an experienced hygiene promoter and that they make use of the key learning points and powerpoint notes provided.
- The session plans provide suggestions as to content, guided by the objectives, but can be adapted by the facilitators as required.
- The powerpoint slides provided also give more detail on content but should be used as a means to encourage discussion. (However, if time is limited, an adapted presentation and short discussion could be used.)
- Notes are provided for each slide and these should be consulted prior to carrying out the training.
- Handouts have been provided and, ideally, participants should make time to read and digest these, prior to the orientation.
- Additional overview papers have been provided for facilitators and may be used as handouts where required but participants should not be overloaded with too many handouts that they will not read.

- It is useful to provide participants with a handout of the powerpoint with the annotated notes at the end of the orientation.
- Some background documentation for trainers is also included in the package.

## Example Timetable

Time	Session	Aim
9.00 – 9.15	Introductions	
9.15 – 10.15	What is Hygiene Promotion and the Hygiene Improvement Framework	Introduce participants to the Hygiene Improvement Framework for emergencies and ensure that participants hold a common understanding of the term Hygiene Promotion
<b>10.15 – 10.30</b>	<b>Break</b>	
10.30 – 11.30	Project Cycle and How do you do Hygiene Promotion?	Deepen participants' understanding of the role of the hygiene promoter and of Hygiene Promotion activities and approaches
11.30 – 12.30	Facilitating participation and accountability	Ensure that participants are aware of practical methods to facilitate participation and accountability and their role in this
12.30– 13.00	Familiarisation with supporting tools	Ensure that participants are familiar with the tools that have been developed to support WASH agencies in carrying out Hygiene Promotion
13.00 – 13.15	Final questions and evaluation	Clarify issues and provide information for future orientations

## **Session 1: Introduction, What is Hygiene Promotion and the Hygiene Improvement Framework for emergencies: 1 hour**

### **Aims**

The session is designed to

- Introduce participants to the Hygiene Improvement Framework for emergencies
- Ensure that participants hold a common understanding of the term 'Hygiene Promotion'

### **Outcomes**

By the end of the session participants will be able to:

- Use a common framework for understanding WASH interventions in emergencies
- Share a common understanding of existing terminology (Hygiene Promotion, Health Promotion, Hygiene Education and Public Health Promotion, Sanitation, Software and Hardware, Approaches and Methods)
- Describe the constraints and opportunities for hygiene behaviour change in emergency context

### **Methods**

- Presentation with Q & A
- Plenary/group discussion
- Brainstorm

### **Resources/Handouts**

- Powerpoint: Slides 1-17
- Hygiene Promotion in emergencies briefing paper
- Terminology and Definitions

## **Session Plan**

### **Time: 60 minutes**

#### **Introduction: 5 minutes**

Background to the WASH HP cluster initiative and what support is available.

Aims and objectives of orientation and session.

#### **Exercise: 15 minutes total**

In 3 small groups ask participants to fill in the boxes in the HIF according to the current emergency context. Ask each group to focus on one particular box but bear in mind the content of the other boxes.

Discuss in plenary and show example of worked HIF on powerpoint. Ask participants if there are limitations to the model if these have not been discussed. Can ORS and ITNs be considered as hardware?

#### **Group Discussion: 20 minutes**

Ask participants to come up with a definition of Hygiene Promotion and show definition on powerpoint slide. Ask participants to identify key terms in the definition. Distribute handout on Terminology and Definitions and clarify the meaning of other terms e.g. health promotion, hygiene education, health education, software, approaches and methods etc.

#### **Presentation: 15 minutes**

Show other slides emphasising the justification for Hygiene Promotion

#### **Wrap up: 5 minutes**

Ask participants for key learning points and develop these where necessary.

Distribute briefing paper and point out appendices with example HIF, key steps, and resources.

### **Key learning points**

Emphasise 'action' and optimal use of facilities rather than just behaviour change or message dissemination.

'Behaviour change' or changes in practice do not always take a long time and change is possible in an emergency (people are often obliged to change their behaviour/routine in many ways).

Emphasise the integration of software and hardware and the responsibility of **ALL members (managers, technicians, engineers, and hygiene promoters)** of the WASH agencies and partners to ensure a comprehensive response.

Emphasise the role of HP in supporting the design/modification of hardware facilities.

Outline the WASH cluster support available: written resources to be discussed/mentors etc.

## Session 2: How do you do Hygiene Promotion?: 1 hour

### Aims

#### The session is designed to

Deepen participants' understanding of the role of the hygiene promoter and of Hygiene Promotion approaches

### Outcomes

#### By the end of the session participants will be able to:

- List common Hygiene Promotion activities
- Describe the approaches, methods and systems used by hygiene promoters (directive approach – emphasis on mass media communication – or participatory approach) and an example outreach system
- List common Hygiene Promotion activities related to the directive approach and participatory approach
- Describe the essential elements of the Hygiene Promotion project cycle

### Methods

- Presentation
- Exercise
- Plenary Discussion

### Resources

Powerpoint slides 18-34

### Handouts

Generic Job descriptions

### Session Plan

**Time: 60 minutes**

**Introduction: 5 minutes**

Aims and objectives

**Exercise: 20 minutes total**

Ask participants to divide into groups of three and brainstorm the activities that hygiene promoters might be involved in.

Ask spokesperson to record some of these activities.

Show bubble model of Hygiene Promotion Components (powerpoint slide 19).

Ask participants to call out activities and discuss in plenary, relating these to the model.

**Powerpoint: 10 minutes**

Show powerpoint slides on example activities to recap.

Provide handout of generic job descriptions available.

**Group Discussion/Presentation: 20 minutes**

Ask participants what the steps are for carrying out Hygiene Promotion.

Show picture of project cycle and discuss different stages and when they occur, including gathering of baseline data (refer to other tools available for developing indicators, collecting data etc.).

Discuss different emergency contexts and phases of the emergency and the implications this has for Hygiene Promotion.

Ask participants to brainstorm the methods and approaches used in Hygiene Promotion. Show powerpoint slides on methods and approaches (include PHAST and Child to Child) and provide brief explanation.

Ask participants to give examples of systems they have come across in Hygiene Promotion to reach large numbers of people and discuss the issue of reach versus effectiveness.

Wrap up: 5 minutes

Ask participants for key learning points from session and clarify where necessary.

### **Key learning points**

Broad range of activities – not just disseminating messages about ‘good’ hygiene behaviour. Activities work in conjunction with ‘hardware’ interventions.

The way that practices such as handwashing are addressed will be different in each culture/context and should start with what people already know and do.

Acknowledge that people are now living in a difficult environment and may need to do things differently or pay greater attention to hygiene issues.

Do not wait until you have all the available information before you start initiating activities.

The stages of the project cycle can run in parallel.

Use a mixture of methods (mass media and interactive) – there is often a trade off between reach and effectiveness such that you can reach more people with mass media methods e.g. radio or use of posters but these may not be as effective as interactive methods that emphasise discussion.

Emphasise reaching as many people as possible in an acute emergency where risks are high, but recognise the importance of setting up systems that will support more interactive methods (refer to Health Belief model<sup>17</sup> and fact that people do sometimes change their practices more easily on the basis of perceived level of risk e.g. when there is a cholera outbreak.).

Initiating a PHAST or Child to Child programme may not be possible in an emergency context BUT the interactive tools that are used for both can be adapted and applied to this context.

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<sup>17</sup> The perceived threat of catching a disease is a key variable in the Health Belief Model developed by Rosenstock, Strecher and Becker, 1994 (see resources for facilitator)

## Session 3: Facilitating participation and accountability: 1 hour

### Aims

#### The session is designed to

Ensure that participants are aware of practical methods to facilitate participation and accountability and their role in this

### Outcomes

#### By the end of the session participants will be able to:

- Describe the participation ladder/steps
- List the ways that they can facilitate participation of those affected by the emergency and participatory Hygiene Promotion
- Describe how Hygiene Promotion can enhance accountability of WASH interventions

### Methods

- Presentation
- Exercise
- Plenary Discussion

### Resources

Powerpoint slides 35-41

### Handouts

Gender/participation checklist  
Accountability Outline  
Sphere Outline

### Session Plan

**Time: 60 minutes**

**Introduction: 20 minutes**

Aims and objectives

Ask participants to brainstorm the meaning of 'participation' and discuss.

Show the participation ladder.

Ask who should participate and ensure that participants refer to women and men, children, those who are vulnerable or from minority groups etc.

Show the powerpoint slide on disaggregated data and ask why this happens. Explain that if you don't look for the differences you may not see them and this will undermine your ability to ensure participation.

Ask participants to define what is meant by 'accountability'

For example the HAP (Humanitarian Accountability Partnership) definition: **Accountability is the means by which power is used responsibly. It can include:**

- Processes through which individuals, organisations and states make decisions that affect others.
- Mechanisms through which individuals, organisations and states seek to explain their decisions and actions.
- Processes through which individuals, organisations and states raise concerns about, and seek redress or compensation for, the consequences of the decisions and actions of



others.

Accountability therefore requires responsible behaviour within all three of these domains.

**Exercise: 30 minutes total**

In small groups consider how you could ensure: 1. that men, women, and children participate in the WASH intervention and 2. that WASH initiatives are accountable to affected communities.

Ask groups to shout out some examples and discuss in plenary (include all stages of the project cycle).

**Wrap up: 10 minutes**

Clarify key learning points and distribute gender and participation checklist.

**Key learning points**

Hygiene Promotion can help to ensure that WASH agencies are accountable to the emergency affected population by making sure that women, men, and children are involved in planning, implementing and judging the agencies' WASH initiatives.

Providing information on planned WASH activities helps people to understand what assistance they can expect.

Talking and listening to those affected (separately if possible) is the basis for ensuring participation and an adequate gender perspective.

Activities should be adapted in response to community feedback.

Different levels of participation are possible at different stages of the emergency.

Disaggregation of data is necessary if you are to know about different segments of the population e.g. men and women, those with disabilities, the elderly, children under five years.

## Session 4: Supporting Tools and Evaluation: 45 minutes

### Aims

The session is designed to:

Ensure that participants are familiar with the tools that have been developed to support WASH agencies in carrying out Hygiene Promotion.

### Outcomes

By the end of the session participants will be able to:

- List the tools available to support HP interventions in the field
- Refer other WASH agencies and actors to the tools available

### Methods

- Presentation
- Exercise
- Plenary discussion

### Resources

Quiz Sheet on tools and Hygiene Promotion  
Example hard copies of WASH HP tools for each group

### Handouts

Electronic copies of WASH HP tools for each participant

## Session Plan

**Time: 45 minutes**

**Introduction: 5 minutes**

Aims and objectives

**Exercise: 15 minutes**

Hand out quiz to small groups and refer participants to table in briefing paper. Explain that the objective of this session is just to ensure that they know where to find further information. Go through questions and tally scores – clarifying outstanding questions.

**Evaluation: 15 minutes**

Ask participants to write 2 key learning points on flash cards in large writing. Collect and redistribute to small groups. Ask groups to go through these and decide on 2-3 key learning points from these. Then compile and discuss.

Wrap up: 10 minutes

Written evaluation and final questions

Close. Provide each participant with CD rom with accompanying tools.

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## Supplementary materials for the Hygiene Promotion orientation package

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

### Handouts:

1. HP FAQs
2. Gender checklist for WASH programming
3. WASH HP tools quiz sheet
4. Evaluation form

### Supporting materials

- **Briefing paper** Short paper describing Hygiene Promotion, what it is and how to do it in emergencies. It is aimed at WASH coordinators to disseminate to all stakeholders to promote common understanding of Hygiene Promotion and consistency of quality.
- **Menu of indicators** for monitoring Hygiene Promotion, for use by field practitioners and promoted by WASH coordinators.
- **Annotated bibliography** List of Hygiene Promotion tools and resources (books, manuals, training modules, and audio visual materials) as reference materials for WASH coordinators and others.
- **List of essential Hygiene Promotion equipment for communication** to inform WASH coordinators and guide field implementing agencies.
- **Non-food items briefing paper and list** A briefing paper achieving maximum impact from the distribution of hygiene related non-food items (NFIs).
- **Generic job descriptions and overview** for field hygiene promoters and community mobilisers/workers as well as alternative potential structures. These aim to inform and guide WASH coordinators and implementing agencies, in order to encourage consistency and minimum standards.

## Hygiene Promotion Frequently Asked Questions

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

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

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

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

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

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

### 3. Should community mobilisers be paid?

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

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

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

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

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

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

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## **Gender checklist for WASH programming**

(adapted from IFRC Gender Checklist)

### **General data**

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

### **Water collection, transportation, and allocation at household (HH) level**

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

### **Access to, and control over, water sources**

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

### **Gender division of time-use in the HH**

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

### **Technical options / operation and maintenance (O&M)**

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

### **Privacy and security**

- Location and design for privacy and security of water points/latrines and bathing facilities. Safety around water sources, especially if women and children are primary users.

- Do women feel constrained to travel alone in public to the water point/sanitation facilities because of real danger of aggression or social disapproval?
- **Sanitary habits of women and girls**
  - What is appropriate to discuss? What types of materials are appropriate to distribute? How are children's faeces dealt with?
  - What are the cultural assumptions with regard to water and sanitation activities during pregnancy, menstruation, anal cleaning, etc?
- **Cultural issues**
  - What are the main cultural issues which impact upon women's and men's access to water and sanitation?
  - Do men and women share the same latrine (at HH level and Community level)?
- **Traditional gender roles and power structure**
  - How do women perceive themselves in traditional roles and active participation? How much of this can be changed and how much cannot be changed?
  - Who decides how much money should be spent on water?

## **Suggestions for improving gender awareness**

### Community consultation

Ensure recruitment of men and women on the team.

Ensure that women are available to talk to women, and men to men, in the assessment (especially when discussing sanitation and personal hygiene).

Work separately with women's and men's groups, where necessary, to counter exclusion and prejudice related to water, sanitation, and hygiene practices.

Women and men need to be consulted about convenient times and locations for meetings, and they need time to be given time to reorganise their schedules.

Involve both men and women in discussions on water and sanitation, including personal hygiene habits, general health, and the needs and fears of children (do not just focus on women).

Conduct consultations in a secure setting where all individuals (including women and girls) feel safe to provide information and participate in discussion and decision making.

Include questions on cultural and ethnic beliefs on water usage, responsibilities, and sanitation practices.

### Link to hardware / community training

Provide 'coaching' advice to engineers and hygiene promoters on how to work with the community and make effective use of women's knowledge of the community.

Provide formal and on-the-job training for both men and women in construction, operation, and maintenance of all types of water and sanitation facilities, including wells and pumps, water storage, treatment, water quality monitoring, distribution systems, latrines, and bathing facilities.

Ensure that the training is suited for the specific needs of women (timing, language, educational requisites, etc). The training needs to be especially tailored to the specific requirements of poor women and vulnerable groups.

Offer training in water management to men (preferably using men to men training), especially for single male-headed HHs in which they have previously relied on women to

collect water and to manage the cooking, personal hygiene and domestic needs for the family.

Work with community groups to expand, operate, and maintain communal facilities, and dispose of liquid and solid wastes.

#### Social research

Through interviews with key informants, try to understand the power and social relations in the target communities. Examine the roles, responsibilities, processes and workloads of children, women, and men, and the rich and the poor, in terms of labour in their homes, hygiene practices, and water use and management.

Determine how women's and men's participation and skills acquisition influence power dynamics at the HH level. Be aware of possible increases in domestic tensions and provide basic conflict resolution and support where possible.

#### Gender sensitisation

Develop special activities on gender sensitisation for men.

Target hygiene programmes not only to mothers, but also to fathers and other carers of children.



## **WASH HP tools quiz sheet**

1. What is a baseline survey (in the context of an emergency intervention)?
2. Why is Hygiene Promotion relevant in an emergency?
3. List four key activities of hygiene promoters.
4. How might you ensure that the different needs of men and women are met during an emergency?
5. What does HIF stand for?
6. List the factors that are important in a WASH response.
7. What should a hygiene kit contain?
8. How would you ensure that chlorine solution/sachets are used appropriately?
9. List three key books/documents that could provide information on how to do Hygiene Promotion.
10. List three key indicators for a Hygiene Promotion programme.
11. List three ways that a WASH cluster coordinator might facilitate the inclusion of Hygiene Promotion in a WASH response.
12. What Hygiene Promotion approaches might be useful in an emergency?
13. How can Hygiene Promotion facilitate accountability in an emergency?
14. How might you ensure that you cater to the needs of disabled men, women, and children in an emergency?

## Evaluation Form

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

		1	2	3	4	5	
Pace of the orientation	Too slow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Too fast
Clarity of the content	Confusing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clear
Level of participation	Too little	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Too much
I enjoyed the sessions	Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agree
I was able to participate	Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agree

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

		1	2	3	4	5	
The sessions were relevant to me	Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agree
I now know more about Hygiene Promotion	Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agree
In my work I will refer to the tools presented and/or share them with others	Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agree

How would you rate the orientation overall?

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

What was the most satisfactory aspect of the orientation?

What was the least satisfactory aspect of the orientation?

How could any particular sessions have been improved?

Other comments?

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

## Supplementary materials for the Hygiene Promotion Orientation Package

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

### Facilitator's resources:

5. PHAST (Participatory Hygiene and Sanitation Transformation)<sup>18</sup> overview
6. Social marketing overview
7. Child-to-Child overview
8. Communication for Social Change and Hygiene Promotion
9. SPHERE
10. Hygiene Promotion and Avian and Pandemic Influenza
11. Hygiene Promotion and HIV and AIDS
8. Humanitarian accountability

### Supporting materials

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

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

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

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

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

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

[Best practice materials produced through the WASH Cluster HP project, c/o UNICEF 2007](#)

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<sup>18</sup> Adapted from IRC information sheets

# **PHAST Overview**

## **(Participatory Hygiene and Sanitation Transformation)<sup>19</sup>**

### **GENERAL DESCRIPTION**

The PHAST approach is a step-by-step hygiene and sanitation promotion field guide written in non-technical language to help community-level field workers and facilitators. The PHAST methodology focuses on participatory learning and aims to empower communities to manage their water supply and to control sanitation-related diseases by promoting health awareness and understanding.

Several derivatives exist including a child-friendly version (CHAST) promoted by Caritas, and a fast-PHAST for emergencies, promoted by the IFRC.

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

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

### **KEY CONSIDERATIONS**

- The guide has seven steps. The first five help take the community group through the process of developing a plan to prevent diarrhoeal diseases by improving water supply, hygiene behaviours, and sanitation. The sixth and seventh steps involve monitoring and evaluation.
- There is a significant amount of preparation to be done before beginning PHAST with a community group. This includes making a culturally relevant tool kit, preferably through local artists and selecting the appropriate group (considering both demographics and size).
- The steps of PHAST should be followed in sequential order since each step equips participants with what they need to do or know to complete the next one.
- The group should keep a record of its findings and decisions for each step. Keeping thorough records means that participants can quickly review their progress when they need to.
- Each activity should be evaluated at its conclusion. Feedback on the relevance of activities, on what the group thought was good or bad, and on where improvements could be made, is important.

### **ADVANTAGES**

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<sup>19</sup> Adapted from IRC information sheets

- The objective of PHAST is not only to teach hygiene and sanitation concepts (where needed) but, more importantly, to enable people to overcome constraints to change. It aims to do this by involving all members of society in a participatory process involving: assessing their own knowledge base; investigating their own environmental situation; visualising a future scenario; analysing constraints to change; planning for change; and finally, implementing change.
- The participatory approach helps people to feel more confident about themselves and their ability to take action and make improvements in their communities. Feelings of empowerment and personal growth are as important as the physical changes, such as cleaning up the environment or building latrines.
- Each step of PHAST contains between one and four easy-to-follow activities and also instructions on how to facilitate each activity.

## **DISADVANTAGES**

- The participatory process will work only if there exists: respect for people's knowledge and ideas, with clear recognition of their individual and collective inputs; faith in the creative potential of people and in the synergy of the participatory process; a minimum of structure, a maximum of participation; loyalty to the group; and a commitment to creating opportunities for people to express themselves.
- PHAST relies heavily on the training of extension workers and on the development of graphic materials that need to be modified and adapted – therefore, if neither of these aspects is done well there can be efficacy problems.
- PHAST mentions that completing all steps can take anywhere from two to six months.

## **LIKELY SCENARIOS**

- Given the initial preparation work, to fully implement PHAST in an acute emergency situation is not possible. Therefore, while various tools and activities can be used, PHAST is more appropriate for long-term post-emergency work where its activities, monitoring, and evaluations can be completed. However, there may be some emergency contexts where PHAST is more likely to work than others, i.e. where there is already some experience of using PHAST and/or where communities have not been disrupted or displaced.

## **PHAST IN EMERGENCIES**

A shorter version of PHAST for use when 'PHAST needs to be FAST' has been proposed by various agencies including IFRC, Oxfam, and UNICEF. However, this may still be problematic during the early stages of an acute emergency and may only work where extension workers or volunteers have already been well trained.

During a large-scale displacement or outbreak of disease the PHAST process could be dramatically shortened as follows:

**Step 1: Problem identification**

**Step 2: Problem analysis**

**Step 3: Selecting options for solutions**

Volunteers would work with small groups of the affected community or water and sanitation committees on each of the above topics in succession. Depending on the urgency of the situation and as time progresses, it may be possible to include other steps and activities in more detail as shown below.

## **EVIDENCE BASE**

PHAST was extensively piloted in four African countries (Kenya, Botswana, Uganda, and Zimbabwe) during 1993.

A randomised controlled trial was carried out in the Kyrgyz Republic in 2003, and showed a 68 per cent reduction in Giardia in school children.

An evaluation of a PHAST programme in Malawi (DeGabriele, 2004) showed that PHAST was being used as a Hygiene Promotion tool but not as a community development tool.

## **KEY TECHNICAL REFERENCES**

[http://www.who.int/water\\_sanitation\\_health/hygiene/envsan/phastep/en/index.html](http://www.who.int/water_sanitation_health/hygiene/envsan/phastep/en/index.html)

December 2007

# Social marketing<sup>20</sup>

## What is social marketing?

Social marketing is the name given to the approach of applying lessons from commercial advertising to the promotion of social goals (in this case, improved hygiene behaviour). It is a systematic approach to influencing people's behaviours and thereby reducing public health problems.

Social marketing is not merely motivated by profit but is concerned with achieving a social objective. It goes beyond marketing alone as it is also concerned with how the product is used after the sale has been made. The aim is, for example, not only to sell latrines but to encourage their correct use and maintenance.

## The key components of social marketing are:

- systematic data collection and analysis to develop appropriate strategies;
- making products, services, or behaviours fit the felt needs of the different consumers/user groups;
- strategic approach to promoting the products, services, or behaviours;
- methods for effective distribution so that when demand is created, consumers within the different groups know where and how to get the products, services, or behaviours;
- improving the adoption of products, services, or behaviours and increasing the willingness of consumers/users to contribute something in exchange; and
- pricing so that the product or service is affordable (financially or in terms of time spent).

## What are the basic characteristics of social marketing?

As in commercial marketing, the 'four Ps' are the basic characteristics of the social marketing approach (see box below). Successful social marketing depends on good research to define each of the four Ps carefully. The four P's are: **Product, Price, Place and Promotion.**

The four Ps of social marketing      Examples:	
<b>Product</b> Decide on the product, its form, format, and presentation in terms of packaging and characteristics.	The marketed product can be: <ul style="list-style-type: none"><li>• a physical item e.g. VIP latrines, SanPlats; or</li><li>• a practice or behaviour e.g. washing hands after using latrines; or</li><li>• an idea e.g. clean environment, good sanitation for health</li></ul>
<b>Price</b> Decide on what the consumer would be willing to pay, both in terms of direct and indirect costs and perceptions of benefits: make the product worth	The price can be : <ul style="list-style-type: none"><li>• monetary or direct costs – cost of products (with or without subsidies), social cost</li><li>• opportunity/indirect costs – time lost from other activities, missed opportunities, transport, loss in production or income</li><li>• psychological or physical costs – stress in</li></ul>

<sup>20</sup> Adapted from: LSHTM/WEDC (1998). [HGuidance Manual on Water Supply and Sanitation Programmes](#).H Published by WEDC for DFID.

getting.	changing behaviour, effort involved in maintaining latrine or obtaining additional water required
<b>Place</b> Where will the product be available to consumers? Include where it is displayed or demonstrated.	The place is every location where the product will be available, e.g. in tea shops, religious buildings, clinics, pharmacies, clubs, and/or local businesses
<b>Promotion</b> How will the consumers know the product exists, its benefits, costs, and where and how to get it?	Promotion relates to the ways of delivery of the information about the product. For example, this can be done through television, radio, newspapers, posters, billboards, banners, folk singers or dramatists, public rallies, or interpersonal contact and counselling. Because of its visibility, this element is often mistakenly thought of as comprising the whole of social marketing.

### What are the key steps in designing a social marketing campaign?

1. A sample of the intended audience is divided into different groups and questioned about needs, wants, and aspirations (sometimes, existing consumer groups may be used to provide the same information). The groups collaborate in the development of feasible, attractive solutions. This data collection and testing is crucial to orientate the promotional activities.
2. Overall marketing (or promotion) objectives are developed.
3. The data are analysed and used to develop an overall marketing plan in collaboration with key stakeholders.
4. The audience is divided into discrete units with common characteristics (audience segmentation).
5. Products and messages are developed based on consumer preferences and characteristics for relevant segments.
6. These are tested among representative samples of target populations. How much are people willing to pay for this product? How far are people willing to travel for this service? How feasible is the new behaviour?
7. Products, messages, and price are modified, refined, and re-tested until they are acceptable. Key stakeholders are consulted throughout this process.
8. The product is launched or service is introduced.
9. The performance of the product or service is monitored and evaluated in the market, and the strategy revised accordingly. This may involve revising the marketing plan or improving the product or service.

### Evidence base

Schellenberg et al (2001) used large-scale social marketing of treated bed nets in rural Tanzania. The approach increased the number of infants sleeping under treated bed nets from 10 per cent at baseline to over 50 per cent three years later, with an associated 27 per cent increase in child survival among one-month- to four-year-olds.

Olembo et al (2004) promoted the CDC Safe Water Systems using social marketing in Zambia. The programme showed a rise in point-of-use chlorination of water from 13.5 per cent in 2001 to 42 per cent in 2004.



### **How can the social marketing approach contribute to Hygiene Promotion in an emergency?**

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

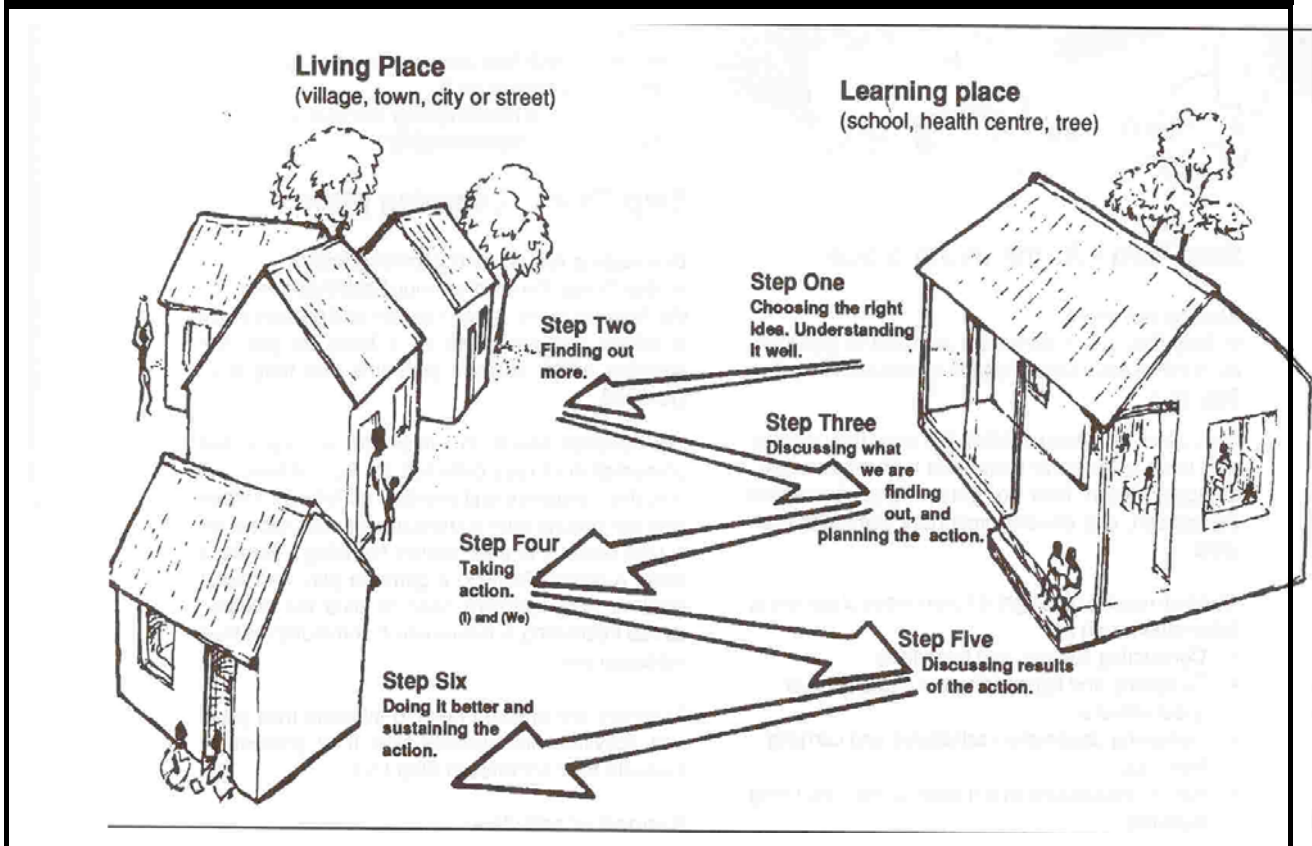
Where there are cyclical emergencies, e.g. cholera outbreaks, social marketing has been used to good effect following the necessary formative research.

December 2007

# Child-to-Child overview\*

Child-to-Child is a way of teaching about health which encourages children to participate actively in the process of learning and to put into practice what they learn. It is an approach that can make health education more exciting. The Child-to-Child approach recognises that children in many countries may be responsible for looking after younger brothers and sisters, and that in their role as caretakers they are in a position to educate and support their siblings to ensure better health. Children may also influence other members of their families and encourage them to take action to promote health in the home and village. Schools can also set an example of better health to the rest of the community and in this way there is a continual interaction 'zigzagging' between school and community.

## The Child-to-Child zigzag approach



\*UNICEF/WES

## Starting the project

- Gathering the children

Projects using the Child-to-Child approach can happen wherever children can get together easily and frequently. This may be a school, a health clinic, or any special place agreed by the community, for example a feeding centre, a water collection point, or under a shady tree.

- Choosing activities

The planning committee, the project organiser, the children themselves, or a combination of these might choose the health topics and activities. All activities should be:

- important for the health of the children and their communities
- easy enough for children to understand
- simple for children to do well
- interesting and fun!

- Getting going

Experience has shown that the Child-to-Child activities work best if they are introduced in a series of steps as shown on the following pages.

### **Step 1 Introduce 'the idea' and help children to understand it better.**

#### **For example caring for children with diarrhoea:**

Diarrhoea is dangerous because it can kill and cause malnutrition. It can be prevented by keeping clean, using clean water, and by eating properly. Children who get diarrhoea may die because they become dehydrated, that is, they lose too much liquid from their bodies. The liquid they lose must be put back into their bodies. Special drinks (ORS) can be prepared by children to help replace the lost water when a child has diarrhoea, and can prevent dehydration.

Use practical activities to reinforce the ideas like role play, puppets, storytelling, and games to understand how people feel and react. For example, the children describe their experiences of diarrhoea, the words used to describe it in their family, and the treatment for it.

### **Step 2 Getting the children to find out more.**

The children can find out things from other children, from parents, and from others in the camp.

For example, the number of children in the group or family who have had diarrhoea, and how it affected them.

### **Step 3 Discussing what the children found out and planning activities that will help.**

#### **Discuss possible action, find out who else can help the children with practical actions, and make a plan of action.**

For example: what can I do to prevent diarrhoea

- what can we do if another child is affected

- what can we do to teach others about the dangers

### **Step 4 Taking action.**

Do practical activities at home. Share new ideas and messages with members of the family and friends. Do activities in the camp.

For example: making, mixing, and tasting a special rehydration drink (ORS)  
giving the special drink to children who have diarrhoea  
checking that people know about dehydration from diarrhoea

### **Step 5 Discussing the results of the activities and asking: “How did we do?”**

Test knowledge and skills of children in the group and of others in the camp.  
Observe attitudes and practices of adults and children.

For example: how many of us now know how to make the special drink?  
how many have passed on the ideas to others?

### **Step 6 Doing the activities better next time!**

Some examples:

1. Clean, safe water

#### **Step 1                      *The Idea***

Every living thing needs water to live, but dirty water can make us ill. We must be careful to keep water clean and safe – where it is found, when we carry it home, and when we store and use it.

Have three pictures of:

1. Two women getting water at a pump
2. A child drinking a glass of dirty water
3. Another child drinking a glass of clean water

First ask the children to make up a story about the first picture, describing who, when, where, what, and why. Ask if the water from the pump is clean?

Then show picture 2 and explain that this is one of the first woman's children drinking water she brought home from the pump. Ask what could have happened between the first and second picture to make the water become dirty. Let the children continue the story.

Next show picture 3 and explain that this is one of the second woman's children drinking water she brought home from the pump. Ask what this woman has done to keep her water clean. Let the children finish the story.

#### **Step 2                      *Finding out more***

Ask the children to make a 'water map' of the camp or community. Go and see the sources of water in the area. Which are clean and well looked after? Which are dirty? Draw the map on a piece of paper.

Find out about how people store water in their homes. Do they put it into a clean, covered container? Do they use a separate container, e.g., a cup, gourd, or ladle to get water out of the storage container? Make a chart like this and record the information.

Water storage containers					
House	1	2	3	4	5
Clean	*		*		
Covered		*	*		
Ladle			*		*

### **Step 3** ***Discussing and planning to take action***

Examine and discuss the maps and the charts the children have made. Use these as a basis for planning activities that address the problems that they have identified. For example, create a play about keeping water sources clean and/or make a poster that depicts a child using a clean, separate container to get water from a storage container. Help the children to get the right message across. It is essential that the health messages are correct and clear; wrong or muddled messages could have long-term, negative effects. Discuss how they will know whether the play helps the community members to keep the water sources clean or if the poster is effective in encouraging people to store water properly.

### **Step 4** ***Taking action***

Create a play about the importance of keeping water sources clean from rubbish, stopping people urinating near them, or allowing animals to drink from them, etc. Perform the play near the water sources or in the market place. Make a poster showing a healthy child using a clean cup or gourd to get water from a storage container, with a message about keeping water clean to stay healthy. Display in health and feeding centres, market areas, etc.

### **Step 5** ***Discussing the results***

Ask the children how well they thought their activities were carried out. Did they encounter any unexpected problems? If so, discuss these and look for alternative solutions. Ask the children what effect their play and/or poster had on the knowledge and practice of other children, families, and the population [suggest 'community'] as a whole. How will they know in the longer term?

Tell the children they should plan to observe the water sources and draw new maps on a regular basis, as well as keep a record of the information. Carry out household surveys using the same time schedule, and record if any positive changes have been made in the practices of storing water.

### **Step 6** ***Doing it better next time***

Tell the children to think about their play and/or poster. What could have been better? How could the message have been clearer? Practise the play again and/or paint the poster with brighter colours, etc. to reinforce the health message for the population. Ask the children to think of ways of keeping water clean that can be used in the long term and become a feature of everyday life.

## **2. Working with Schools**

Sometimes a school can agree an action plan to help everyone receive and understand such messages. Staff, parents, and even children can list those that they think are most vital for children to know and do. They can then plan how to achieve them through:

- health teaching

- reinforcing the ideas in other subjects
- action to make the school a good example
- community activities organised by the school.

They can then decide how to check to what extent these plans are being achieved.

It may be possible for the whole school to become a living example of Child-to-Child in action, by staff and children agreeing a set of rules to live by, for example:

- In a Child-to-Child school, we should all know...
- In a Child-to-Child school, we practise.....
- In a Child-to-Child school, we spread these ideas.....

### ***From Child-to-Child: in Mozambique, good hygiene begins at school***

In the outlying area of Beira City in Mozambique, primary school children as young as seven are transforming once dank and dirty schools into healthy, inviting places of learning. In the process they are educating their peers, their families, and their communities about the importance of safe water, good hygiene, and private, separate sanitation facilities.

In the year 2000, UNICEF found that 80 per cent of all primary schools here had no toilets for either boys or girls and no handwashing facilities, and that few schools promoted better hygiene. To change this situation, UNICEF/WES supported the building of latrines for primary school students and teachers and handwashing facilities to enable people to practise hygienic behaviours. They also trained 17–24 year-olds to teach students about the role they could play to improve their school and community.

The most potent tool in the programme turned out to be the children themselves. In 15 primary schools with 18,000 students, Child-to-Child sanitation clubs sprang up, promoting hygiene and healthy school environments. The young people pushed for central rubbish collection spots so that they no longer had to share their play spaces with garbage, and, through theatre, song, dance, and games, they warned of the dangers of unhygienic environments, especially for children. Irene Luisa da Costa Tivane, a 10 year-old Child-to-Child club member, is certain that she is making a difference.

"Participating in Hygiene Promotional activities is fighting diarrhoeal diseases," she said. "That's why everybody should drink chlorinated water and know how to use a latrine."

Flávo Varela de Araújo, 14, is an active member of the Child-to-Child radio programme, which supports the school sanitation clubs. He is very proud of the changes he has seen taking place in the school. "Because of the club the school environment is changing," he said. "And the students' behaviours are changing too. We will continue supporting safe practices."

And the students' exemplary behaviour is catching on, as parents are listening to their children and practising better hygiene at home. After seeing the changes in their children's schools, parents have begun to press local authorities to provide better hygiene education and services in all schools.

Meanwhile, UNICEF is working closely with the Ministry of Education to see how this programme can be replicated elsewhere.

The benefits of Child-to-Child sanitation clubs combined with building latrines and handwashing facilities have exceeded all expectations. Not only have these efforts provided safer, healthier learning environments, they have also encouraged girls' education. Older girls used to drop out of school for lack of privacy, but now they are staying in school to complete their basic education. The improved hygiene facilities have given girls back their dignity – and their books.

**Source: UNICEF/WES**

December 2007

# Communication for Social Change<sup>21</sup>

Communication for Social Change (CFSC) describes an iterative process where 'community dialogue' and 'collective action' work together to produce social change in a community that improves the health and welfare of all of its members.

The guiding philosophy of communication for social change can readily be traced to the work of Paulo Freire (1970), the Brazilian educator who conceived of communication as dialogue and participation for the purpose of creating cultural identity, trust, commitment, ownership, and empowerment (in today's term).

Communication for Social Change builds on these principles and draws on the broad literature on development communication as well as on theories of communication, dialogue, and conflict resolution.

For social change, a model of communication is required that is cyclical, relational, and leads to an outcome of mutual change rather than one-sided, individual change. The model describes a dynamic process that starts with a 'catalyst/stimulus' that can be external or internal to the community. This catalyst leads to dialogue within the community that, when effective, leads to collective action and the resolution of a common problem.

Community dialogue and action can be seen as a sequential process or series of steps that can take place within the community, some of them simultaneously, and which lead to the solution of a common problem. The literature and previous experience indicate that if these steps are successfully completed, community action is more likely to be successful. Every time a community goes through the dialogue and collective-action processes to achieve a set of shared objectives, its potential to cooperate effectively in the future also increases.

Seven outcome indicators of social change have been proposed: 1) leadership, 2) degree and equity of participation, 3) information equity, 4) collective self-efficacy, 5) sense of ownership, 6) social cohesion, and 7) social norms. Taken together, these outcomes determine the capacity for cooperative action in a community. The model also describes a learning process, which increases the community's overall capacity for future collective action and increases its belief in, and value for, continual improvement.

Communities are not homogeneous entities but are comprised of subgroups with social strata and divergent interests. As a consequence, issues of disagreement and conflict are also incorporated into the CFSC model.

In the CFSC model, information is shared or exchanged between two or more individuals rather than transmitted from one to the other. All participants act on the same information; none are passive receivers of information. The information can be created by the action of any participant, or it may originate from a third source such as television or radio, or a person or institution not directly participating, such as a church, school, non-governmental agency and so on. The second feature of the model is that it stresses the important role of the perception and interpretation of participants, and understanding is seen in terms of a dialogue or ongoing cultural conversation.

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<sup>21</sup> Adapted from: Figueroa, M.E., Lawrence Kincaid, D. Rani, M., Lewis, G. **Communication for Social Change, Working Paper Series 2002** The Rockefeller Foundation and Johns Hopkins University Center for Communication Programs.



The 10 steps of community dialogue are:

1. **Recognition of a problem.**
2. **Identification and involvement of leaders and stakeholders.**
3. **Clarification of perceptions.**
4. **Expression of individual and shared needs.**
5. **Vision of the future.**
6. **Assessment of current status.**
7. **Setting objectives.**
8. **Options for action.**
9. **Consensus on action.**
10. **Action plan. .**

The PHAST approach draws significantly on this model of communication for social change.

### **What relevance does CFSC have for Hygiene Promotion in emergencies?**

CFSC is more commonly associated with the process of long-term change but many of the principles of CFSC can be applied to working in emergency contexts and can lead to a more creative way to work with people affected by disaster that ensures that where possible they have a greater say in the process of response and recovery.

While time may be at a premium and it may not seem feasible to work through the 10 steps of community dialogue, the importance of dialogue and the role that those affected have to play in influencing others and achieving community level change rather than individual change, should not be underestimated. The disruption caused by the emergency can in itself provide the necessary 'catalyst' to start the change process.

The knee-jerk reaction in emergencies has often been to simply disseminate one-way messages to change the hygiene behaviour of individuals. However, a greater focus on the way people can work together to achieve a common aim may be more successful. Those affected by an emergency may also feel greater urgency to work with others to achieve solutions to the problems they are facing, and the potential of this resource can often go to waste when more conventional approaches to Hygiene Promotion are employed.

December 2007

# Sphere ([www.sphereproject.org](http://www.sphereproject.org))

## What is Sphere?

Sphere is based on two core beliefs: first, that all possible steps should be taken to alleviate human suffering arising out of calamity and conflict, and second, that those affected by disaster have a right to life with dignity and therefore a right to assistance. Sphere is three things; a handbook, a broad process of collaboration, and an expression of commitment to quality and accountability.

The Sphere Project was launched in 1997 by a group of humanitarian NGOs and the Red Cross and Red Crescent movement. To date, over 400 organisations in 80 countries, all around the world, have contributed to the development of the minimum standards and key indicators. This new (2004) edition of the handbook has been significantly revised, taking into account recent technical developments and feedback from agencies using Sphere in the field.

## Aim of Sphere

To improve the quality of assistance to people affected by disaster and improve the accountability of states and humanitarian agencies to their constituents, donors, and the affected populations.

## Sphere and WASH

The minimum standards in water, sanitation, and Hygiene Promotion are a practical expression of the principles and rights embodied in the Humanitarian Charter. The Humanitarian Charter is concerned with the most basic requirements for sustaining the lives and dignity of those affected by calamity or conflict, as reflected in the body of international human rights, humanitarian, and refugee law

## Sphere and Hygiene Promotion

The aim of any water and sanitation programme is to promote good personal and environmental hygiene in order to protect health. Hygiene Promotion is defined here as the mix between the population's knowledge, practice, and resources, and agency knowledge and resources, which together enable risky hygiene behaviours to be avoided. The three key factors are: 1) a mutual sharing of information and knowledge, 2) the mobilisation of communities, and 3) the provision of essential materials and facilities. Effective Hygiene Promotion relies on an exchange of information between the agency and the affected community in order to identify key hygiene problems and to design, implement, and monitor a programme to promote hygiene practices that will ensure the optimal use of facilities and the greatest impact on public health. Community mobilisation is especially pertinent during disasters as the emphasis must be on encouraging people to take action to protect their health and make good use of facilities and services provided, rather than on the dissemination of messages. It must be stressed that Hygiene Promotion should never be a substitute for good sanitation and water supplies, which are fundamental to good hygiene.

Hygiene Promotion is integral to all the standards within this chapter. It is presented here as one overarching standard with related indicators. Further specific indicators are given within each standard for water supply, excreta disposal, vector control, solid waste management, and drainage.

### **Hygiene Promotion standard 1: programme design and implementation**

All facilities and resources provided reflect the vulnerabilities, needs, and preferences of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate.

#### **Key indicators** (to be read in conjunction with the guidance notes)

- Key hygiene risks of public health importance are identified (see guidance note 1).
- Programmes include an effective mechanism for representative and participatory input from all users, including in the initial design of facilities (see guidance notes 2, 3 and 5).
- All groups within the population have equitable access to the resources or facilities needed to continue or achieve the hygiene practices that are promoted (see guidance note 3).
- Hygiene Promotion messages and activities address key behaviours and misconceptions and are targeted for all user groups. Representatives from these groups participate in planning, training, implementation, monitoring, and evaluation (see guidance notes 1, 3 and 4, and Participation standard).
- Users take responsibility for the management and maintenance of facilities as appropriate, and different groups contribute equitably (see guidance notes 5 and 6).

#### **Guidance notes**

**1. Assessing needs:** an assessment is needed to identify the key hygiene behaviours to be addressed and the likely success of promotional activity. The key risks are likely to centre on excreta disposal, the use and maintenance of toilets, the lack of handwashing with soap or an alternative, the unhygienic collection and storage of water, and unhygienic food storage and preparation. The assessment should look at resources available to the population as well as local behaviours, knowledge, and practices, so that messages are relevant and practical. It should pay special attention to the needs of vulnerable groups. If consultation with any group is not possible, this should be clearly stated in the assessment report and addressed as quickly as possible (see Participation standard and the assessment checklist in Appendix 1).

**2. Sharing responsibility:** the ultimate responsibility for hygiene practice lies with all members of the affected population. All actors responding to the disaster should work to enable hygienic practice by ensuring that both knowledge and facilities are accessible, and should be able to demonstrate that this has been achieved. As a part of this process, vulnerable groups from the affected population should participate in identifying risky practices and conditions and take responsibility to reduce these risks measurably. This can be achieved through promotional activities, training, and facilitation of behavioural change, based on activities that are culturally acceptable and do not overburden the beneficiaries.

**3. Reaching all sections of the population:** Hygiene Promotion programmes need to be

carried out with all groups of the population by facilitators who can access, and have the skills to work with, different groups (for example, in some cultures it is not acceptable for women to speak to unknown men). Materials should be designed so that messages reach members of the population who are illiterate. Participatory materials and methods that are culturally appropriate offer useful opportunities for groups to plan and monitor their own hygiene improvements. As a rough guide, in a camp scenario there should be two hygiene promoters/community mobilisers per 1,000 members of the target population. For information on hygiene items, see non-food items standard 2.

**4. Targeting priority hygiene risks and behaviours:** the objectives of Hygiene Promotion and communication strategies should be clearly defined and prioritised. The understanding gained through assessing hygiene risks, tasks, and responsibilities of different groups should be used to plan and prioritise assistance, so that misconceptions (for example, how HIV AND AIDS is transmitted) are addressed, and information flow between humanitarian actors and the affected population is appropriate and targeted.

**5. Managing facilities:** where possible, it is good practice to form water and/or sanitation committees made up of representatives from the various user groups, and with equal numbers of men and women. The functions of these committees are to manage the communal facilities such as water points, public toilets, and washing areas, to be involved in Hygiene Promotion activities, and also to act as a mechanism for ensuring representation and promoting sustainability.

**6. Overburdening:** it is important to ensure that no one group is overburdened with the responsibility for Hygiene Promotional activities or management of facilities, and that each group has equitable influence and benefits (such as training). Not all groups, women, or men have the same needs and interests and it should be recognised that the participation of women should not lead to men, or other groups within the population, not taking responsibility.

For further information see [www.sphereproject.org](http://www.sphereproject.org)

December 2007

# Hygiene Promotion and Avian and Pandemic Influenza

Avian Influenza and the threat of Pandemic Influenza are serious public health risks. Avian Influenza currently affects both the lives and livelihoods of many people in countries that also experience large-scale emergencies. There are also concerns that the currently circulating Avian Influenza A/H5N1 strain may give rise to the next Pandemic Influenza virus which in itself could constitute a global emergency. Hygiene Promotion has a role to play in addressing both problems, as maintaining hygiene – both personal and food hygiene – can contribute to reducing the spread of disease.

WHO recommends the following precautions to limit the spread of Avian Influenza and Pandemic Influenza.

Basic good health habits that will help reduce the spread of influenza virus in the home include:

- Cover your mouth and nose with a tissue when coughing or sneezing
- Wash your hands often, especially:
  - before, during, and after you prepare food
  - before you eat
  - after you use the bathroom
  - after handling animals or animal waste
  - before feeding babies
  - when your hands are dirty, and
  - more frequently when someone in your home is sick
- Avoid touching your eyes, nose, or mouth. Infections are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.
- People should avoid contact with chickens, ducks, or other poultry unless absolutely necessary.
- Take all precautionary measures to ensure that poultry and poultry products are properly prepared and safe to eat.

For more details on the role of Hygiene Promotion in limiting the spread of Avian and Pandemic Influenza see: [Questions & Answers on potential transmission of avian influenza \(H5N1\) through water, Sanitation and Hygiene and ways to reduce the risks to human health \[pdf 338kb\]](#) April 2007

[http://www.who.int/csr/disease/avian\\_influenza/guidelinestopics/en/index.html](http://www.who.int/csr/disease/avian_influenza/guidelinestopics/en/index.html)

## **Other potentially useful websites:**

1. UN Consolidated Action Plan on avian flu Nov 2006

[http://un-influenza.org/files/review\\_nov06\\_dec07.pdf](http://un-influenza.org/files/review_nov06_dec07.pdf)

2. Bird flu and the poor - CARE's approach 16 February 2006

<http://www.careinternational.org.uk/Bird%20flu%20and%20the%20poor%20-%20CARE%27s%20approach+5548.twl>

3. Responding to the avian influenza pandemic threat - Recommended strategic actions

[http://www.who.int/csr/resources/publications/influenza/WHO\\_CDS\\_CSR\\_GIP\\_05\\_8-EN.pdf](http://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_05_8-EN.pdf)

4. Avian influenza frequently asked questions *revised 5 December 2005*

[http://www.who.int/csr/disease/avian\\_influenza/avian\\_faqs/en/](http://www.who.int/csr/disease/avian_influenza/avian_faqs/en/)

December 2007

# Hygiene Promotion and HIV and AIDS

AIDS is not a water-related disease and HIV is not spread via contaminated water or poor hygiene, however, given the devastating impact of HIV AND AIDS, it must be taken into consideration in the planning and implementing of humanitarian programmes.

In carrying out your assessment you need to consider two essential questions:

- How will HIV and AIDS affect the programme?
- How will the programme affect HIV and AIDS prevalence?

And, in answering those questions, you need to appreciate the risk factors in situations of conflict and displaced persons' camps – whether there is HIV prevalence in the area of origin (of displaced people), whether there is HIV prevalence in the area of stay (host population/non-displaced population), and the duration of the emergency and, therefore, sustained vulnerability of the affected community. You need to appreciate how the programme will affect the prevalence of HIV and AIDS, the caring of people living with HIV and AIDS (PLWHA), and how to mitigate the impact of HIV and AIDS.

Diarrhoea is one of the common complaints suffered by people with HIV and AIDS and, when chronic, can lead quickly to debilitation. In addition to the usual guidelines about water and latrine planning and supply, the following should be considered:

- train water and sanitation committees so that they understand HIV issues and the needs of those affected or infected in terms of sanitation and access to water
- be prepared for 'drop-outs' as illness may be an issue for committee members too
- consider the 'out-of-sight' needs of chronically ill and bedridden people
- consider lower pump handles and 5-litre jerricans for children's use
- consider ramps instead of steps and a bar to hold when squatting

When raising awareness about HIV and AIDS be aware of the following:

- although it is good to give out information, do not just add on a message about HIV to general public health messages
- do not be negative
- provide information in an integrated way that is culturally appropriate, for example when discussing protection issues with women in a camp
- address the gender dimensions of the epidemic but do not portray women as victims
- touch the heart as well as the mind, making the message relevant and related to real life, and ask the audience to take action

Adapted from *Humanitarian Programmes and HIV and AIDS*, Oxfam GB, 2007

For further information see:

1) Humanitarian Programmes and HIV and AIDS: A practical approach to mainstreaming [Paperback, CD ROM], by Vivien Margaret Walden, Marion O'Reilly and Mary Yetter, Oxfam GB (2007)

The book explains both how HIV affects emergencies and how emergencies affect HIV, as well as identifying the particular needs of potential vulnerable groups. There is guidance particularly for managers in the planning stage, but the book also suggests how to mainstream HIV and AIDS throughout the emergency project cycle. It includes useful checklists and planning tools, with examples of inductions, trainings, and awareness-raising sessions both for staff and for community members.

<http://publications.oxfam.org.uk/oxfam/display.asp?K=9780855985622>

2) HIV and AIDS and Water, Sanitation and Hygiene, by Evelien Kamminga and Madeleen Wegelin-Schuringa (KIT) (IRC) (2006)

AIDS is not a water-related disease. HIV is not spread via contaminated water or poor hygiene. So why do we need a Thematic Overview Paper (TOP) on the influence of HIV and AIDS on the water, sanitation, and hygiene (WASH) sector? The first answer to that question lies in the devastating impact of the HIV and AIDS epidemic on the staff and the customers of WASH service providers in the worst-hit countries. The second reason that this paper is pertinent, relating to the changing demands for WASH services brought about by the effects of HIV and AIDS on households and communities. Thirdly, improved WASH services can and do have a crucial role to play in slowing the progression of HIV and in reducing the number of AIDS-related deaths.

This TOP is relevant not only for those countries that are already highly affected by the epidemic (mainly in Africa), but also those countries with rapidly increasing infection rates (in Asia and Eastern Europe) and those that are in the beginning stage or not yet affected by the epidemic. Among other things, this TOP addresses:

- the linkages between HIV and AIDS and water, sanitation, and hygiene from different perspectives;
- the impact of HIV and AIDS on water and sanitation organisations and service provision;
- the lessons learned in preventing and mitigating the effects of HIV and AIDS both outside and inside the water and sanitation sector;
- what the water and sanitation sector can do about the problem of HIV and AIDS at different levels.

[http://www.irc.nl/content/download/4199/48511/file/TOP2HIV\\_AIDS05.pdf](http://www.irc.nl/content/download/4199/48511/file/TOP2HIV_AIDS05.pdf)

December 2007



# Humanitarian accountability

A current working definition of accountability to those affected by crisis is the following:

**People and communities with whom we work systematically inform programme choices and implementation, throughout the lifetime of the project, and are the most important judges of programme impact.**

At a minimum, humanitarian project staff should:

1. Provide public information to beneficiaries and other stakeholders on their organisations, its plans, and relief assistance entitlements.
2. Conduct ongoing consultation with those assisted. This should occur as soon as possible at the beginning of a humanitarian relief operation, and continue, regularly throughout it. 'Consultation' means exchange of information and view between the agency and the beneficiaries of its work. The exchange will be about:
  - The needs and aspirations of beneficiaries
  - The project plans of the agency
  - The entitlements of beneficiaries
  - Feedback and reactions from beneficiaries to the agency on its plans and expected results
3. Establish systematic feedback mechanism that enable:
  - Agencies to report to beneficiaries on project progress and evolution
  - Beneficiaries to explain to agencies whether projects are meeting their needs
  - Beneficiaries to explain to agencies the difference the project has made to their lives
4. Respond, adapt, and evolve in response to feedback received, and explain to all stakeholders the changes made and/or why change was not possible.  
(adapted from the ECB Good Enough Guide, [www.ecbproject.org](http://www.ecbproject.org))

Humanitarian Accountability Partnership International is the humanitarian sector's first international self-regulatory body. Its work is based on the findings of the **Humanitarian Accountability Project**, an inter-agency action research initiative that started in 2001. However, the origins of the Partnership go still further back, to the Joint Evaluation of the International Response to the Genocide in Rwanda.

This seminal report published in 1996 included the following recommendations:

- i. Systems for improving accountability need to be strengthened..... The Red Cross/NGO Code of Conduct commits signatories to "hold ourselves accountable to both those we seek to assist and those from whom we accept resources". Full implementation of this commitment would entail establishment of NGO mechanisms for consultation with people affected by humanitarian emergencies.....*
- ii. Establish a unit in UN/DHA that would ..... serve as ombudsman to which any party can express a concern related to the provision of assistance or security  
Identify a respected, independent organisation or network of organisations to act on behalf of beneficiaries of humanitarian assistance*

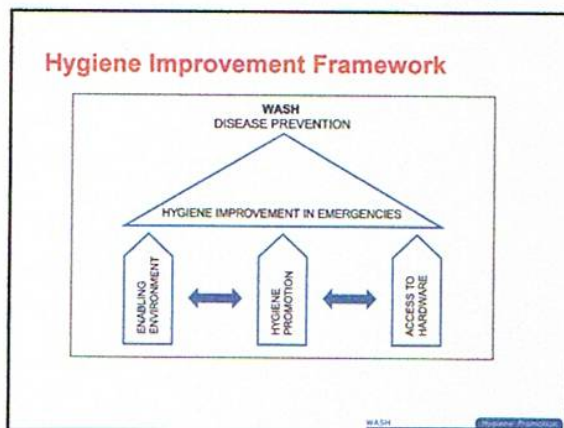
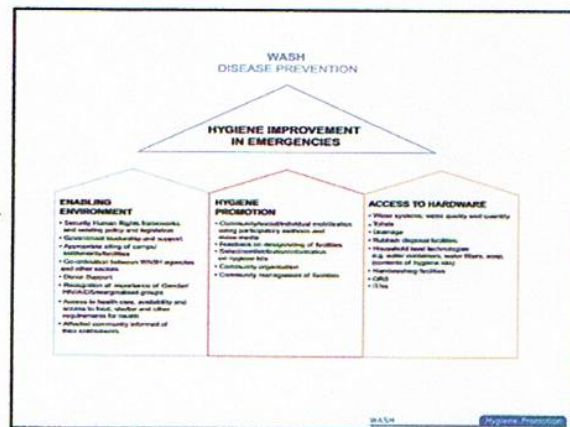
For further information see the website <http://www.hapinternational.org/>  
December 2007

# PowerPoint

WASH Hygiene Promotion

## Hygiene Promotion in emergencies

Orientation package  
December 2007  
(amended graph December 2008)



### Hygiene Promotion

- Hygiene promotion is the **planned, systematic** attempt to **enable** people to **take action** to prevent or mitigate water, sanitation, and hygiene related diseases.
- It can also provide a practical way to facilitate community participation and accountability in emergencies.
- It involves ensuring that **optimal use** is made of the **water, sanitation, and hygiene enabling facilities** that are provided.

### Exercise 1 (15 minutes total)

- In small groups provide examples of what might be included under 'enabling environment', 'hygiene promotion', and 'access to hardware' (10 minutes)
- Each group calls out a few examples for each
- Clarify and discuss using completed example on next slide

### Terminology

- Hygiene education  
The provision of education and/or information to encourage people to maintain good hygiene and prevent hygiene related disease.  
It remains a part of Hygiene Promotion and is often most effective when undertaken in a participatory or interactive way.
- Health promotion  
The process of enabling people to increase control over, and to improve, their health.  
The focus is on broader health issues rather than just those associated with water and sanitation.

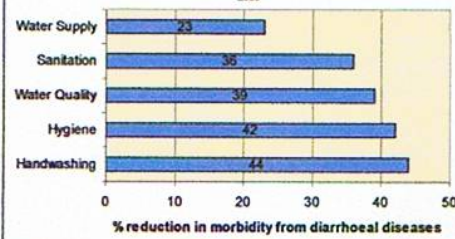
## Why do we need Hygiene Promotion?

WASH

Hygiene Promotion

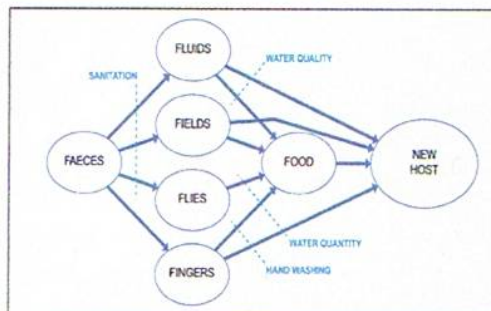
### WASH interventions critical for child survival

Source: Meta-analysis by Fewtrell & Colford, 2004; Handwashing data by Curtis & Cairncross, 2003, Updated sanitation data by Cairncross, 2008



Data leads to some controversy, partly due to the difficulty of splitting impacts of interventions. For example:  
 \* Hand-washing is not possible without a water supply, so 'hand-washing' is in fact 'water supply and hand-washing'  
 \*\* Water quality at household will also have involved some hygiene promotion when setting up the household water treatment processes

## Transmission of diarrhoeal disease



WASH

Hygiene Promotion

## Why do we need Hygiene Promotion?

### 1. Optimal use of facilities



- Facilities may not be used or may be used in a way that was not intended
- Discussions with users can ensure the best possible design of facilities
- Systems that ensure the cleanliness and maintenance of facilities need to be set up

WASH

Hygiene Promotion

## Why do we need Hygiene Promotion?

The priority focus of Hygiene Promotion in an emergency is the prevention of diarrhoea through:

- The safe disposal of excreta
- Effective handwashing
- Reducing household drinking water contamination

WASH

Hygiene Promotion

## Why do we need Hygiene Promotion?

### 2. To support participation and accountability



Photo: IFRC

WASH

Hygiene Promotion



### Why do we need Hygiene Promotion?

#### 3. To monitor the acceptability of facilities and impact on health



WASH

Hygiene Promotion



**Hygiene Promotion is not just about message dissemination and behaviour change**

WASH

Hygiene Promotion

### Sphere & Hygiene Promotion Standard 1:

- All facilities and resources provided reflect the vulnerabilities, needs, and preferences of the affected population.
- Users are involved in the management and maintenance of hygiene facilities where appropriate.



WASH

Hygiene Promotion



**Effective Hygiene Promotion emphasises:**

**action and dialogue**

WASH

Hygiene Promotion

### Team integration

- Team goals and objectives
- Joint work planning and systematic sharing of information
- Joint field visits and training where possible
- Shared monitoring and reporting systems
- Joint interagency meetings

WASH

Hygiene Promotion

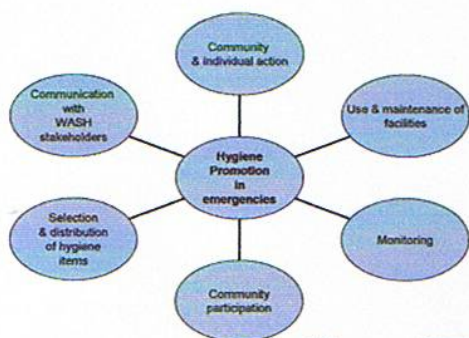
### Exercise 2 (20 minutes total)

- In groups of 3, brainstorm some Hygiene Promotion activities (10 minutes)
- Discuss in plenary (10 minutes)

WASH

Hygiene Promotion

## Components of Hygiene Promotion



## Hygiene Promotion activities

- Consult on content and acceptability of items for hygiene kits and advise logistics personnel
- Ensure optimal use of hygiene items (e.g. potties, ITNs)

Selection & distribution of hygiene items



Example expected outcome:  
Men, women, and children use hygiene items effectively to improve hygiene

## Hygiene Promotion activities

Use & maintenance of facilities

- Feedback to engineers on design and acceptability of facilities
- Establish a voluntary system of cleaning and maintenance, or train latrine attendants
- Identify, organise, and train water and sanitation committees (with engineers) and/or latrine attendants

Expected outcome:

The toilets provided are used by men, women, and children in comfort and safety, and are kept clean.

## Hygiene Promotion activities

Individual & community action

- Train outreach system of hygiene promoters to conduct home visits
- Organise community dramas and group activities with adults and children
- Use available mass media e.g. radio to provide information on hygiene

## Hygiene Promotion activities

Community participation

- Consult with affected men, women, and children on design of facilities, hygiene kits, and outreach system
- Support community organisations, organisers, and communicators
- Carry out a basic gender analysis and disaggregate assessment data
- Identify and respond to vulnerability (e.g. disabled people, elderly people)

Example expected outcome:

People with disabilities are identified and solutions are found to ensure their improved access to water and sanitation facilities.

## Hygiene Promotion activities

Individual & community action

Example expected outcome:  
75% of (men, women, and children) wash their hands with soap after using the latrine, within 4 months of starting the intervention

Example expected outcome:  
Communities are mobilised to dig drainage ditches around their shelters





## Hygiene Promotion activities

- Collaborate with government ministries and personnel
- Train women's groups/ co-operatives, faith based institutions, government workers, and national NGOs

Example expected outcome:

'Programming is designed to maximise the use of local skills and capacities...'

Communication with WASH stakeholders



Photo: IFRC

WASH

Hygiene Promotion

## Hygiene Promotion first steps

- Work in close liaison with other members of WASH team
  - including engineers/technicians/logisticians, and coordinators.
- Conduct rapid assessment and identify high risk practices and disease burden
  - and positive practices and motivation for these.
- Explore community organisation and dynamics
  - including opinion leaders and influential men, women, and children.
- Identify channels of communication (traditional and modern):
  - use a mix of directive and message based (mass media) methods and interactive methods that encourage feedback and discussion.
- Set objectives and indicators and collect baseline data
  - in conjunction with engineers and other team members.
- Monitor process and action taken
  - in conjunction with engineers and other team members.

WASH

Hygiene Promotion

## Hygiene Promotion activities

Collect, analyse, and use data on:

- Appropriate use of hygiene items
- Optimal use of facilities
- Community satisfaction with facilities

Example expected outcome:

"Systems are in place to ensure the regular collection of information... to identify whether the indicators for each standard are being met" e.g. in relation to disability (Example from Sphere)

Monitoring



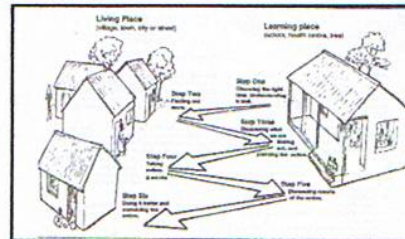
Photo: Oxfam

WASH

Hygiene Promotion

## Communication approaches

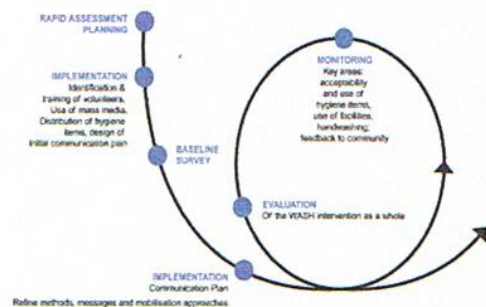
### Child to child



WASH

Hygiene Promotion

## Project Cycle and Hygiene Promotion steps



WASH

Hygiene Promotion

## Communication approaches

- PHAST?
- Faster PHAST
- CHAST

WASH

Hygiene Promotion

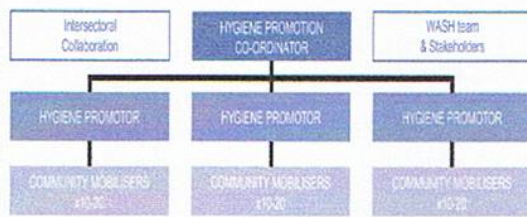
## Communication approaches

- Social marketing?
- Campaigns
- Peer education

WASH

Hygiene Promotion

## Hygiene Promotion systems in emergencies



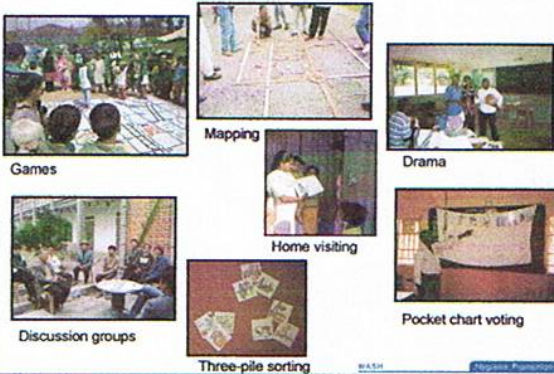
Structure will depend on context. Alternatives are: Community Health Clubs or Water and Sanitation Committees

Sphere recommends at least 2 outreach workers per 1,000 population and WHO 1:1000

WASH

Hygiene Promotion

## Communication methods



WASH

Hygiene Promotion

## Participation and Accountability

WASH

Hygiene Promotion

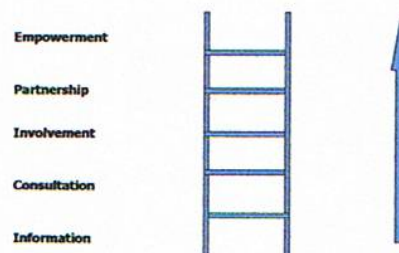
## Communication methods

- Radio Programmes
- TV/Video
- Leaflets
- Posters/Notice boards

WASH

Hygiene Promotion

## Participation Ladder



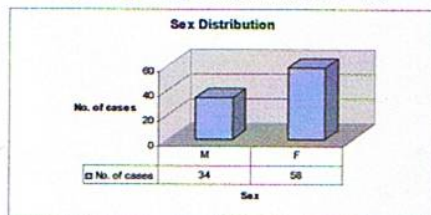
WASH

Hygiene Promotion



## Disaggregation of data

Sex distribution of cholera cases,  
Kiryandongo Refugee Camp, Masindi, 2002 - IRC



## Exercise 3: 15 minutes

In small groups consider what you can do in this context to ensure:

1. that women, men, and children participate in the WASH emergency response
2. that WASH initiatives are accountable to the affected community

## Activities to promote participation

- Listen to men and women separately and analyse their different perspectives and needs
- Identify those who might be vulnerable (e.g. women, young children, elderly, those with disabilities, or minority or excluded groups) and ensure access to facilities, information, and education
- Feed back information to those affected (e.g. from surveys or meetings)
- When possible, allow people to set their own objectives for action and to determine the success of the intervention

## Practical accountability

- Feed back concerns of the affected community and advocate for these to be addressed
- Ensure men and women are aware of their rights and entitlements (e.g. with regard to hygiene kits)
- Ensure monitoring system is in place and that it is used to inform future activities
- Monitor satisfaction and participation

## Improving accountability

- Facilitating participation
- Monitoring intervention – including satisfaction and acceptability and impact on health
- Link between those affected and other actors