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WASH guidelines for hygiene promotion in emergency operations

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**IFRC WASH GUIDELINES FOR HYGIENE PROMOTION
IN EMERGENCY OPERATIONS
1319400 10/2017 E**

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WASH Guidelines for hygiene promotion in emergency operations

The guidelines assist Red Cross Red Crescent staff and volunteers to work systematically in delivering hygiene promotion in emergencies, starting with understanding the problem and target

groups, the barriers and motivators for behaviour change by involving the community at all stages and ensuring the response is effective and appropriate to the needs.

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List of Acronyms

CHS	Core Humanitarian Standard
CLTS	Community-Led Total Sanitation
ERU	Emergency Response Unit
HP	Hygiene Promotion
IEC	Information Education and communication
IFRC	International Federation of Red Cross and Red Crescent
MHM	Menstrual Hygiene Management
MSM	Mass Sanitation Module
NDRT	National Disaster Response Team
NFIs	Non-Food Items
NS	National Society
RCRC	Red Cross Red Crescent
RDRT	Regional Disaster Response Teams
WASH	Water, Sanitation and Hygiene
PHAST	Participatory Hygiene and Sanitation transformation
PoA	Plan of Action
FGD	Focus group discussion

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Note

This Hygiene Promotion in Emergencies pack consists of the following.

1. IFRC Guidelines for Hygiene Promotion in Emergencies (*this document*)
 - This provides guidance on how to plan and implement hygiene promotion in emergencies with links for further information
 2. A 16-page summary of the IFRC Guidelines to Hygiene Promotion in Emergencies
 - A summary, which describes the outline, with a brief description of all the steps
 3. A short one-page summary of the IFRC Guidelines to Hygiene Promotion in Emergencies
 - To give an overview (*Annex*)
 4. A training manual to help put these IFRC Hygiene Promotion guidelines for Emergencies into practice;
 - With learning objectives and session plans that can be adapted to the context.
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Introduction

Introduction

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

This document is summarised in a short six-page document and there is also a one-page (annex 1.2) overview document and a training manual with suggested sessions for training on emergency hygiene promotion linked with this document is produced. All these documents and the links to tools, resources and reference material mentioned in the documents are linked and will be available on the IFRC <http://watsanmissionassistant.org>.

WASH guidelines for hygiene promotion in emergency operations

Who is this document for?

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

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

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

RCRC Definition of Hygiene Promotion in Emergency

Hygiene promotion (HP) in Emergencies in the Red Cross is defined as: 'a planned, systematic approach delivered by RCRC staff and volunteers; to enable people to take action to prevent water, sanitation and hygiene-related diseases by mobilising and engagement of the affected population, their knowledge and resources; and to maximize the use and benefits of water and sanitation items and facilities'.

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

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

hygiene facilities is part of hygiene promotion, along with influencing attitudes to change behaviour.

An emergency situation can impact on health in different ways; water sanitation and hygiene facilities may be limited, e.g. if people are displaced living in temporary shelters, left their homes (e.g. due to conflict, or a natural disaster), the infrastructure is damaged (e.g. following earthquake, floods), there is a lack of resources (e.g. soap), lack of health care facilities, lack of food, lack of shelter, overcrowding etc.; all of which can make the risks for water and sanitation related diseases increase.

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



The focus of hygiene promotion is determined based on the public health risks. Normally the key issues to address are:

- Safe disposal of excreta
- Effective hand washing
- Reducing the contamination of household drinking water

But it is not limited to these alone, other issues such as vector control, waste management and menstrual hygiene management should be included, depending on the need and context of the disaster.

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



Figure 1: Hygiene Improvement Framework (Source: Sphere handbook 2011)

The ‘campaign’ approach has been the most widely used method for hygiene promotion in emergency in the Red Cross Red Crescent. Campaigns have been structured following principles of hygiene education, delivering educational activities in a prescriptive and formal way, for example by standing in front of a group of beneficiaries and explaining the Disease Transmission chart (F chart) with a poster. Weak consideration has been showed on how to engage those groups in activities that generate some level or action. Using the same example, groups of women can discuss

the F chart and agree on which barriers can be placed to break the transmission routes in the F chart and helping them to put in practice their ideas.



Key components of Hygiene Promotion are:

Community participation	Consult with the affected men, women, and children on the design of the facilities, the hygiene kits and the outreach system, identifying the vulnerable and working with existing community structures
Use and maintenance of facilities	Feedback to/from the engineers or community on design and acceptability of facilities. It will encourage community ownership and taking the responsibility of cleaning and maintenance of facilities
Selection and distribution of hygiene items	Working with the community on the type of hygiene items needed
Community and individual action	Using principles of behaviour change communication, training community based volunteers as Hygiene Promoters, organising community activities such as dramas, and engaging individuals with home visits
Communication with WASH stakeholders	Collaborate with Government, other organisations (both international and national) working in the area, participate in coordination mechanisms, such as the WASH cluster
Monitoring	The use and the community's satisfaction to the programme and facilities

For more information on these points refer to the **WASH Cluster Hygiene Promotion briefing paper**. All RC WASH programmes should include all these components.

Principles and Standards

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

- ↘ The Red Cross Fundamental Principles
- ↘ The Red Cross Movement Code of Conduct
- ↘ The Standards in the Sphere handbook
- ↘ Community Engagement and Accountability (CEA)

Sphere handbook

The main aim of Sphere handbook¹ is to improve the quality of the humanitarian response in situations of disaster and conflict, and to enhance the accountability of the humanitarian system to disaster-affected people.

There are two standards for Hygiene Promotion in the Sphere handbook (2011)², which should be used with the key actions and indicators.

Sphere Standard 1: Hygiene promotion implementation

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

Sphere Standard 2: Identification and use of hygiene items

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

As the Sphere handbook states Hygiene Promotion gives the affected community an opportunity to get involved, ensuring that

¹ ICRC, IFRC (2008) Guidelines for assessments in emergencies.

² Sphere 2018 will be launch in the beginning of 2018

the facilities are appropriate to the risks and the needs and are therefore used appropriately.

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

Common Pitfalls in Hygiene Promotion

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

Too much focus on

- Dissemination of one-way messages without listening to different groups in the population
- Designing promotional materials such as posters and leaflets before understanding the problem properly
- Personal hygiene and not enough on the use, operation and maintenance of facilities.

Not enough focus on

- Practical action that people can take and how to communicate
- How to address many behaviours and audiences at the same time
- Using motivators such as nurture, disgust and affiliation and the belief that the promise of better health is the key motivator
- Listening, discussions and dialogues for people to clarify issues and work out how to adapt required changes to their specific situation.

Community mobilisation is especially appropriate during disasters as the emphasis must be on encouraging people to take action to protect their health. Promotion activities should include,

where possible, interactive methods rather than focusing exclusively on the mass dissemination of messages (**Sphere handbook, 2011**). If the methods are interactive with all the community (men, women, children, marginalised groups), with the opportunity to share information, discuss and ask questions, there will be more in-depth knowledge about what influences what people think and do.

Accountability

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

The **WASH cluster Accountability Project** developed some simple tools to help WASH fieldworkers understand the practical aspects of accountability. Accountability is described as having five dimensions: participation, transparency, feedback mechanisms and complaints, staff competencies and attitudes and monitoring and evaluation.

It is strongly encouraged for hygiene promoters to read the booklet as this suggests key activities for both the first acute phase and the second phase/chronic emergency. The Accountability Booklet elaborates on all of the dimensions of accountability. The key aspects of accountability to beneficiaries includes explaining and taking responsibility on what you do and do not do, providing accessible timely information, ensuring mechanisms are set up for feedback and complaints and enabling the affected people to make decisions on the WASH interventions.

The Core Humanitarian Standard (CHS) on Quality and Accountability sets out nine Commitments that the Red Cross can use to improve the quality and accountability to communities and people affected by crisis; the CHS places communities and people

affected by crisis at the centre of the humanitarian action and promotes respect for their fundamental human rights. It links to the Red Cross Fundamental Principles of humanity, impartiality, independence and neutrality. The CHS will be soon incorporated in the Sphere handbook 2018.



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

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

How to implement Hygiene Promotion in emergencies?

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

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

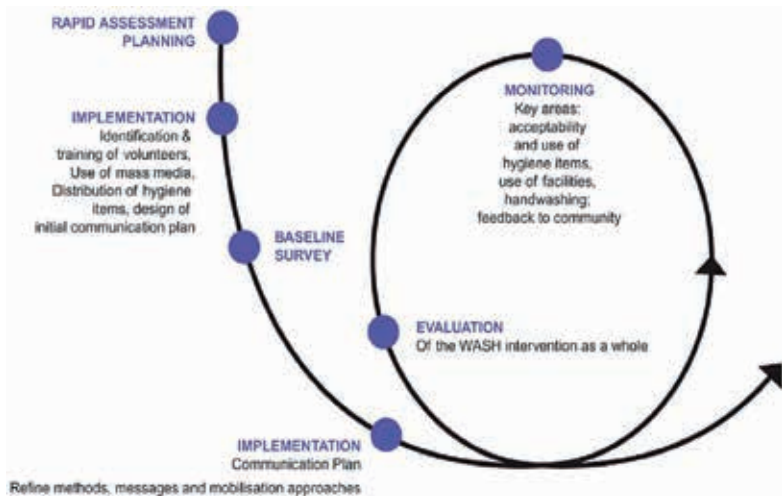


Figure 2: Hygiene promotion project cycle (Source: WASH Cluster, Hygiene Promotion – A Briefing Paper)

8 Steps for Hygiene Promotion in Emergencies

A step by step process has been chosen to facilitate the implementation of hygiene promotion activities in emergency response operations. The teams of hygiene promoters, either grass root volunteers or/with RCRC staff will follow an eight-step process. Volunteers and staff can follow an easy and structured path for delivering basic hygiene promotion activities and managers and / or volunteers' supervisors and team leaders can better support and mentor their team by knowing which steps have been accomplished.

In summary, there are the 8 steps for hygiene promotion in emergencies for the RCRC. These steps have some additional steps to the project cycle on Figure 2. It is to make the process more related to the RCRC disaster response style and to ensure accountability to beneficiaries is achieved by having a participatory approach.

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

These steps are described in more detail below, with links to approaches and tools. By completing the 8 steps hygiene promoters in the Red Cross will be able to deliver hygiene promotion activities in a more structured and systematic way. At the end of step

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5 (planning), the hygiene promotion team will have a systematic behaviour change plan to implement. Campaigns will have clear behaviour change objectives and promotional tools will be selected according to the target group.

Depending on the context at the onset of the emergency, completing **Step 1 to 5 may take from 7-10 days**, using the information available pre-disaster, the data generated through rapid assessment and some specific information for consultation with NS, community and key stakeholders. **From week 2 of the emergency response a first round of implementation (Step 6) and M&E (Step 7) need to be executed to cope with major risks and needs. Step 8 is certainly important in month 1 when the situation might be becoming more stable so re-adjusting becomes crucial.** At this stage, it is important for hygiene promoters to understand the need to come back to step 1 with more comprehensive assessment (step 1-3) or ideally a baseline survey, followed by proper planning process (step 4-5). These timings are all provisional and provided for guidance only.



STEP 1
IDENTIFYING
THE PROBLEM



Step 1: Identifying the Problem



The aim of the assessment is to understand the situation in order to identify the problem(s), the source of the problem(s) and consequences of the problem(s), the needs and capacities of the affected population. “Whilst good information does not guarantee a good programme, poor information almost certainly guarantees a bad one.”¹

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

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

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



What Information?

A rapid assessment should provide information about:

- Public Health situation
- Community structure

¹ ICRC, IFRC (2008) Guidelines for assessments in emergencies.

- It should be as follow:
- Safe drinking Water
- Safe excreta disposal
- hygiene practices & handwashing
- Vector control
- Waste management
- Drainage
- Menstrual Hygiene
- Priority and vulnerable groups

The details of questions on these main areas can be found on the sample **Assessment form**.

How?

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

The assessment should use interactive participatory methods, with all sectors of the community; men, women and children, and different groups of people (and it is important not to leave out marginalized, less visible vulnerable groups, including people with disabilities), to gather information, and engage with the community to identify the problem to help them find a solution. The choice of the methods depends on the context, access, resources and timing. It is useful to use a combination of methods,

including quantitative data (e.g. number of available latrines per population), and qualitative information (e.g. whether all the people are using the latrines are satisfied with the design, location etc.). It is important not to make assumptions: observe and talk with people.

All data should be disaggregated by age and sex. Gender and other social/cultural factors (including age, disability health status, social status, ethnicity, etc.) shape the extent to which people are vulnerable to, and affected by emergencies. Refer to the **IFRC Minimum standard commitments to gender and diversity in emergency programme**, to ensure that commitments to dignity, access, participation and safety of the affected communities are addressed in the assessment, planning, implementation and monitoring of the WASH programmes.



The assessment should consider all sections of the community, not forgetting marginalised, less visible, vulnerable groups.

Primary and Secondary Data

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

Further information on WASH assessment techniques and tools can be found in [here](#).

The WASH assessment techniques that are most used in the Red Cross are direct observation and interviews with local authorities and community members, especially during the first phase of the response. Other tools, frequently used after the onset of the response, like three pile sorting, mapping, voting chart, survey, etc. should be used as soon as possible as they foster community engagement and prompt community member to agree on joint action. Some tools could be combined with the same group of people, e.g. Three-pile sorting with a Focus Group Discussion, depending on the context – people’s time etc. These participatory, interactive methods may not be easy in the early stages of an emergency response, but use these methods as much as possible during the initial assessment, working with the NS and the community.

Secondary data can be collected from various sources such as NS, Government ministries, local authorities, health clinics in the district or community, other agencies working in the communities. It is important to gather secondary data from reliable sources.

Sample Assessment Form provides an outline checklist of information to collect and the type of collection sources: this should be adapted to the context

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

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



Q: What are the challenges of when doing a Rapid assessment.

- A:**
1. It is often difficult, especially in large-scale emergencies to identify the most at-risk and vulnerable groups; coordination and collaboration with other organisations is essential, to ensure there are no gaps and to avoid duplication. Aim to gather information from the most affected areas.
 2. As the initial rapid assessment may target the most vulnerable groups, it is not always possible to generalise this information for all the affected area
 3. The data can quickly become out-dated or irrelevant, particularly in disaster that involves on-going population movement
 4. Rapid assessments may take time to complete, especially in a chaotic environment, so care should be taken not to spend too long on the assessment and delay the implementation to respond to the priority needs

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

A: No, if there are immediate urgent needs, the response should start; e.g. In a response to a cholera outbreak, the population might need urgent help and information on treating drinking water. BUT – a rapid assessment should always be done to make it effective response. For example; in a cholera outbreak it will not be effective to give out posters if the population is illiterate and without proper assessment this information might not be known. And doing some few HP activities in the communities will provide you guidance for future activities on what people accept and like.

Step 1 Identifying the Problem



STEP 2
IDENTIFYING
TARGET GROUPS



Step 2: Identifying Target Groups



The second step in the process of developing the Hygiene Promotion plan, is to identify the target groups. For each of risks or hygiene problems identified in assessment (Step 1), it is important to identify who needs to be prioritised.

Important considerations must be given to the following.

- Identify those who are most at risk. To ensure that all WASH activities reach out to the most vulnerable¹, a gender and diversity analysis should be done for selecting the target groups and participation criteria.
- If working in refugee/camps for displaced people, it may be appropriate to consider the surrounding host population, depending on the context.
- Identify who are the influencers (e.g. community and religious leaders) in the affected community, do a stakeholder analysis.
- Identify the different sections of the affected community, considering their different needs: (including children, older people, people with disabilities, marginalised and hidden groups) and other stakeholders
- Special emphasis on the needs of babies and young children, as they need different WASH facilities
- Ensure that the aspects that affect specific groups such as menstrual hygiene management for women and adolescents is considered.

¹ IFRC, 2015, Minimum standard commitments to gender and diversity in emergency programming, pilot version

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

Work with the engineers when identifying target groups, visit the communities together, the hardware and the software needs to link together.

An important aspect to consider is assessing how different groups in our target population communicate. Knowing their communication habits before the emergency and how they communicate now in the new emergency setting is important for the selection of communication channels later. This should be part of the assessment. Understanding the daily life of the different groups in the new setting, what opportunities they have for interaction and communication, and what channels are more effective may inform the design of the hygiene promotion intervention.



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

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

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

STEP 3
ANALYSING BARRIERS
AND MOTIVATORS
FOR BEHAVIOUR
CHANGE



Step 3: Analysing Barriers and Motivators for Behaviour Change



In Step 1 the key public health risks and the needs were identified. In step 2, those who are most at risk, therefore need to be prioritized in the intervention, have been identified. Step 2 has also helped to understand how they can be engaged in the action and how they communicate.

Step 3 will help hygiene promoters to understand people's behaviour by listening and discussing with all sectors of the community. To understand their behaviours and what motivates these behaviours; these are influenced by the context, their beliefs, values and social pressure. In an emergency, there will be many barriers and constraints.

There are many models that describe the complex issue of behaviour change; but in general, it is widely recognized that hygiene promotion intervention in emergency need to move away from the common assumption that imparting knowledge about germs and disease will change behaviour are needed. It is more complex to change behaviours than simply giving out information; e.g. telling someone to wash their hands and expecting them to do it.

A simple way of approaching behaviour change is first to acknowledge that people living in extreme conditions caused by disaster may have already some level of automated hygiene behaviour often as part of an existing pre-disaster routine. It is important to find these behaviours with the assessment, so proper

physical means can be offered to ensure those behaviours can be sustained by the affected community.

Secondly it is important to examine the barriers and motivators – they are not always what you think!

During the assessment, the team gathers information about the different motivators that can trigger change in the affected population. Although this step is part of the assessment

- **Motivators:** anything that would motivate people to practice correct hygiene behaviours. In the light of emerging developments in psychology, anthropology and marketing science, it has been proved that most of human beings regardless their physical, cultural and social context share some key drives and emotions that are connected to a state that is good for their survival. Those drives have been identified as universal drivers and can be categorised:

Motivator	Tendency	Example
Disgust	Tendency to avoid objects and situations carrying disease risk.	Faeces, urine, bodily fluids and rotten or dead items are universally found to be particularly repulsive. For some, the smell or sight of faeces alone is enough to motivate handwashing.
Status	Tendency to seek to optimize social rank	Being seen to be clean could lead to being admired and respected, being labelled as ‘dirty’ is often thought shameful and to be avoided at all costs.

Affiliation	Tendency to seek to conform to reap the benefits of social living	Being a good member of society by joining in and by doing what everyone else is perceived to be doing is an important motive to practice key hygiene behaviours. This helps ensure membership in the social groups. Conformity with local social norms is known to be a powerful driver of behaviour.
Attraction	Tendency to be attracted to, and want to attract, high-value mates.	In some cultures, cleanliness is a seductive art. Note that cultures that value modesty and purity, this driver cannot be easily discussed.
Nurture	Tendency to want to care for offspring.	Parents, specially mothers, almost always placed children first. Mothers feel a keen responsibility and a duty to ensure the smooth functioning of the family, to keep the child growing well. These feeling could be even more exacerbated during emergency time

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Comfort	Tendency to place one's body in optimal physical, chemical conditions.	People value having a skin that is free from disgusting substances and enjoy the sense of cleanliness directly and as a state of mind: being clean implied inner comfort, freshness, readiness for anything, confidence and purity.
Fear	Tendency to avoid objects and situations carrying risk of injury or death (Specific health fears have been used in the past during emergency response around life-threatening diseases such as cholera and recently about Ebola and others).	For example, reports have suggested that handwashing did increase during epidemics of cholera (Uganda, Senegal, Kenya and Peru). However, people reported that they returned to their usual handwashing habits once this danger had passed.

- ↳ Assessment techniques such as Focus group discussions (FGDs) and in-depth key informant interviews can offer a good insight of what drivers and emotions can be factored in the behaviour change plan, influencing the selection of promotional activities and formulation of hygiene messages.

The same assessment techniques mentioned above should also provide evidence of what stops people taking action by themselves:

- **Barriers:** anything that will hamper people from practicing correct hygiene behaviours; e.g. physical barriers – access to facilities such as soap, water, suitable toilets; social barriers – norms and customs, lack of trust of health workers and health information; biological barriers: mental state. The table below explains different kinds of barriers in detail.

Socio cultural barriers

- In some cultures, hygiene practices, such as handwashing with soap might be avoided due to various local traditions and beliefs; such as soap is not used because it is considered to bring bad luck, reduce life expectancy, weaken the resistance of the body to external illnesses and witchcraft or harm a pregnant / menstruating woman.
- These beliefs are very diverse and specific to local cultures, as one would expect. People in general, however, do not share such beliefs to the interviewers, unless it is prompted, for reasons; they will be labelled as being superstitious, they are accepted without reasons of doubt and they do not find fault in it.
- Some hygiene practices such as handwashing belong to the private, individual sphere therefore not perceived as a social norm.
- Gender relation influence how water is allocated to the different members of the family and when it is scarce specific group like women, children, elderly, etc. may not get an equal share.

**Physical
barriers**

- Physical factors that affected the practice of key hygiene behaviours in emergency included water, soap and toilets.
- Access to enough water is a key constraint in emergency. When services are provided, queueing and intermittent supply might continue to be a problem for some people. A water source specifically for handwashing, needs to be located near the toilet units.
- Soap is often unavailable at the onset of the emergency. When distributed, soap bars can still be difficult to access due to family members keeping it wrapped and held out of reach, to save them from being ‘wasted’ or being dirtied or from being eaten by domestic animals. It is important to note that convenience of use is important, the presence of soap near the latrine and kitchen area drives people to wash their hands more than not having it around or going somewhere else to find soap to wash their hands.
- Access to sufficient number of hygienic toilet in emergency is a great challenge. Public toilets or defecation grounds provided at the beginning of the emergency operation can be distant, difficult to maintain and not the preferred option for vulnerable groups such as women, children and those with less mobility.

Biological barriers

- Often mothers and caretakers are busy during emergency time securing shelter and provision of relief items. Those are more urgent with little time for personal and domestic hygiene.
- At the onset of the emergency, mothers and care takers can be simply tired, exhausted and emotionally drained to focus in non- priority matters that are not easily perceived as life/saving (such as water, food and shelter).

A planning tool such as the table below (Sample table to analyse barriers and motivators) which finds the barriers and motivators for specific target groups and the reasons for the actual behaviour and understandings can be used to understand different behaviours and to analyse it.

Sample tool to analyse barriers and motivators

Target group	Behaviour	Barriers	Motivators	Approaches to reduce barriers	Approaches to increase motivators
Pregnant women	Do not use soap for washing hands and body	Socio-cultural barrier: Belief that soap brings bad luck and causes miscarriage	Nurturing: desire to protect children	Clear mis-conceptions about using soap with help from community leader/health workers.	Community champions – images/films of women perceived as 'good mothers' washing their hands with soap.
		Physical barrier: No soap	Affiliation: Desire to fit in with others and be perceived as a good mother	Distribute soap	Promote the idea that everyone is doing it.

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

Barriers to Behaviour Change

Remember that those factors stopping people to behave safely are not always related to lack of knowledge about the theory of germs or disease transmission paths. More often those barriers are related to socio-cultural factors (in some cultures a woman and her father-in-law cannot share the same toilet), religious (specific siting of facilities) or physical (absence of facilities or no access to them).

Assumptions should not be made that people do not have the knowledge, they may understand differently! It is the task of the hygiene promoter to discuss with the community, and analyse how people think, in conjunction with what they know.

Hygiene Promoters should try to reduce the barriers and build on the motivators



Q: Doing a barrier and motivator analysis in emergency takes time and this might not be a priority by managers, fellow engineers and team leaders. How can hygiene promoters convince others that this is important?

A: The analysis of barriers and motivators for hygiene promotion should be done ideally as part of the general assessment and not a separate exercise. By spending the same resources, hygiene promoters should draw some basic conclusions from the assessment and judge which of those factors are having more likely value than others in promoting safe hygiene behaviour. Hygiene promoters should be encouraged by colleagues and team leaders to take some time for greater assessment and planning, encompassing concepts such as motivators and barriers.

STEP 4
FORMULATING
HYGIENE BEHAVIOUR
OBJECTIVES



Step 4: Formulating Hygiene Behaviour Objectives



The next step in the process is setting the objectives. After identifying the major risks and problems (step 1), prioritising the groups within the target population, understanding who influence them and how they communicate (step 2), hygiene promoters need to work with the community, the engineers and other key stakeholders (e.g. Government) and consider:

- Are there any existing coping mechanisms?
- What capacity does the community have?
- What assistance is being provided by others?
- What are the gaps?

The objectives for the hygiene promotion plan can be related to hygiene behaviour (such as increasing handwashing practice at key times) or an enabling factor (e.g. availability of handwashing facilities with soap) so engineers need to be part of the process. For example, Specific Operation & Maintenance (O&M) objectives should be included in the planning (e.g. engaging the affected population in maintenance of toilets and water systems).

The formulating hygiene behaviour objectives means setting up specific directions of the hygiene promotion activities to focus on the most important things to enable people to change behaviour. Addressing to reduce barriers and to boost motivators for different target groups (from the analysis done on Step 4) by setting objectives and activities to make a pathway to minimize risky health behaviours and to reduce diseases.

It will be good to link these objectives identified with the objectives given on the **IFRC PoA template** and the **WASH activities list**

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for emergencies. The objectives and activities chosen by hygiene promoters may not be the same but it will provide guidance and structure to the hygiene promotion team delivering activities on the ground and to their managers and / supervisors. Sometimes objectives for hygiene promotion in NS Plans, IFRC PoAs or ERU logical frameworks might be general, short and concise but this step advocate for hygiene promoters taking proper time to plan their own objectives and developing comprehensive and detailed plans.



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

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

STEP 5 PLANNING



Step 5: Planning



The next step is finishing the hygiene promotion plan by putting together all elements identified in previous steps: major risks (Step 1), priority target groups (Step 2), motivations / barriers (Step 3) and objectives (Step 4). The Step 5 on planning is about documenting properly the previous steps and creating a work plan that includes all those elements above and linking to specific activities with methods and tools, resources needed (both financial and human) and a monitoring and evaluation plan.

The hygiene promotion plan should not be made in isolation by the hygiene promotion team. This plan is more effective when hygiene promoters work with others; the engineers (who are designing and implementing hardware such as toilets, water and washing facilities), the affected community, local government, other agencies, NS staff, etc. The hygiene behaviour objectives are set from the identified problems for the different target groups with the motivators and barriers. These objectives will be the basis of the planning. The approach and methods must be selected to meet these objectives.

The hygiene promotion team might be very focused in developing their own hygiene promotion plan, but they need to also contribute into other planning processes like:

- a. **Completing the Logframe or Plan of Action of the wider WASH operation, incorporating their own monitoring plan and hygiene promotion plan**
- b. **Preparing and conducting baseline survey**
- c. **Recruitment of the Hygiene Promotion Team**
- d. **Designing the methods, tools and materials**
- e. **Pilot and pre-test the materials and methods**

a. Completing the Logframe, with a monitoring plan

The WASH team together should compile an ‘integrated’ (i.e. hardware and software) logframe (Logical Framework) or Plan of Action (PoA) for the Emergency WASH programme as a tool to guide the programme; including the hygiene promotional activities, the hardware construction activities – i.e. the WASH facilities, and any Non-Food Items (NFIs) needed.

A monitoring plan must be made as part of the planning process. The indicators form the basis of the monitoring and should give a clear idea of what changes are needed and by who. The full list of indicators is given **here**.

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

Example of part of a logframe (from BRC MSM Handbook):

Outcome	Indicators	Means of Verification
Men, women and children in the target population (x no.) have sufficient access to, and make optimal use of, sanitation and hygiene facilities, and take effective action to protect themselves against threats to public health.	<ul style="list-style-type: none"> ↘ Areas within X m radius of all dwelling and water points free from observable excreta by end of Phase 1 ↘ X% of target population using sanitary latrines by end of Phase 1 ↘ X% of latrines are clean on spot inspections ↘ X% of the target population washing hands with soap / alternatives by the end of Phase 1 	<ul style="list-style-type: none"> Exploratory walk reports Focus Group Discussions Information from other organisations Surveys Community monitoring tools

b. The Baseline Survey

Once the target group and programme plan are agreed a baseline survey needs to be done to establish the current situation and to enable programme impacts to be measured. This will be the starting point of monitoring the hygiene promotion activities. The baseline survey will be developed based on the indicators identified during the planning stage. Baseline and end-line survey questionnaires will form the base of the evaluation of the impact of the intervention. The baseline should collect information disaggregated by sex, age and disability – plus ethnicity/caste where relevant.

- **Questionnaire design for household interviews:** The baseline questionnaire is developed based on the indicators. Only include those changes that you are hoping to achieve – each question should be linked directly to an indicator. Use observations (e.g. of water storage, hand washing points or latrines) wherever you can and avoid closed questions (with a yes/no answer). The questionnaire should be short and simple, based on approximately 10-15 questions. Make sure the questionnaire is translated, back translated and checked for accuracy. If possible and applicable to the context, digital mobile survey questionnaires can also be used.
- **Sampling:** A simple random sample is the best approach to use, so every subject in the sampling frame has the same probability of being selected. For all sizes of population, a random sample of around 150 households should be sufficient. If a random sample is not used then the sample size will need to be increased. The simplest approach to sampling is to use a spatially distributed sample with a random start¹. For more information and guidance on sampling, refer to **the IFRC ERU-MSM sampling document**.
- **Survey implementation:** Working with the NS to get access to the community, including informing the community and gaining consent, with permission from authorities/armed groups. Ensure the logistics is organised, and security is considered. Make sure you are not putting the volunteers or target population at risk by involving them in the survey. Questionnaires should be anonymous. Ensure the team is trained in both quantitative and qualitative data gathering and they are involved and understand the process. For household interviews, think about whom you want to question in each household – household head, caregiver or women

¹ Sample every Nth household. $N = \text{Sampling interval} = (\text{No. houses/or tents in total population} / \text{No. houses/or tents which need to be sampled})$. Random start is a random number between 1 and N.

15 – 49 years? Pilot the survey to ensure the questions are clear, appropriate and the sampling method works. Record the methods used, so the end-line survey repeats the same methods. The end-line should be a repetition of the baseline as far as reasonably possible; using the same questions and sampling approach – even repeating the same errors! Document the results and feedback to the team, the users (e.g. WASH team, NS other organisations) and the affected population.

c. Recruitment of the Hygiene Promotion Team

Identifying appropriate Hygiene Promotion staff and volunteers is important for an effective hygiene promotion programme. The existing system of NS volunteers may be adequate, but it is likely to respond to an emergency, the team will need to be expanded, depending on the context.

The structure of the Hygiene Promotion team will depend on the context, such as the size of the emergency, the capacity, the needs, the risks, the presence of ERU teams. One model is:

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

The numbers of staff and volunteers at each level would depend on the context; e.g. if there are high numbers of population with many risks, more volunteers would be needed at community level. But for planning and supervision it is normally recommended to have teams of 7-10 people.

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Some NS have Volunteer Management Policies. Those policies may have a special section for emergency response, but in general they provide guidance about per diem, days per week they are expected to work, type of volunteers, recruitment, retention and motivation.

The issue of remuneration and incentives for staff and volunteers should be agreed before the recruitment and selection of the team and in coordination with IFRC and other RCRC teams operating in the same area. This should be led by the NS, with other key stakeholders, and in coordination with other organisations working in the areas. The volunteer management policy can be useful for setting up a per diem framework for the hygiene promotion interventions.

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

In an emergency response, it can be challenging to get the ideal qualified staff and volunteers from the NS local branches. When selecting staff and volunteers for Hygiene Promotion team. General IFRC guidelines on Volunteer and Youth engagement can be found [here](#).

Ensure that NS volunteers have insurance. In case you need further information please contact insurance.unit@ifrc.org

d. Designing the Hygiene Promotion methods, tools and materials

Selecting the Approach and Methods

It is important to select the most suitable approach and methods for Hygiene Promotion; ensuring they are the most appropriate for the target groups, context and the hardware facilities. The analysis of barriers and motivators in step 3 need to inform selection of promotional approaches / methods and the development of messages and supporting IEC materials.

It is essential that the approach focuses on 'enabling the community', helping them to agree on community actions and facilitating the implementation of the actions; rather than simply 'we are doing hygiene promotion' which often translates into teams of hygiene promoters telling communities what to do, or educating others with standard messages, acting as if they know better; this approach is rarely effective.

Separate consultations with women and other vulnerable groups (people with disabilities and transgenders, etc.) might be needed as they might not be willing to share it in a large group.



Key points for planning methods to promote hygiene

- Ensure the methods for hygiene promotion **respond to the hygiene behaviour objectives (in Step 4)**, the overall aim, and the context, based on the risks identified in the assessment
- Ensure the methods consider **the barriers and the motivators appropriate to the context (Step 3)**, based on the findings of the assessment (Step 1), aim at encouraging healthy behaviours

- Use a **combination of methods** with different type of communication tools that can be used for different purposes (increasing awareness, sharing knowledge, influencing & inspiring others, make decisions, etc.).
- **Focus on the target groups identified in Step 2.**
 - When designing the methods, tools and materials, focus on the target group, involve the community in choosing the most appropriate methods and tools for their situation
 - Consider the public health risks, and chose the methods appropriate for the different target groups. For example, children under five years of age, who are more at risk for diarrheal disease, involve their mothers and caregivers to focus on proper hand washing at key times (e.g. after using a toilet, before feeding a child) but also involve children in interactive activities, (such as games, puppets, clowns, dramas), to promote action such as hand washing. Games such as Snakes and Ladders board game are popular with children (going ‘down the snake’ for problems – e.g. open defecation or ‘up the ladder’ for good behaviour, e.g. knows the key times to wash hands). People follow what they like or they are part of rather than what they hear.

- **Focus on participatory methods**
 - Not all methods for hygiene promotion require the use of ‘hygiene messages’. Participatory techniques, for example three-pile sorting, are focused on creating debate rather than simply passing on a message. The aim is to identify problems and agree on potential solutions that require community action, by working with the community.
- **Choose an appropriate channel for communication**
 - Through a trusted channel; are there particular people (gatekeepers/influencers) or channels which people do and do not trust (this information is gathered in Step 2 when understanding people’s communication habits)– this may be specific to the information/activity
 - Reaching the audience in the planned setting; for example, most households may have radios, but they may be only used by certain family members.
 - Tailored to the target group, e.g. for children in schools – use something that is suitable to them such as puppets or dramas.
 - Culturally appropriate in this context. In some contexts, dancing and singing are acceptable; in others, it is not appropriate.
 - Enjoyable / Participatory: people should enjoy the activity and feel involved, are able to discuss the information, so that it is two-way communication – not simply passing on messages.

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- **Choose an appropriate location**
 - Schools, youth groups for young children
 - Community central areas for group meetings
 - Quiet areas for Focus group discussions
- **Work with the engineers to ensure that the hygiene promotion methods link with the hardware**
 - With the engineers, work with community groups such as WASH committees to strengthen and promote the community engagement (e.g. maintenance of facilities), ownership and sustainability.

There are a wide range of hygiene promotion methodologies which are split here into six groups. Using a combination of these methods in this list will help reach all sectors of a community:

Mass communication through the media (TV, radio, SMS, social media, leaflets, etc.)

Think about who has access to the media used and what groups will be reached. If mobile phone use is common with all the population, it will be easy to pass rapid messages with mobile text, e.g. about cholera. Mass communication may be helpful in the early stages of the response, but there needs to be more emphasis on working with the community as a two-way process. Include some interaction, e.g. 'phone-ins' with questions on radio programmes. Some good examples of using mass media in emergency hygiene promotion are given **here**.

Step 5 Planning

<p>Community activities (e.g. drama/mime, songs, storytelling, films etc., focusing on key hygiene practices such as hand washing. Activities specifically for children, e.g. puppet shows, clowns, games etc.</p>	<p>Teams from the community are trained to put on shows in a small number of communities. Also, short shows with music and songs to be sung together. More ideas can be found here.</p>
<p>Group activities (e.g., visual aids, such as posters and flip charts, F-diagram/diarrhoea transmission, community mapping, three-pile sorting, pocket chart voting, board games; all linked with discussions</p>	<p>Trained hygiene promoters and community mobilisers work with groups of varying types and sizes, depending on the activity and the context. Most of these are taken from the PHAST and CLTS toolkits (see below for information on PHAST and CLTS), but need to be adapted to the emergency context; i.e. the process should be quicker.</p>
<p>Identify and work through community ‘champions’</p>	<p>Families/individuals which are influential in the community and whose positive hygiene behaviours can be taken as examples by other community members. These community ‘champions’ can be used to promote positive behaviours and be involved in promotion activities.</p>
<p>Personal communication: home visits, group discussions</p>	<p>Working with volunteers (e.g. NS volunteers), community mobilisers, community leaders, religious leaders etc.</p>

Nudging	Nudges are environmental cues engaging unconscious decision-making processes to prompt behaviour change. Examples of nudges: (1) connecting latrines to the handwashing station via paved pathways that were painted bright colors; and (2) painting footprints on footpaths guiding users to the handwashing stations and hand-prints on stations (3) mirrors at the hand washing stands
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Existing/current methodologies used by the NS

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

- **CLTS:** Community Led Total Sanitation (CLTS) is an approach widely used by many NSs to eliminate open defecation by triggering shock of the ‘disgust’ in rural communities. It is the government policy of many countries in Asia and Africa and the NSs use it. The initial aim of CLTS of shocking people into action may not be relevant or useful in the aftermath of a disaster. Similarly, negative images and ideas should be used with caution especially if practices were good prior to the disaster and the main barriers are linked to lack of services.

➤ **PHAST:** The Participatory Hygiene and Sanitation Transformation (PHAST) approach aims to improve hygiene behaviours to reduce diarrheal disease and encouraging effective community management of water and sanitation services. The principle of the approach is the participation of communities in their own projects, empowering and engaging them in the decision-making about the services they need and want to improve or maintain. PHAST tools can be adapted for use in the assessment and as participatory group activities during implementation. Community Action Plans could be a useful tool to get a community to work together to take action to improve their situation.

Sharing information with the affected community: DON'T DISSEMINATE – COMMUNICATE!

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

Hygiene messages sometimes are understood as printed materials that contain graphic messages (in writing or picture). The hygiene message is more than a printed material. All hygiene promotional activities are constructed around a central message, even participatory tools like mapping are always undertaken around a theme or message (use latrines, do not defecate in the open). Hygiene messages are in general derived from the need to communicate in brief to a target group.

As printed and visual materials are always part of the hygiene promotion activities in an emergency it is important to understand how messages can be created professionally. In some situations, messages will be provided by the Ministry of Health

and hygiene promoters will have little room for changing those printed messages. However, in those situation, when messages can be shifted and adapted to the context, it is recommended for hygiene promoters to develop a message brief: this helps to develop the concepts, craft the messages, and create materials for the intervention.

Message briefs should be:

Simple: use simple wording and use words commonly used in the local language/dialect so people can understand. Remember what you say can make a difference on how you say it. Do not overload people with too much information at one time. Messages must depend on the context and the circumstances.

Tailored: to both the cultural context and the actual hygiene problems; you need to use messages that beneficiaries will not find offensive or insulting; hygiene issues may be very specific. Information needs to be tailored for each stage of the response and developed in parallel to development of hardware.

Feasible: the messages and the changes you want to trigger need to be feasible. For instance, it would be pointless to encourage beneficiaries to practice hand washing with soap if you find out that there is no soap available.

Accurate and Consistent: Provide people with consistent information. Collaborate and coordinate with other organisations, Health Authorities etc. to ensure there are no potential discrepancies.

Contain a mix of information and emotional motivators: Linking to an emotional motivator can lead to a higher impact than information based messages which people may already be aware of. CLTS has some strong emotional motivators around disgust which can be adapted. Messages should emphasize to point out the benefits of convenience, comfort and privacy.

Participatory: Community members must be involved in structuring the messages to ensure that the messages are intent on the community for enabling acceptance and understanding. This will also help the community to follow and advocate the messages.

e. Pilot and pre-test the materials and methods

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

It is important to pilot and pre-test each activity with small groups from each target group identified in step 2 to check they are clear and understood; this could be done with a small group before using it more widely. Involve a representative group from the target audience in the pre-testing (e.g. radio show, songs, group activity) followed by a group discussion (and/or several semi structured interviews) to help identify the following points:

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

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



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

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

Q: How do I practically pre-test?

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

Q: Do I need to wait until completing Step 1-5 to develop my message brief?

A: It is recommended to cover some of the key essential elements in steps 1-5 to develop a good message brief and create an effective set of IEC materials for the interventions. Even when pre-ready materials from the MoH are available, the HP team should ensure that they meet the message brief table (page 60) : Simple, tailored, feasible, accurate and consistent, contain a mix of information and emotional motivators, participatory.

A man wearing a brown cap and a yellow and black patterned jacket is crouching on the ground, looking towards the camera. He is surrounded by a group of children and adults in a rural, outdoor setting. The ground is dry and dusty. In the bottom left corner, there is a blue plastic bucket. A green circular graphic with a dotted border is overlaid on the top right, containing the text 'STEP 6 IMPLEMENTATION'. A smaller white circular graphic with a blue pattern is also overlaid on the right side.

STEP 6
IMPLEMENTATION



Step 6: Implementation



Completing Step 1 – 5 is the way to ensure there is an effective planning of hygiene promotion activities. But as it is an emergency response, the implementation needs to start quickly, as soon as all the key stakeholders agree the plans. In most of the contexts where RCRC operates there is an enormous pressure to initiate the implementation phase, as some urgent actions are needed at the onset of the emergency. Hygiene promoters may cover quickly some of the key elements in the Step 1-5 and move right away into implementation. Plans however need to be re-visited and implementation re-adjusted. Pre-tests of materials and methods may lead to some adjustments and adaptations, to ensure that they are realistic and appropriate.

Training of the Hygiene Promotion team

Although it is an emergency, and there will be pressure to respond quickly; all staff and volunteers should have some basic training on how to work/volunteer for the Red Cross; this includes knowledge, understanding and how to put into practice the Red Cross Fundamental Principles, Code of Conduct and humanitarian standards.

It is not realistic to start with a long training programme; start with 1 day covering the essential points and build on the skills with additional training sessions (for example plan for 2 hours of training/review per week). Daily or weekly debriefing of volunteers in the field may also be part of training / mentoring. This type of 'learning-on-the-job' approach is often very effective and appreciated by volunteers. The training is contextualised and practical, building on the existing knowledge, skills and experiences and focusing on real needs.

All the staff and volunteers should know the objective of hygiene promotion. In summary:

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

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

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

- ↘ Part 1- overview on how to implement HP in emergencies according to these new guidelines.
- ↘ Part 2- how to train new volunteers and staff on Hygiene Promotion in emergencies.

The WASH Cluster has a set of training materials (with a Visual Aids library) that can be used for training a Hygiene Promotion team adapting to the context as needed. These training materials are available on the **WASH Cluster website**.

Managing the hygiene promotion team

As with all the team, it is important that all the staff and volunteers are well managed – that they are clear of their role and can follow their job description and they are not overloaded with work, it is likely the staff and the volunteers will be affected by the emergency themselves. National Societies have their volunteer management policies where the key rules for engaging volunteers are stated. Note that the policy may have a specific set of rules of emergency time.

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

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

Hygiene Promotion with the Community

The selection of methods is discussed above in Step 5: Planning and they should be outlined in the Hygiene Promotion Plan. Remember to ensure the methods are appropriate to the needs (Step 1), target groups identified in step 2 and the cultural context. They should respond to the objectives fixed in step 4 and reflect the analysis of barriers and motivators from step 3.

Use a combination of methods, with as much focus on interaction as possible, with community engagement, not forgetting the emphasis is to enable to affected community are able to take action to prevent water, sanitation and hygiene related diseases.

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

Using the Hygiene Promotion Box

The Hygiene Promotion box is a box (or set of boxes) with a selection of items that are useful for hygiene promoters to rapidly start hygiene promotion activities immediately after a disaster. The IFRC box contains useful items that may not be instantly easily available including stationary, coloured paper, scissors, paints, a basic laminator, camera, megaphone, sets of pictures for 4 Sets adapted for different regions : Africa, Middle East , Asia and Americas, and a sewing kit for making puppets, a full list is [here](#). Many NS and the MSM ERUs have made their own context specific HP boxes.

Choose an appropriate setting and timing

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

Contracts and Scheduling for mass media

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

Working together with engineers and others

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

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

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

correct height, are children able to reach the tap stands, is there provision for sanitation for children?

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

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

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

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

Access to safe drinking water

Hygiene promoters might also work in collaboration with the engineers for ensuring the population has access to safe water. Depending on the context, if needed – the hygiene team will promote household water treatment at community and household level, supporting the RCRC Engineers in conducting training with

the community of water treatment products; and doing follow up to ensure the community are using any water treatment products correctly and the water is safe for drinking, ensuring it is safely stored at household level, in clean containers.

Access to appropriate hygiene items: Relief distribution

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

Coordination and communication with all key stakeholders

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

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



Q: Why is it important to distribute soap during emergency response?

A: Soap is important because soap helps to remove the clinging pathogens and bacteria sticking in the skin, which cannot be removed water alone. More information on soap and hand hygiene can be found [here](#).

Q: Is it important to include Menstrual Hygiene Management and what is the role of hygiene promoter in this?

A: Yes. It is very important to include menstrual hygiene management (MHM) in the hygiene promotional activities and messages. The role of the hygiene promoter is to discuss with the women in the community, to find out what common practices exist, their preferences and current resources for menstrual hygiene and use that information to influence the design of the family kits (also called dignity kits, menstruation kits, women kits, etc.) by giving feedback to the Relief teams. More information on MHM can be found [here](#).

Q: What if CASH is transferred instead of hygiene items distribution, should hygiene promoter be involved?

A: Cash transfer programming is getting more accepted, and in emergencies Cash (vouchers, coupons or cheques) is distributed instead of hygiene items. The hygiene promoters' work will still be important; it is essential to consult with the communities to understand their needs and preferences and if a cash/voucher system would work for them, ensure the people understand the process and monitor how they make decisions (e.g. buying hygiene items for the family) to reduce their exposure to public health risks in disasters and follow the correct use of items.



STEP 7
MONITORING
AND EVALUATION



Step 7: Monitoring and Evaluation



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

Involve the affected population in the monitoring; not only in the collecting of the information, but also, they should be involved in the analysis to help ensure the programme is appropriate to their needs – they will know best what has happened and why and by including all sectors of the population, it will help empower them to have more control and ownership of the programme. Different people in the community will have different needs and maybe different access to facilities, so it is important to involve all groups of people in the monitoring, e.g. men, women, children, vulnerable groups etc.

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

Methods for monitoring include:

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

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

Monitoring should not only focus on quantitative indicators (such as numbers of latrines), but should also include qualitative indicators (with feedback from the affected population, whether all sectors of the community are using the latrines and are satisfied with them). Listen to people, including the NS volunteers, track and follow up on rumours. Monitoring forms, which can be adapted, are provided in table below. One team member should be responsible for collating, recording and sharing all the monitoring data.

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

WASH guidelines for hygiene promotion in emergency operations

Indicator	Means of verification	Frequency
All sections of the community, including vulnerable groups, are consulted and represented at all stages of the project	FGD	Monthly

It is also useful as part of monitoring, to keep a decision log, documenting how and why decisions about the programme are made; this is important in an emergency context, as there may be rapid turnover of staff, and reasons for decisions may quickly get forgotten.

Evaluation

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

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

Key criteria that are generally used for evaluation humanitarian action are¹:

Relevance/ appropriateness	<ul style="list-style-type: none"> ↘ Is the hygiene promotion programme relevant to the priorities and policies of the key stakeholders – the affected population, the NS, the government? ↘ Are the activities and outputs of the hygiene promotion programme consistent with the overall goal and achieving the objectives
Effectiveness	<ul style="list-style-type: none"> ↘ Have the objectives of the hygiene promotion programme been achieved? ↘ What are the factors influencing the achievement of the objectives?
Efficiency	<ul style="list-style-type: none"> ↘ Efficiency measures the outputs (qualitative and quantitative) in relation to the inputs. ↘ Were the hygiene promotion activities cost-effective? ↘ Were the objectives achieved on time? ↘ Was the programme implemented in the most efficient way compared to alternatives?
Impact	<ul style="list-style-type: none"> ↘ Are there positive and negative changes because of the programme (directly or indirectly; intended or unintended). ↘ What has happened because of the programme? ↘ What real difference has the hygiene promotion programme made to the beneficiaries?

¹ OECD, DAC criteria

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

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

The evaluation should be documented, with a short, clear report and shared with all the stakeholders, and most importantly, it must be used; fed back to the community and referenced when planning future interventions.

Monitoring and evaluation play a critical part in showing progress; but also for learning and improving.



Q: How can I involve the community in monitoring?

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



STEP 8
REVIEW, RE-ADJUST



Step 8: Review, Re-Adjust



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

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

Documentation and Handing over

It is important that if the response includes ERUs, it is done in collaboration with the NS (e.g. in large emergency with RDRT and ERU teams, they should all work with the NS, helping to strengthen their capacity as needed); all the work should be documented and shared with the NS, IFRC and other RDRTs and ERUs working in the disaster response. This will help to avoid duplication of work and the planning of the follow-up work.

The lessons learnt should be documented and shared as part of the handover. The documentation does not have to be reports alone, it can be pictures or short video clips, demonstrating the way the hygiene promotion has been implemented and the lessons learnt.

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Annex
QUICK FIX







IFRC GUIDELINES TO HYGIENE PROMOTION- QUICK FIX

RCRC Definition of Hygiene Promotion in Emergency

Hygiene promotion (HP) in Emergencies in the Red Cross is defined as: ‘a planned, systematic approach delivered by RCRC staff and volunteers; to enable people to take action to prevent water, sanitation and hygiene-related diseases by mobilising and engagement of the affected population, their knowledge and resources; and to maximize the use and benefits of water and sanitation items and facilities’.

HYGIENE PROMOTION IN EMERGENCIES

STEP	INCLUDES	ACTORS	INFORMATION SOURCES
 STEP 1: IDENTIFYING THE PROBLEM	<p>Gathering quantitative and qualitative information to understand; what the community knows, does, and understands, what are their needs, risks, practices and community structures and the impact of the disaster, by using:</p> <ul style="list-style-type: none"> ↳ Existing Secondary data ↳ Mapping ↳ FGD with community group (3 pile sorting and pocket chart activity) ↳ Observations and Transect walks ↳ Interviews local authorities, other agencies, WASH cluster, RCRC staff and volunteers 	<p>WASH hardware engineers, community, other sectors working in the same communities, Government institutions and other NGOs</p>	<p>IFRC Minimum standard commitments to gender and diversity in emergency programme</p> <p>IFRC Guidelines for Emergency Assessment in English, French, Spanish, Arabic</p> <p>Sphere Project Water and Sanitation Initial Need Assessment Checklist</p> <p>Transect Walk</p> <p>Working with communities: a Toolbox</p>
 STEP 2: IDENTIFYING TARGET GROUPS	<p>Identify the target groups together with the community. The target groups must include: who is most at risk, the influencers in the community, all sections of community (children, older people and people with disabilities) and special emphasis groups (e.g.: babies/young children) with different requirements.</p>	<p>Community leaders and Health workers, WASH Hardware people, other agencies working in the area</p>	<p>Target group selection</p> <p>Gender checklist for WASH cluster accountability</p>

STEP	INCLUDES	ACTORS	INFORMATION SOURCES
 STEP 3: ANALYSING BARRIERS AND MOTIVATORS FOR BEHAVIOUR CHANGE	<p>Gathering information on different motivators and barriers to trigger behavior change and eliminate/reduce barriers.</p> <p>And assessing any reactions, triggers and cultural compatibility and making changes according to the observations and feedbacks.</p>	<p>WASH hardware people, beneficiaries, Health department staff, Government and other NGOs</p>	<p>Transmission route</p> <p>Good and Bad behaviors</p>
 STEP 4: FORMULATING HYGIENE BEHAVIOUR CHANGE OBJECTIVES	<p>Setting objectives for each of the risks identified which can be related to hygiene behavior change or enabling factors.</p>	<p>Community leaders and Health workers, Trained HP staff and volunteers, Community group selected for pre-testing.</p>	<p>IFRC PoA Template – Indicators</p> <p>Outcomes, Output and Activities View</p>
 STEP 5: PLANNING	<p>Working with hardware engineers and others to make a work plan from the identified objectives and choosing output and indicators using a snapshot (survey and other methods) of the situation. And it also includes:</p> <p>Choosing a method or approach and communication channels to target different groups</p> <p>Preparing materials for HP activities (make use of the HP Box)</p> <p>Choosing volunteers for HP interventions</p> <p>Pilot and Pre-test the methods and activities by trying out it on a small group of people</p> <p>Make changes and start implementation</p> <p>Preparing monitoring and reporting plan for the activities</p> <p>Schedule and conduct the hygiene promotion activities</p>	<p>Trained HP staff and volunteers, Community focal points and hardware engineers</p>	<p>Volunteer Management Toolkit</p> <p>PHAST</p> <p>CLTS</p> <p>Sampling</p>
 STEP 6: IMPLEMENTATION	<p>Following the plan and implementing the activities. The key activities are:</p> <p>Working with hardware engineers and others to establish the needed behavior change communication which goes along with the WASH facilities</p> <p>Recruiting and Training the volunteers and staff</p> <p>Working together with Relief Teams to give feedback from/ to communities on distribution of HP items</p>	<p>Trained HP staff and volunteers, Community focal points</p>	<p>Watson & Health NFI Guidelines</p> <p>WASH & Health NFI Guidelines</p> <p>IFRC Guidelines to Hygiene Promotion in Emergencies Trainer's Manual</p> <p>WASH Cluster Training Material</p> <p>IEC Materials</p>
 STEP 7: MONITORING AND EVALUATION	<p>Use the HP monitoring forms prepared on Step 5</p> <p>Collect data again after 3 months compare with the initial baseline data from Step 1 and evaluate.</p> <p>Make changes to HP work plan to address the hygiene behavior objectives of the new scenario</p>	<p>Trained HP staff and volunteers, Community focal points</p>	<p>Monitoring and Evaluation</p>
 STEP 8: REVIEW, RE-ADJUST	<p>Follow the changes to the situation and re-plan and re-adjust to address the current problems.</p>	<p>Trained HP staff and volunteers, Community focal points and hardware engineers</p>	

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

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

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

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

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

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

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

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

For more information on this IFRC publication,
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