WASH **Hygiene Promotion**

# *Training for Hygiene Promoters and HP Coordinators*

Part 2 of 3

# Useful To Know Training for Hygiene Promoters

Introduction to Hygiene Promotion
Training for Community Mobilizers
Training for Hygiene Promoters and HP Coordinators
- Part 1 Essential To Know
- Part 2 Useful To Know
- Part 3 Additional Training for HP Coordinators

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

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

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Global WASH Cluster, UNICEF New York, 3 UN Plaza, New York, NY 10017, USA web: www.humanitarianreform.org/WASH

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The interpretations and commentaries expressed in this training do not necessarily reflect positions of all the Global WASH Cluster members.

Please inform washcluster@unicef.org and copy washhygienepromotion@googlemail.com

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# WASH Cluster Hygiene Promotion Resources

## *HP Training and Resources CD*

### 1. Introduction to HP Tools and Approaches

- Briefing paper on the essentials of Hygiene Promotion,
- Indicators for Hygiene Promotion
- Advice on Hygiene Promotion-related Non Food Items selection and delivery
- Example Job Descriptions for Hygiene Promotion Coordinators, Hygiene Promoters and Community Mobilisers
- Equipment lists for Hygiene Promotion Communication
- Annotated Bibliography of resources for Hygiene Promotion
- Terminology and definitions

A 4-hour training package aimed at providing a general overview of hygiene promotion

- Session plans
- Handouts
- Facilitators resources
- PowerPoint

English, French & Spanish

### 2. Training for Community Mobilisers

- Training sessions for community members in hygiene promotion. This training is aimed at community members who may have limited literacy skills and relies mainly on interactive exercises using picture sets, role-plays and demonstrations etc. It does not include handouts or power-point slides.

English, French & Spanish

### 3. Training for Hygiene Promoters

Part 1: Essential To Know Training for Hygiene Promoters

- Session Plans
- Handouts
- PowerPoint

Part 2: Useful To Know Training for Hygiene Promoters

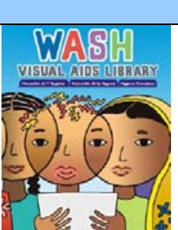
- Session Plans
- Handouts
- PowerPoint

Part 3: Additional Training for Hygiene Promotion Coordinators

- Session Plans
- Handouts
- PowerPoint

English, French & Spanish

## *Visual Aids Library DVD*




Drawings, picture sets, photos and promotional resources (videos, radio spots, flip charts, leaflets and posters) for use in hygiene promotion programmes. Includes instructions for games and interactive picture sets.

English, French & Spanish

# Where to find information

| On: | Where to find |
|---|---|
| Accountability | Orientation Pack in Introduction CD<br>Part 1 Participation & accountability<br>Part 3 Managing accountability |
| Assessment | Part 1 Assessment and baseline<br>Part 1 Focus group discussions<br>Part 1 Participatory methods<br>Part 1 Introduction to baseline<br>Part 1 Questionnaire survey<br>Part 3 Designing and managing an assessment<br>Part 3 Data analysis and reporting |
| Avian flu/pandemics | Orientation Pack: facilitators resources |
| Cholera | Part 2: Cholera control issues |
| Gender | Orientation Pack: facilitator's resources<br>Part 2 Introduction to gender<br>Part 2 Introduction to protection |
| HIV/Aids | Orientation Pack: facilitator's resources<br>Part 2 Introduction to HIV/AIDS |
| Hygiene kits | Briefing paper in Introduction CD<br>Part 1 Hygiene Kits Selection and distribution |
| Malaria | Part 2 Malaria control issues |
| Monitoring & Evaluation | Part 1 Hygiene Kits: Selection and Distribution<br>Part 2 Monitoring<br>Part 3 Impact & Evaluation<br>Part 3 Logical Framework<br>Part 3 Monitoring for Managers |
| PHAST | Orientation Pack: facilitator's resources<br>Part 1 Participation & accountability<br>Part 1 Participatory methods |
| Protection | Orientation Pack: facilitator's resources<br>Part 2 Introduction to protection |
| Sphere | Introduction orientation facilitators resources<br>Part 2 Introduction to Sphere |
| Sustainability | Part 1 Community involvement in design of facilities<br>Part 2 Community participation<br>Part 2 Community management of facilities |
| WASH Cluster | Part 1 WASH Cluster and coordination<br>Part 3 Coordination responsibilities<br>Part 3 Developing partnerships |

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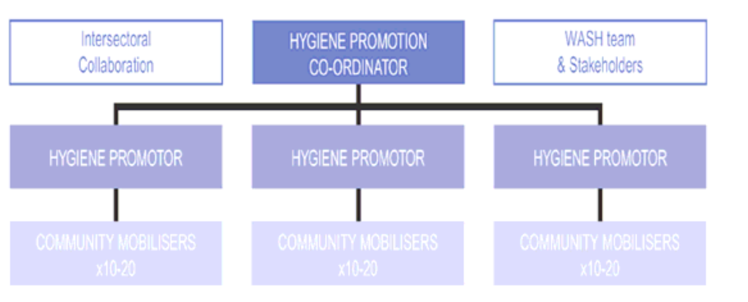
# Introduction

Water, sanitation and hygiene related diseases cause significant deaths and sickness in emergencies. Even without the disruption of an emergency, diarrhoea is the second biggest killer of children under five after acute respiratory tract infections. In emergency situations, epidemics of diarrhoeal diseases can also cause a high death toll in the adult population. In order to have an impact on health, it is critical that interventions address not only the provision of the hardware such as water pumps and toilets but also ensure that these facilities are used effectively. Hygiene promotion aims to ensure that facilities are used and that men, women and children take action to mitigate water and sanitation related disease. In working closely with communities, hygiene promotion at its best can help promote participation and accountability.

The training courses have been developed to target hygiene promotion co-ordinators, hygiene promoters and community mobilisers as detailed in the organisational structure below. Engineers and technicians working on a WASH programme may also find many of the sessions useful and relevant to their work and may also be responsible for co-ordinating hygiene promotion.




This training course comprises the key aims and objectives, session plans and handouts for training **Hygiene Promoters and Hygiene Promotion Co-ordinators** and is organised into parts covering three key areas: sessions that provide information on the background **Context**, sessions aimed to develop **Hygiene Promotion Skills** and sessions focused on ensuring that trainees know the specific tasks and responsibilities of their job, **Role of the Hygiene Promoter or Job Specifics**.

This training course comprises 3 Parts relating to the training of hygiene promoters. **Part 1: Essential To Know Training for Hygiene Promoters** contains sessions that are high priority and need to be covered in the early stages of an emergency. **Part2: Useful To Know Training for Hygiene Promoters** contains sessions that are important but that can be covered later in the training programme and some sessions that may be relevant for some agencies and in some situations and can be included as needed.

**Part 3** includes additional training that is aimed specifically at **those co-ordinating, managing and training field hygiene promoters** (including those who may not have a background in hygiene promotion) as they will need to have an overview of the situation and more developed skills in human resource management, data collection and analysis and monitoring.

The materials for training are based on the requirements of the **WASH Hygiene Promoter Job Description** and the **WASH Hygiene Promotion Coordinator Job Description** but these sessions can be adapted as the trainer or facilitator sees fit or as the situation demands. It is intended that anyone using this training package will decide

for themselves how to structure the course based on what needs to be covered and the degree of urgency of the situation and ideally, the facilitator will be an experienced trainer.

Example job descriptions for a hygiene promoter and a hygiene promotion co-ordinator can be found in **Appendices**. It should be remembered that group training sessions or workshops provide only one means of training hygiene promoters and supervision, mentoring, coaching and self-study are also useful ways to help develop hygiene promotion capacity.

# Training Course Objectives

To enable field practitioners to rapidly carry out effective hygiene promotion in an emergency in order to:

- Promote safe WASH practices, including the appropriate use and maintenance of WASH facilities and services
- Ensure appropriate community involvement in the design and delivery of essential WASH services and facilities.
- Ensure that the hardware and software aspects of a WASH response are integrated and work together to achieve a common goal

# Before you run your training:

- Think what you want people to do after the training and design your training accordingly

- Read the objectives and facilitators' notes and use these as a starting point to guide your session plan

- Try not to use the PowerPoint as a crutch - they are additional visual aids to support your training – you should be able to train without them if necessary

- Ask questions and stimulate interaction from the group you are training

- Adapt the pictures and examples to match the context you are in

- More time may be needed for some sessions depending on the size and experience of the group

- Plan the session with your co-facilitators before you start to check compatibility of style. Be clear about divisions of content and the linkages between sessions.

# Using the training material as a resource for learning about hygiene promotion

| If you are: | Part 1: Essential To Know<br>Training for Hygiene Promoters | Part 2: Useful To Know<br>Training for Hygiene Promoters | Part 3: Additional Training for<br>Hygiene Promotion Coordinators |
|---|---|---|---|
| **A hygiene promotion trainer wishing to design a first phase training for field hygiene promoters** | 4 day training – can be run concurrently or in half or one day blocks.<br>Covers basics of HP in emergencies | Additional sessions that can be run as time allows and as required.<br>Optional sessions on:<br>Baseline and questionnaire survey<br>Malaria<br>Cholera<br>ORT | |
| **A hygiene promoter wishing to consolidate your knowledge about HP in emergencies and responsible for training community volunteers or mobilisers** | All sessions will be relevant. You may only need to read through them and note the objectives and key learning points. | All sessions will be relevant. You may only need to read through them and note the objectives and key learning points. | |
| **An engineer or technician wishing to know more about hygiene promotion so you can ensure an holistic approach to WASH programmes** | Overview of basics of HP in emergencies | Optional<br>Of interest may be:<br>Behaviour change versus social change<br>Other promotional methods<br>Community management of facilities | |
| **A hygiene promoter who will be managing the HP response and other field hygiene promoters** | All sessions will be relevant. You may only need to read through them and note the objectives and key learning points. | All sessions will be relevant. You may only need to read through them and note the objectives and key learning points. | Optional sessions on how to manage response & field hygiene promoters |
| **An experienced engineer who is responsible for co-ordinating a hygiene promotion response as part of a WASH project or programme and managing other hygiene promoters** | All sessions relevant particularly:<br>WASH Cluster and coordination<br>Public health in emergencies<br>Hygiene promotion in emergencies<br>Assessment and baseline<br>Hygiene kits: selection and distribution<br>Monitoring | Optional<br>Of interest may be:<br>Behaviour change versus social change<br>Other promotional methods<br>Community management of facilities | HP human resource issues<br>Promoting Integration<br>Co-ordination responsibilities<br>Designing and managing an assessment<br>Data collection & analysis<br>Monitoring<br>Accountability |
| **A generalist programme manager responsible for a WASH agency programme or project and responsible for overall management of response** | Provides overview of basics particularly:<br>WASH Cluster and coordination<br>Public health in emergencies<br>Hygiene promotion in emergencies<br>Assessment and baseline<br>Hygiene kits: selection and distribution<br>Monitoring | Optional<br>Of interest may be:<br>Behaviour change versus social change<br>Other promotional methods<br>Community management of facilities | Overview and project cycle<br>HP human resource issues<br>Promoting Integration<br>Co-ordination responsibilities<br>Designing and managing an assessment<br>Data collection & analysis<br>Monitoring<br>Accountability |
| **A specialist hygiene promoter who has not worked in emergencies** | All sessions will be relevant. | All sessions will be relevant. You may only need to read through them and note the objectives and key learning points | Overview and project cycle<br>Development versus emergency<br>HP human resource issues<br>Co-ordination responsibilities<br>Designing and managing an assessment<br>Data collection & analysis<br>Monitoring<br>Accountability |
| **A WASH Cluster Coordinator who needs to ensure that HP is carried out by all agencies as an integral part of the response.** | Adapt following sessions:<br>Hygiene kits<br>Selection and support of community mobilisers | Of interest may be:<br>Behaviour change versus social change<br>Other promotion methods | Overview and project cycle<br>HP human resource issues II<br>Promoting Integration<br>Messages versus dialogue |

Useful To Know
Training for Hygiene Promotion

# Hot Topics

Below is a list of subject areas and where you can find out more about hygiene promotion 'hot topics':

| HP hot topics | Part 1: Essential To Know Training for Hygiene Promoters | Part 2: Useful To Know Training for Hygiene Promoters | Part 3: Additional Training for Hygiene Promotion Coordinators |
|---|---|---|---|
| Assessment methods, data collection, data analysis | Assessment and Baseline<br>Focus Group discussions<br>Participatory Methods | Introduction to baseline survey<br>Questionnaire Survey | Designing & Managing an Assessment<br>Data Analysis & Reporting |
| Public Health & Hygiene Promotion | Public health in Emergencies<br>Hygiene Promotion in Emergencies<br>Key water and sanitation priorities<br>Key actions to prevent diarrhoea | Water & Sanitation Related Diseases<br>Behaviour change and Social Change<br>Introduction to HIV/AIDS<br>Use of Oral Rehydration Therapy<br>Cholera Control Issues<br>Malaria Control Issues | Evidence Base<br>Overview of HP Intervention<br>HP Communication Strategy |
| HP communication methods and approaches | Participatory Methods<br>Communication Skills I and II<br>Working with children<br>Carrying out a campaign | Behaviour change & Social Change<br>Other promotional methods<br>Using Visual Aids<br>Understanding different perspectives | Overview of HP Intervention<br>HP Communication Strategy |
| Human resource issues/staffing requirements | Job description<br>Selection and Support of Community Mobilisers<br>Adult Learning<br>Planning training & training practice | | Job description<br>Recruitment & Managing Others |
| Key indicators, monitoring and evaluation | Hygiene Kits: Selection and Distribution<br>Monitoring | | Impact & Evaluation<br>Logical Framework<br>Monitoring for Managers |
| Coordination, collaboration and integration | WASH Cluster & Coordination | | Development versus Emergency<br>Promoting Integration<br>Developing Partnerships<br>Coordination Responsibilities<br>Managing Meetings |
| Hygiene kits | Hygiene Kits: Selection and Distribution | | Logistics and Financial Systems |
| Participation and accountability | Participation and Accountability<br>Participatory Methods<br>Community Involvement in Design of Facilities<br>Communication Skills I and II | Introduction to Sphere<br>Introduction to Gender<br>Community Participation<br>Understanding different perspectives<br>Introduction to Protection | Managing Accountability<br>Monitoring for Managers<br>Advocacy |
| Community management | Community Involvement in Design of Facilities | Community Participation<br>Community Management of Facilities | Development versus Emergency |

# Trainers Notes

**Structure**

The sessions are divided into three parts but the content of the actual training must be defined by the needs of the situation and agency priorities and guidelines. This means that some of the sessions in Part 2 such as promoting the use of insecticide treated nets or ORS would become 'essential training' sessions and some 'essential' sessions may not always be relevant. It is the responsibility of the trainer to make the link between sessions and to ensure it provides a relevant and coherent training experience.

| Part 1 | Part 2 | Part 3 |
|---|---|---|
| ESSENTIAL TO KNOW TRAINING FOR HYGIENE PROMOTERS | USEFUL TO KNOW TRAINING FOR HYGIENE PROMOTERS | TRAINING FOR HYGIENE PROMOTION COORDINATORS |

For **Part 1 and 2** the sessions have also been structured around **3 Key Knowledge and Skill Areas: context, skills and job specifics. Review & Evaluation** of these areas is also a vital part of the training as shown below.

| Training Sessions | Context | Hygiene Promotion Skills | Hygiene Promotion Job specifics | Review & Evaluation |
|---|---|---|---|---|
| Content | Learning about the current context, background information and hygiene risks | Learning about the skills, methods and approaches used in HP work. | Learning about the specific job participants are expected to do and practice using the skills | Reviewing course and session objectives. Monitoring work and evaluating learning |

Unlike Parts 1 and 2 the sessions in Part 3 have been grouped into 4 categories that relate to the generic job description for a hygiene promotion coordinator:

- **Programme Approach**,
- **Information Management**,
- **Implementation**
- **Resources Management**.

The actual structure of the course and the sessions chosen can be defined according to the needs of a particular emergency context and it is not possible to provide a 'one size fits all' training package that will cover all of the different contexts and training needs of a wide variety of participants.

**Adapting the training**
The training course should be based on the hygiene promoter's **Job Description** that details the requirements of their particular job. In adapting the training course it may be helpful to ask the following questions:

- What do you want the participants to be able to do?
- Are you training people at the beginning of an acute emergency or in a more stable setting?
- How much time do you have available for training?
- Will you be able to conduct follow on training?
- Will the participants be required to work long term or short term?
- What balance is required between classroom-based learning and on the job learning?
- What arrangements are there for supervision, mentoring and support after the training?
- What is the level of experience of the participants and what do they know already?

It is important that, where possible, the training draws on examples from the existing situation and allows participants time to practice new skills in the field. Where the training is undertaken in other circumstances, it is important to work through the questions above and either organise fieldwork experience or make use of a specific case study. It should be remembered that the participants will usually be working and undertaking the training at the same time and it should therefore be possible to ensure **follow up** and **supervised practice** in the field after the training.

**Length of Course**
**Essential To Know Training for Hygiene Promoters** could be covered in **4 – 5 days** and it is advisable that most of these sessions are covered as early as possible into the emergency. The newly recruited Hygiene Promoters should then be supported and mentored as they carry out their work. However, the training does not have to be carried out on successive days nor in the session order suggested but can be structured according to the demands of the specific context and the judgement of the trainer.

Training sessions can be run for a few hours each day, for one day a week or in blocks of two to three days. If possible all the subjects should be covered within a period of six to eight weeks. The example timetable will need to be adapted for each specific situation. To run all the sessions in **Essential To Know Training** and **Useful To Know Training for Hygiene Promoters** would take **approximately 12 days** including fieldwork.

In Part 2 Useful to Know Training there are suggested sessions for orientating fieldworkers who would be carrying out a questionnaire survey. This only provides a summary of issues to cover rather than detailed session plans as the process of doing a baseline survey is not standardised will vary according to different agency protocols. Training staff to carry out a **questionnaire survey will usually take 2-3 days** and the trainees should be supervised and supported during the survey.

**Number of participants and facilitators**
The ideal number of participants for the training is between 12-20 people. A larger group will be difficult to manage and will increase the timing required for sessions. With

larger groups there may also be a greater temptation to feed participants with information rather than to facilitate discussion.

In an acute emergency it may be difficult to identify more than one facilitator in each agency to run the training. However, running a three-day course on consecutive days with only one facilitator can be exhausting and it is suggested that there are at least two facilitators. Agencies might be interested in organising joint training courses for their staff.

**Timing of sessions**
Given the task of trying to devise a training package for use during an acute emergency, it has been difficult to afford each training topic the length of time it probably deserves whilst ensuring a training that is rapid and covers all of the issues that newly recruited staff will need to know. A rough time check is given periodically in the session plans but this may need to be adapted according to the participants' needs and context specific issues.

**Visual Aids and Picture Sets**
Example picture sets for various participatory exercises e.g. three-pile sorting and the chain of contamination are available on the WASH Visual Aids Library DVD. These may need to be adapted to the specific context but will provide the basis for initial training activities and discussions whilst preparations are made to develop context specific resources.

**PowerPoint Slides**
Power point slides accompany the Training for Field Hygiene Promoters but it is not intended that the training be based around a power point presentation for each session. Beware of 'Death by PowerPoint' and turning each session into a lecture. The main purpose of the power point slides is to provide visual information that can equally be used as a handout or copied onto flip chart paper. Where possible the photographs should be replaced by photographs from the actual situation. Most of the power point slides have brief notes to accompany them (see notes view). If you do use PowerPoint presentations, make sure you are open to and also ask questions rather than lecture participants.

**Handouts**
The handouts are optional. These provide some additional information for participants but will not always be pertinent to the specific situation and may need to be adapted or interpreted in general terms. An **example evaluation form** and **an example certificate**, for participants who complete the course, are also provided in the handouts section.

**Preparation Time**
The often cited time for preparation is equal to the teaching time so for a seven day course one facilitator would need seven days preparation time. However, this can often take longer, especially if the material is unfamiliar. The logistical arrangements such as organising the venue, food, photocopying etc. will also need to be scheduled into preparation time.

**Course Trainers/Facilitators**
The course is designed for experienced hygiene or health promoters who have practical experience of working in emergencies and a good knowledge of adult learning and

facilitation techniques. An assumption is made that the people using this training material will know how to structure and time a training session according to the learners needs. Some sessions such as Protection and Gender may be facilitated better by specialists in these areas either from your own agency or from outside agencies.

### Background of Participants

The course is designed for people who have minimal experience of hygiene promotion but who do have skills in communication and working with communities. It is expected that participants will be literate and will be able to undertake a certain amount of self directed study such as reading and applying the information in the written handouts. Where possible participants should have access to some of the background materials listed in the session outlines so that they can develop their learning further. Access to the background materials is not essential and the handouts should provide enough written material to support the learning from the sessions.

### Theory into practice

The training is designed for use in the early stages of a large-scale emergency. This would involve running training at the same time as the implementation of the project and participants would apply their knowledge to the concrete situation as they went along. However, if the training is scheduled as a preparedness measure then additional practical fieldwork should be built into the timetable and an appropriate case study selected.

### Feedback

On the last page of each part of training sessions there is space to record additional information about the training sessions and suggestions for future improvement. Please send any comments to washhygienepromotion@googlemail.com

# Course Overview

| Part 1: Essential To Know Training for Hygiene Promoters | | | | |
|---|---|---|---|---|
| Context | Session | Content | Timing | Part 1 Page |
| | WASH cluster and co-ordination | Rationale of the WASH cluster and importance of co-ordination | 45 minutes | 26 |
| | Public health in emergencies | Importance of other sectors for impact on health | 45 minutes | 28 |
| | Hygiene promotion in emergencies | Overview of HP and key responsibilities | 90 minutes | 30 |
| | Key water and sanitation priorities | Overview of WASH response and priority focus of Hygiene Promotion | 60 minutes | 32 |
| | Key actions to prevent diarrhoea | F diagram and key ways to block transmission routes in specific context | 60 minutes | 34 |
| | Participation & accountability | Relevance to work of HP and practical responsibilities of hygiene promoter | 60 minutes | 36 |
| Skills | Communication skills | Overview of factors necessary for good communication | 60 minutes | 38 |
| | Communication skills II | Further exercises to improve communication skills | 60 minutes – 2 hours 30 minutes | 40 |
| | Participatory methods | Rationale for using participatory methods and practice in common methods: 3 pile sorting, chain of contamination, take 2 children, mapping and pocket chart voting | 3 hours total | 44 |
| | Adult learning | Key principles of adult learning and organising training | 60 minutes | 48 |
| | Focus group discussion | Introduction to best practice and pitfalls<br>Recording data | 2-3 hours (including fieldwork practice) | 51 |
| Job specifics | Job description | Clarifying job description and key tasks | 60 minutes | 52 |
| | Assessment and baseline | Overview of assessment process and key tasks of hygiene promoter | 60 minutes | 54 |
| | Hygiene kits: selection and distribution | Identifying needs through community consultation and monitoring suitability | 60 minutes | 56 |
| | Selection & support of community mobilisers | Mobiliser attributes. Involving the community in selection. Hours of work and remuneration. | 60 minutes | 58 |
| | Community involvement in design of facilities | HP role in promoting participation in design and siting of facilities and in obtaining feedback on acceptability | 60 minutes | 60 |
| | Working with children | Difference between child and adult learning. Child protection issues. Ideas for promoting hygiene with children | 60 minutes | 62 |

| | | | | |
|---|---|---|---|---|
| | Carrying out a campaign | Key elements of a campaign and context specific planning | 90 minutes | 64 |
| | Planning training and training practice | Overview of training responsibilities and practice using the CM training package | 3 Hours | 66 |
| | Monitoring | Rationale and key responsibilities. Practice in use of monitoring formats | 90 minutes | 68 |
| | Fieldwork and Feedback session | Provide an opportunity for hygiene promoters to apply the knowledge they have gained from other training sessions | 2-3 hours | 70 |
| **Review and Evaluation** | | Consolidate learning on hygiene promotion and evaluate training | 30 minutes | 71 |
| **Part 2: Useful To Know Training for Hygiene Promoters** | | | | |
| **Context** | **Session** | **Content** | **Timing** | **Part 2: Page** |
| | Water and sanitation related diseases | Main water and sanitation diseases in current context and ways to prevent these | 90 minutes | 25 |
| | Introduction to Sphere | Overview of WASH sector standards and indicators | 60 minutes | 27 |
| | Introduction to Gender | Definition of gender and relevance to WASH programming. Practical ways to ensure intervention is gender aware. | 60 minutes | 29 |
| | Introduction to Protection | Definition of protection and why relevant to work of hygiene promoter | 60 minutes | 31 |
| | Introduction to HIV/AIDS | Overview of HIV and relevance to WASH intervention and the emergency context | 60 minutes | 34 |
| | Community participation | Meaning of community participation and what it is not. Participation ladder and stages of emergency. Vulnerability and ways to enable participation. | 90 minutes | 36 |
| **Skills** | Behaviour change & social change | Factors influencing change and common misconceptions | 90 minutes | 40 |
| | Understanding different perspectives | The importance of empathy and seeing other people's point of view | 45 minutes | 44 |
| | Use of visual aids | Visual literacy and adapting visual aids. Best practice guidelines for designing leaflets and posters. | 90 minutes | 46 |
| | Other promotional methods | Overview of PHAST, Social Marketing, Child to Child and Street Theatre and relevance to current situation. Use of radio and other mass media. | 2 hours 15 minutes | 48 |

| | | | | |
|---|---|---|---|---|
| Job Specifics | Community management of facilities | Community management issues and role of hygiene promoter. Setting up of committees and their roles and responsibilities | 90 minutes | 51 |
| | Further training practice | Using and adapting training material and visual aids | 6 hours | 55 |
| | Introduction to baseline survey | Qualitative and quantitative methods and introduction to sampling | 90 minutes | 57 |
| | Questionnaire survey | Piloting questionnaire, training data collectors, analysis of data | 2 days approx | 59 |
| | Use of ORT | Management of diarrhoea with ORS (and SSS if appropriate). Recognising dehydration. | 60 minutes | 61 |
| | Cholera Control Issues | AWD, government response, outbreak response | 60 minutes | 63 |
| | Malaria Control Issues | Context specific background. Key prevention methods. Use of ITNs or LLINs. Importance of early diagnosis and treatment. | 2 Hours | 65 |

| Part 3<br>Additional sessions for HP Co-ordinators | | | | |
|---|---|---|---|---|
| Programme Approach | Session | Content | Timing | Part 3 Page |
| | Evidence Base for HP and WASH | Available evidence for HP and interpretation | 90 minutes | 25 |
| | Bridging Development and Emergency | Differences and convergences between two contexts | 2 hours | 28 |
| | Operation, Maintenance & Sustainability | What sustainability means in an emergency, community management issues | 90 minutes | 31 |
| | Managing Accountability | Principles and accountability frameworks. Ways to promote greater accountability to those affected | 75 minutes | 33 |
| | Advocacy | Advocacy and Rights Based Approach, WASH advocacy issues | 90 minutes | 36 |
| Information Management | Designing and managing an assessment | Information management tools, use of Gantt chart, co-ordination | 2 hours | 39 |
| | Data analysis and reporting | Emphasis on how to analyse and interpret data | 2 hours | 42 |
| | Planning & Logical Framework | Importance of planning and use of logical framework matrix | 60 minutes | 45 |
| | Monitoring for managers | Monitoring plan and different levels of responsibility | 90 minutes | 47 |
| | Impact & Evaluation | Key principles and management of evaluation and measuring impact | 60 minutes | 49 |
| | Promoting Integration | Practical ways to address constraints and overcome negative attitudes | 60 minutes | 52 |
| | Co-ordination Responsibilities | Intra-sectoral and cross sectoral co-ordination | 2 hours | 54 |

| | | | | |
|---|---|---|---|---|
| **Implementation** | Job description | Ensuring familiarity with tasks and responsibilities and identifying training and support needs | 90 minutes | 57 |
| | Overview of HP Intervention | Phases of emergency, HP steps and timeline, project cycle | 90 minutes | 59 |
| | HP Communication Strategy | Articulating messages, limitations of one way communication, importance of dialogue | 60 minutes | 61 |
| | Managing meetings | How to get the best from a meeting | 60 minutes | 63 |
| | Developing Partnerships | Mapping capacity, MoUs, working with counterparts | 2 hours | 65 |
| Resources Management | Recruitment and Managing Others | HR issues, support and training | 2 hours | 67 |
| | Logistics and financial management | Managing a budget, using logistics systems effectively | 60 minutes | 71 |
| Total | | | Approx 3.5 days | |

# List of Handouts & Resources

| Part 1: Essential To Know Training for Hygiene Promoters | | | |
|---|---|---|---|
| Session | *Handouts/PowerPoint Slides* | Session | *Handouts/PowerPoint Slides* |
| WASH cluster and co-ordination | *Cluster Overview*<br>*Slides 2-4* | Focus group discussion | *Focus Group Discussion*<br>*Focus group discussion sample questions*<br>*Analysing qualitative data and reporting* |
| Public health in emergencies | *Public Health Model Slide 5-8* | Job Description | *Hygiene Promoter job description*<br>*PowerPoint Slide 42-43* |
| Hygiene promotion in emergencies | *Terminology and Definitions*<br>*Hygiene promotion briefing paper*<br>*Hygiene Promotion Slides 9-20* | Assessment and baseline | *Qualitative and Quantitative Assessment*<br>*Leading Questions*<br>*Assessment Methods*<br>*Overview of Data Collection for Hygiene Promotion*<br>*Example rapid assessment checklist*<br>*Example observation guide for an exploratory walk*<br>*PowerPoint Slides 44- -48* |
| Key water and sanitation priorities | *Fewtrell Diagram - Slide 21-22* | Hygiene Kits: Selection & Distribution | *Hygiene Related Non Food Items Briefing Paper*<br>*Hygiene Kit Monitoring Form* |
| Key actions to prevent diarrhoea | *F diagram (also slides 23 -35)*<br>*Instructions for management of diarrhoea* | Selection and support of Community Mobilisers | *Information on community mobilisers and example job description*<br>*Community mobiliser attributes* |
| Participation and Accountability | *Humanitarian accountability and hygiene promotion*<br>*PowerPoint slide 34-45* | Community Involvement Design of facilities | *PowerPoint Slides 49-51* |
| Communication skills | *Listening Techniques*<br>*Observation and Listening -slide 36-39* | Introduction to Working with Children | *Child protection good practice guide*<br>*Child Protection Scenarios*<br>*Child to Child Activity Sheets*<br>*Example activities for children*<br>*Children and Learning*<br>*PowerPoint slides 53-56* |
| Communication skills II | *Communication Worksheet*<br>*Training and communication skills* | Training Practice | *HP 2 Training for Community Mobilisers* |
| Participatory methods | *Facilitation skills for participatory methods*<br>*Instructions for activities* | Monitoring | *Example of a WASH logical framework matrix*<br>*Indicators for monitoring hygiene promotion in emergencies*<br>*Example hygiene promotion monitoring form*<br>*Examples of PHAST* |

| | | | |
|---|---|---|---|
| | | | *monitoring forms*<br>*Monitoring Exercise*<br>*Example SMART and not so SMART indicators* |
| Adult learning | *How adults learn*<br>*PowerPoint slide 40-41* | Example review session | *Example Quiz Sheets* |
| **Part 2: Useful To Know Training for Hygiene Promoters** | | | |
| Session | *Handouts/PowerPoint Slides* | Session | *Handouts/PowerPoint Slides* |
| 1. Water & Sanitation Related Diseases | *PowerPoint slide 2-3 F diagram*<br>*WASH related diseases*<br>*Table of transmission of diseases*<br>*Disease fact sheets (Hepatitis A, Hepatitis E, Malaria, Cholera, Dengue, Diarrhoea, Scabies)*<br>*Pair wise ranking instructions* | 2. Introduction to Sphere | *Minimum standards for water, sanitation and hygiene promotion & Minimum standards for shelter and non food items (available from www.sphereproject.org )*<br>*PowerPoint Slide 4-9*<br>*Hygiene Promotion and Sphere* |
| 3. Introduction to Gender | *Gender Roles Exercise*<br>*Gender Checklist*<br>*PowerPoint Slide 10-13* | 4. Introduction to Protection | *Protection Handout* |
| 5. Introduction to HIV/AIDS | *Hygiene Promotion and HIV/AIDS*<br>*HIV transmission three pile sorting exercise* | 6. Community Participation | *Gender and community participation worksheet*<br>*Participation Ladder Exercise*<br>*PowerPoint Slides 14-17*<br>*Roles and statements for the power walk (optional exercise)*<br>*How to do Venn Diagrams (optional exercise)* |
| 7. Behaviour Change and Social Change | *Catalyse Model - see slide 21*<br>*Behaviour Change Models*<br>*Communication for social change and hygiene promotion*<br>*PowerPoint Slides 18-22* | 9. Use of Visual Aids | *Guidelines for designing posters*<br>*Designing a leaflet*<br>*PowerPoint Slides 23-26* |
| 10. Other Promotional Methods | *Overview of social marketing*<br>*Overview of PHAST*<br>*Overview of Child to Child*<br>*Using role plays and drama*<br>*PowerPoint Slides 27-32* | 11. Community Management of Facilities | *Oxfam Briefing Document*<br>*Bujumbura Case Study*<br>*Roles of Committee Members* |
| 13. Introduction to Baseline Survey | *Designing baseline study*<br>*PowerPoint Slides 33-37* | 14. Questionnaire Survey | *Example Questionnaire*<br>*Guidance Notes for carrying out surveys* |
| 15. Use of ORT | *'F' Diagram*<br>*Instructions for management of diarrhoea (see session on Key Actions to Prevent Diarrhoea)* | 16. Cholera Control Issues | *Cholera Toolkit*<br>*Factsheet on cholera (from session on water and sanitation related diseases)* |
| 17. Malaria Control Issues | *Malaria Quiz*<br>*PowerPoint slides 38-40*<br>*Focus group discussion framework*<br>*RBM Information Sheet (see www.rbm.who.int/ multimedia/rbminfosheets.html)* | | |

| Part 3:<br>Training for Hygiene Promotion Coordinators | | | |
|---|---|---|---|
| Session | *Handouts/PowerPoint Slides* | Session | *Handouts/PowerPoint Slides* |
| **Evidence Base** | Summary of Key Evidence Base<br>One page handouts on PHAST and Social Marketing (from Part 2)<br>PowerPoint Slides 2-4 | **Bridging Development and Emergency** | PowerPoint Slides 5-10 |
| **Operation, Maintenance & Sustainability** | Factors affecting sustainability of water systems<br>PowerPoint Slides 11-17 | **Managing Accountability** | Draft WASH Accountability Checklist<br>Sources of Humanitarian principles<br>PowerPoint Slides 18-22 |
| **Advocacy** | WASH advocacy in emergencies<br>Planning advocacy initiatives<br>WASH advocacy case study<br>WASH advocacy case study analysis<br>PowerPoint Slides 23-27 | **Designing and managing an assessment** | WASH CAT assessment flowcharts<br>Basic checklist for planning hygiene promotion<br>PowerPoint Slides 28-32 |
| **Data analysis and reporting** | Analysing qualitative & quantitative data<br>Example questionnaire (see Part 2)<br>Exercise on mortality rates<br>PowerPoint Slides 33-35 | **Planning & Logical Framework** | Example WASH Logframe Matrix<br>PowerPoint Slides 36-44 |
| **Monitoring for managers** | Example hygiene promotion monitoring plan<br>Participatory monitoring and measuring participation<br>PowerPoint Slides 45-46 | **Impact & Evaluation** | Evaluation Criteria<br>PowerPoint Slide 47-48 |
| **Promoting Integration** | Teamwork and integration<br>PowerPoint Slide 55 | **Co-ordination Responsibilities** | Draft Health and Nutrition WASH Matrix<br>Draft Education WASH Matrix<br>Draft Emergency Shelter WASH Matrix<br>PowerPoint Slides 49-53 |
| **Coordinator Job Description** | Hygiene Promotion Co-ordinator Job Description<br>Learning and Professional development | **Overview of HP Intervention** | Hygiene Promotion Steps<br>Example Hygiene Promotion Activities<br>PowerPoint Slides 54-58 |
| **Communication strategy** | Developing messages<br>PowerPoint Slide 59-60 | **Managing meetings** | Effective meetings<br>Multi-language meetings<br>PowerPoint Slide 61-62 |
| **Developing Partnerships** | Developing Partnerships<br>Stakeholder analysis<br>Example Community Agreement/MoU<br>PowerPoint Slide 63-64 | **Recruitment and Managing Others** | Recruiting and selecting staff<br>Human Resources Issues<br>Group development and team working |
| **Logistics and Financial Management** | Managing finance | | |

# Trainer or facilitator's role[1]

Ideally the training would be run by at least 2 facilitators/trainers especially if the training is held on consecutive days. In an emergency there may not be sufficient people with facilitation and hygiene promotion experience in one organisation but it may be possible to enlist the support of people with the required skills from either government ministries (e.g. the Ministry of Health or Social Welfare) or from National NGOs. There may also be other organisations interested in running training courses and willing to collaborate on the facilitation of them.

- **Take responsibility for keeping participants on track.** During exercises, discussions and practice sessions, it is important to circulate throughout the room to catch problems and assist or encourage people as needed.
- **Be aware of the time.** Make sure that presentations and exercises don't run on for too long. Several minutes before an exercise or practice session is to end, facilitators should alert participants about the amount of time left.
- **Be aware of how teams are working together.** It may take some time for the teams to get comfortable with each other if the participants do not know each other. However, if participants do know each other, experience has shown they may tend to spend time chatting and not keep on task. Be prepared to help the teams stay on task.
- **Use real examples and anecdotes to make your points come alive.** Encourage participants to share relevant experiences as well.
- **Create a safe, comfortable learning environment.** Participants should enjoy the sessions and feel that they can speak their mind without being made to feel that they are inadequate.
- **Encourage participants to get acquainted during breaks.** Tea breaks and meals allow participants to network and learn from each other and compare notes.
- **Help participants review the content of each day's activities.** An important aspect of training is providing participants with the "big picture" of what they're learning. Be sure to allow a few minutes at the end of each day to summarize key points so that participants recognize how much they have learned and done.

[1] Adapted from Spot on Malaria, Facilitator's manual for adapting, developing and producing effective radio spots

# Introductions, Icebreakers and Energisers

**Suggestions for Energisers**[2]
Energisers can be used to stimulate participants following a particularly long session or to break sessions up. They may be particularly useful to re-energise participants during the afternoon when they may start to find it difficult to concentrate fully. Energisers can also be used as a useful way to divide the participants into smaller groups for the group work activities. Often participants will have attended other training courses and they may have their own favourite energisers that can be used.

Energisers can also be a very useful method to enhance cross-cultural learning as music or symbols pertinent to a particular culture and suggested by participants can also be used. Participants could also be asked to learn how to say 'hello' in all of the different languages known by the group or asked to explain the meaning of their name during short interludes between sessions.

- The facilitator chooses a number of well-known phrases, and writes half of each phrase on a piece of paper or card. For example, they write '*Happy*' on one piece of paper and '*Birthday*' on another. (The number of pieces of paper should match the number of participants in the group.) The folded pieces of paper are put into a hat. Each participant takes a piece of paper from the hat and tries to find the member of the group with the matching half of the phrase.

- Ask the group to move around the room, loosely swinging their arms and gently relaxing their heads and necks. After a short while, shout out a word. The group must form themselves into statues that describe the word. For example, the facilitator shouts "peace". All the participants have to instantly adopt, without talking, poses that show what 'peace' means to them. Repeat the exercise several times.

- The group pretends that they are attending a football game. The facilitator allocates specific cheers to various sections of the circle, such as '*Pass*', '*Kick*', '*Dribble*' or '*Header*'. When the facilitator points at a section, that section shouts their cheer. When the facilitator raises his/her hands in the air, everyone shouts "Goal!"

**Suggestions for Introductions and Icebreakers**
Icebreakers can be used at the start of a training course where participants do not yet know each other well. They can help participants to feel more at ease and not be self-conscious about offering suggestions and ideas.

- Everyone writes their name, along with four pieces of information about themselves on a large sheet of paper. For example, '*Alfonse likes singing, loves football, has five wives and loves PRA*'. One of the pieces of information should be a lie. Participants then circulate with their sheets of paper. They meet in pairs, show their paper to each other, and try to guess which of the 'facts' is a lie.

[2] Several examples adapted from International HIV/AIDS Alliance, 100 ways to energise groups

- Participants think of an adjective to describe how they are feeling or how they are. The adjective must start with the same letter as their name, for instance, "I'm Henri and I'm happy". Or, "I'm Arun and I'm amazing." As they introduce themselves, they can also mime an action that describes the adjective.

- Invite each participant to come to the front of the room and write their name on the board or on flip chart paper so that everyone can see it. They are then asked to say a few things about their name e.g. the origin of it or what they liked being called or common mistakes in spelling or pronunciation.

# References

**ACF (Action Contre La Faim), Sri Lanka** (no date): Leonie Barnes, An Integrated WatSan/Hygiene Promotion Manual in the Post-Tsunami context
**ACF** (2002) A Manual for implementing health education in the field, Deborah Tsuchida
Bockhorn-Vonderbank, M. (2004) Children's Hygiene & Sanitation Training (CHAST). A practical guide. Caritas Luxembourg/Caritas Switzerland (Swiss Group).
**HIV/AIDS Alliance** (2002)100 ways to energise groups, games to use in workshops, meetings and the community, Brighton, UK.
**IRC** (2007) Environmental Health Field Guide, 3rd Edition. New York: International Rescue Committee.
**IRC** (no date) Hygiene Committee Training Manual, Bujumbura Rural
**Oxfam** (2000) Public Health Promotion Training Manual
**OXFAM** (2007) Improving the safety of civilians, A Protection Training Pack, Oxfam Publishing, Oxford
**Tearfund** (2007) Child Health Club Trainers Guide
**Uganda CBHC** (1991) Facilitator's Resource Manual Uganda (MoH Uganda, Unicef and World Neighbours)
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**UNICEF Pakistan RWSSP** (no date) Health and Hygiene Manual
Ferron S., Morgan, J. and O'Reilly, M. (2000) Hygiene Promotion: A Practical Manual for Relief & Development London ITDG
**UNICEF** (2006) Behaviour change communication in Emergencies: A Toolkit
**UNICEF** (1999) Hygiene Promotion: Towards Better Programming. Water, Environment and Sanitation Technical Guidelines Series - No. 6
**USAID** (2005) Spot on Malaria, Facilitator's manual for adapting, developing and producing effective radio spots
Harvey, E (2002) Participatory Methodology and Facilitation Guide, WaterAid Mozambique

# Session Plans

## Context

## Water and Sanitation Related Diseases

Aims:

**This session is designed to:**
Ensure that hygiene promoters know the main water, sanitation and hygiene related diseases that are prevalent in the area and how to prevent them during emergencies

Outcomes:

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

- List the main water, sanitation and hygiene related diseases
- Describe the link between malnutrition and disease
- Prioritise water, sanitation and hygiene interventions

90 Minutes

**Resources/Handouts:**

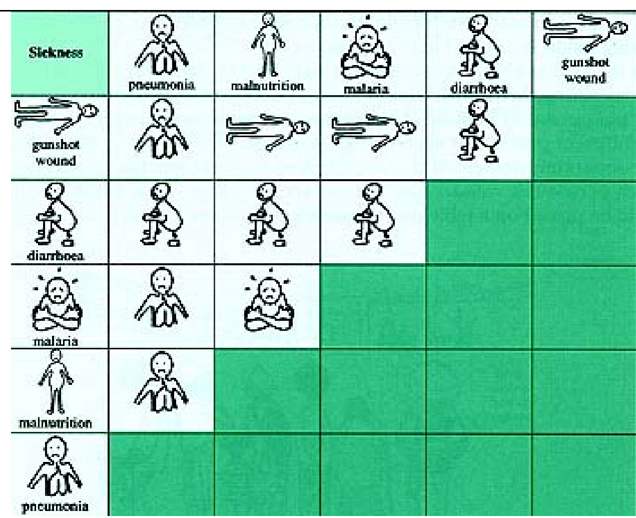
- PowerPoint slide 3 F diagram
- Table of transmission of diseases
- Disease fact sheets
- WASH related diseases
- Pair wise Ranking Instructions

**Session Plan:**

Introduction to session aims and outcomes.

Brainstorm the different diseases that are common in the existing context and identify those that are WASH related.
**10 minutes**

Construct a ranking matrix on the board or flip chart (see picture below) and ask participants to come to an agreement on which is the most serious disease by pairing one off against the other (see pair wise ranking instructions)




**20 minutes**

In small groups ask participants to provide the signs, symptoms and main prevention methods for the following diseases using the information in the Fact Sheets:

- Faecal-oral diseases including diarrhoea, dysentery, cholera, typhoid, giardia and hepatitis A (or whatever is most common in the area)
- Scabies
- Conjunctivitis
- Malaria

Each group should feedback to the larger group with the facilitator clarifying their presentations. Ensure that the link between malnutrition and disease – especially diarrhoea is explained if this hasn't been done in the introduction

**60 minutes**

**Facilitators Notes/Key Learning Points:**

- Hygiene Promotion training often spends a good deal of time on water and sanitation diseases. However, time can probably be better spent learning the skills that are needed for hygiene promotion and hygiene promoters only need to have an overview of the different diseases and specifically how these can be prevented.
- Poor water, sanitation and hygiene practices can cause diarrhoea that is spread by the faeco-oral route.
- There is an important link between malnutrition and diarrhoea.
- There is a need to prioritise the water, sanitation and hygiene practices that will make the most difference in reducing disease, and these include excreta disposal, hand washing with soap, and the use of safe water.
- It is important to know the key messages on sanitation, hand washing with soap and safe water use.

**Where can I find out more?**

- Where there is no doctor
- Hygiene Promotion: A practical manual for relief and development pp233-242
- Cholera outbreak management IFRC

# Introduction to Sphere

Aims:

| This session is designed to: Provide participants with an overview of the Sphere minimum standards that relate to water, sanitation and hygiene promotion |
|---|

Outcomes:

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

- Explain the importance of Sphere for monitoring and accountability
- List the minimum standards for hygiene promotion
- Give examples of key indicators that relate to hygiene promotion

## 60 Minutes

Resources/Handouts:

Minimum standards for Water, Sanitation and Hygiene promotion and Shelter and Non Food Items (see www.sphereproject.org )
PowerPoint slides 5-9
Hygiene Promotion and Sphere

Session Plan:

Briefly introduce the session

Ask what Sphere is and if participants have experience of using Sphere. Briefly explain the purpose of Sphere and its role in monitoring and accountability.

Use the PowerPoint slides on example standards and indicators or copy the PowerPoint slides onto flip chart paper and present these to the group (it may be sufficient to copy the standards only and then to read out the indicators and refer participants to the handouts) ensuring that they ask questions where necessary
**20 minutes**

Divide participants into 3-4 groups and give each group a set of the standards for water, sanitation and hygiene and for (shelter and) non food items

Ask each group to think about how the standards apply to the current situation and whether they are being met. Provide each group with 2-3 relevant standards and indicators only and ask them to prepare a presentation to the rest of the group on the current situation.

Ask each group to provide a 5 minute feedback in plenary and ask for comments and questions from the rest of the group. Try to clarify any misunderstandings.
**30 minutes**

Explain that there are also general standards that apply to all sectors which include assessment, participation and monitoring and they should try to find time to read up on

these also. Explain that Sphere provides a means to help monitor an emergency situation and calls all those working in that situation to account if people's rights are not being upheld.
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- Explain that the standards are usually couched in general terms and should apply to every situation.
- The indicators provide an example of how the standard can be measured but will not always be feasible in a short space of time and may change in different situations. It should also be remembered that the examples given only represent a MINIMUM level of acceptability
- The standards and indicators provide a benchmark against which the progress of the intervention can be measured.
- In addition, the satisfaction of the affected population with the facilities and services provided is crucial.
- As a supplementary or additional session the Sphere Quiz can be used to help familiarise the group with the Sphere Manual

**Where can I find out more?**

Sphere Manual (Chapter on Water, Sanitation and Hygiene Promotion)
Sphere Introductory Training and Water and Sanitation Training Modules

# Introduction To Gender

Aims:

**This session is designed to:**
Ensure the participants have a basic understanding of the term gender and how this relates to hygiene promotion programmes

Outcomes:

**By the end of the session participants will be able to:**
- Describe what gender is and why it is relevant to WASH programming
- Describe the actions they can take to ensure that their work is gender aware.

## 60 Minutes

**Resources/Handouts:**
- Gender roles exercise and picture set (see Visual Aids Library)
- Gender checklist
- PowerPoint slides 11-13

Session Plan:

Introduction to aims and outcomes.
Ask the group what they understand by the term 'Gender'. Explain that gender refers to the different socially defined roles and responsibilities associated with being a man or a woman and that these often change over time and in different places. Ask them to think about how their lives have changed compared to their mothers or fathers in terms of what is expected of them as a man or a woman?

Show PowerPoint or flipchart of slide depicting incidence of cholera and ask why this is the case. Explain that in many cultures women often care for those who are sick and so may be more vulnerable to disease. If we don't look for these differences, we often don't see them so it is important to try and collect data on both men and women and to understand their different perspectives and needs.
**10 minutes**

Divide the participants into smaller groups and give them the sets of activity/role pictures and ask them to decide whether these are done by men or women, or both. Ask the groups to feedback their decisions to the large group and discuss.
**30 minutes**

Ask the participants what implications does gender have for the current programme? For example are we consulting enough with men and women? How do we encourage women's participation if they are not allowed to come to meetings or do not have the confidence to speak out? Are men and women willing to dig latrines, work as labourers, work as water point/latrine attendants (don't be afraid to challenge preconceptions and suggest asking women themselves)? Are some men engaged in caretaking of family members - have they been forced to take on these roles because

more women than men have died (as in the Asian Tsunami)? Do men and women have specific needs in relation to maintaining hygiene e.g. sanitary protection or razors? Are there both men and women on the WASH team - is there a difference in the roles that they perform?

Show PowerPoint slide/flip chart on possible gender actions
**10 minutes**

End the session by reviewing what the participants have understood from the session and whether this will make them do anything differently in their work or at home.
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- Understanding Gender can take time and participants will need to explore the issue more in subsequent training sessions and in the field if they are unfamiliar with the concept. This session provides an introduction only.
- Where possible concentrate on specific actions that are possible in the current context. The role of the hygiene promoter is to try to identify the different perspectives of men and women and ensure that the work they do responds to the needs of both. However, it should also be borne in mind that there are frequently barriers to women's participation and special efforts may be needed to ensure that their needs and rights are respected.

**Where can I find out more?**

- www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=659
- Oxfam Gender Training Manual

# Introduction to Protection[3]

Aims:

This session is designed to:
Ensure that participants have a basic understanding of the concept of Protection and what it means for their work

Outcomes:

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

- Explain what Protection is
- Describe the actions that they can take to help protect the safety of the population

## 60 Minutes

Resources/Handouts:

Protection Handout

Session Plan:

Briefly introduce the session
Ask the group what they think Protection means or if anyone has experience of protection.

Explain that Protection is about improving the safety of people. For example in Darfur, Sudan women collecting water or firewood outside of an IDP camp have been the object of attacks and ways need to be found to prevent this occurring.
**5 minutes**

There are two sides to protection - reducing the negative consequences of our actions, and proactively helping people stay safer. We will focus on the latter.
Humanitarian organisations help people stay safer by reducing risk.

Risk exists when there is **a threat**, such as the threat of violence or exploitation, and people are **vulnerable** because, for example, they are a woman, are from a certain ethnic group, or because they have to leave their village to get water. The longer the time people are exposed to a threat the greater the risk - for example collecting water four times a day is riskier than collecting it twice a week.

**There are three types of threats:**

**Violence** - deliberate killing, wounding, sexual violence, rape, torture and the threat of any of these.
**Coercion** (forcing someone to do something against their will) - forced prostitution, sexual slavery, sexual exploitation, forced or compulsory labour, forced displacement or

[3] This training session is adapted from OXFAM Improving the safety of civilians

return, restriction of movement, prevention of return, forced recruitment, being forced to commit acts of violence against others.
**Deliberate Deprivation** – destruction of homes, wells and clinics; preventing access to land or markets; preventing delivery of relief supplies; deliberate discrimination in getting jobs, education, land or services; illegal 'taxes' or tolls.

**NGOs try to improve the safety of people by doing one or more of:**

- reducing the level of threat
- reducing the level of vulnerability
- reducing the amount of time exposed to the risk.

**15 minutes**

In pairs ask the participants to think about the existing threats to people's safety and the ways that various organisations might try to protect them – especially in relation to water and sanitation.

Ask for feedback and write up the suggestions on a flip chart.

Explain that there are various actions an organisation might take, and pick an example of each of the ways below from the flip chart:

**To reduce the threat**

- **Advocacy:** convincing those with power to protect people or getting others to put pressure on them to protect people e.g. siting of camp and facilities
- **Capacity-building:** supporting the authorities to protect civilians
- **Presence:** using physical presence to deter attacks on civilians

**To reduce vulnerability**

- **Assistance:** directly providing services or goods so that people can avoid threats
- **Voice:** helping people to negotiate their own safety e.g. allowing people to express their concerns to decision makers
- **Information:** providing impartial information to help people make informed decisions about their safety e.g. ensuring that people know that distributed items are provided free of charge

**20 minutes**

In groups ask participants to think what they can personally do to help protect the people they are working with and ask for suggestions from each group.
**20 minutes**

**Answers might include:**
Listening to men, women and children's concerns and providing feedback in agency meetings or other relevant forums
Using their position and corresponding power as a health promoter responsibly
Making people aware of their rights e.g. that distribution items are provided free of charge
Making sure that children are not exposed to abuse when organising activities with them

**Facilitators Notes/Key Learning Points:**

- As with the session on Gender, the concept of Protection may be unfamiliar to

many participants. Further training will probably be necessary to deepen participants' understanding

- Protection is a rights based approach to humanitarian response which is concerned with addressing the broader threats to human health and wellbeing in an emergency rather than just their physical wellbeing. The threats identified include violence, coercion and deprivation.

**Where can I find out more?**

- www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=613
- Oxfam Improving the Safety of Civilians: A Protection Training Pack Oxfam Publishing, Oxford 2008

# Introduction to HIV/AIDS

Aims:

This session is designed to:
Ensure that participants understand the importance of HIV/AIDS as a global emergency and are aware of how this affects their work

Outcomes:

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

- Explain what HIV/AIDS is and who is at risk
- List the factors that make people vulnerable to HIV/AIDS in the current context
- List some of the ways that the WASH programme can mitigate these risks

## 60 Minutes

Resources/Handouts:

Hygiene Promotion and HIV/AIDS
Three pile sorting cards on HIV/AIDS (see Visual Aids Library)
HIV transmission three pile sorting exercise

Session Plan:

Briefly introduce the session
Ask participants to explain what HIV/AIDS is and who is at risk.
**10 minutes**

In small groups use a three pile sorting activity to discuss good, bad and in between activities in relation to the transmission of HIV/AIDS and feedback in plenary.
**20 minutes**

Ask participants in pairs to discuss why people are more vulnerable to HIV/AIDS in emergencies and especially in their specific context. Ask them to feedback their suggestions in plenary.

Some possible answers might include:

- Population displacement
- Disruption of family and social structures
- Disruption of social networks
- Sexual contact with military and paramilitary personnel
- Economic vulnerability leading to the exchange of sex for money or goods
- An increase in sexual violence or coercive sex
- Disruption to curative and preventative health services
- Unsafe blood transfusions (because of increase in demand for blood)
- Higher prevalence of sexually transmitted infections

Record the participants' responses on flip chart paper
**10 minutes**

Ask the participants if they can think of anything that they can do to try to mitigate the risks of HIV being transmitted or to respond to people with HIV/AIDS. Ask them to reflect on the previous suggestions and think about specific situations from the context they are working in.

Some suggestions might be:

- Analyse the context and the risks of HIV transmission
- Ensure men, women and children can access water and sanitation facilities safely
- Consult with community – particularly women - to ensure that distribution of aid or location of facilities is not putting people at risk
- Ensure that women are aware of their rights in relation to the distribution of goods and that this carries no obligations for sexual or other favours
- Ensure water and sanitation facilities are accessible by the chronically sick
- Find out from carers the best way to involve them and their dependents in project activities

**10 minutes**

Ask participants to think of two things they will use from this session (either for themselves or their families or in their work as hygiene promoters) and to share it in the next review session

**10 minutes**

**Facilitators Notes/Key Learning Points**

- Once again this is a very short session but a complex subject. The actual length of the session will depend on the level of knowledge of the participants.
- The three pile sorting exercise is a good way to get people discussing the issue freely and clarifying misconceptions and even in an apparently experienced group some surprising misconceptions can come to light so it is worth spending time on this. Don't spend too long on the initial review before doing the three pile sorting but rather use the activity as a basis for clarifying issues.

**Where can I find out more?**

Humanitarian Programmes and HIV and AIDS: A Practical Approach to Mainstreaming, O'Reilly, M. Walden, V. & Yetter, M. (2007) Oxfam
HIV/AIDS and Water, Sanitation & Hygiene: www.irc.nl/page/3462

# Community Participation

**Aims:**

**This session is designed to:**
Identify ways to ensure the participation of all sections of the affected population in the emergency response

**Outcomes:**

**By the end of the session participants will be able to:**
- Explain what is meant by community participation
- Describe how and why certain groups may be particularly vulnerable in an emergency and the importance of their participation
- Explain the different levels of participation
- Describe the opportunities and constraints to participation in this context

## 90 Minutes

**Resources/Handouts:**

Gender and Community Participation Worksheet
Participation Ladder Exercise
PowerPoint slides 11-13
Roles and Statements for the Power Walk (optional exercise)
How to do a Venn Diagram (optional exercise)

**Session Plan:**

Introduction:

Copy the following quote onto flip chart paper (or a similar quote that is specific to your situation):

> *"When hundreds of refugees come flooding across the border, you don't think about whether they are men or women, girls or boys, you see a mass of miserable people who are suffering great loss and trauma and who are in dire need of shelter, food, water and medical care".*[4]

Ask participants to discuss this statement and whether they agree with it or not.
**10 minutes**

Divide participants into small groups and ask them to complete the community participation and gender worksheet on large flipchart paper.

Ask one group to feedback and others to add their suggestions and comments.
**35 minutes**

[4] Taken from Gender Perspectives: A collection of case studies for training purposes IFRC

Ask participants to consider the meaning of participation and provide examples from their own experience.

Participants may provide the following suggestions/examples for the meaning of participation:

- Provides manual labour when requested
- Member of the health committee but does not often attend meetings
- Gives monetary contribution when requested but does not wish to take part in activities
- NGO consults with the community and then decides on latrine design
- NGO plans to install hand pumps in a village/camp
- Community member attends planning meetings, takes part in work and helps to encourage and organize friends and neighbours
- Marginalised members of community help to identify problems, organize resources and mobilizes others to become involved in project
- Community member becomes a volunteer committee member and actively carries out his/her responsibilities
- NGO provides a range of options to do with the design and long term management of the protected water system and allows men and women in the community to choose what suits them best

Clarify the suggestions given and explain that the definition is **NOT about the provision of labour, time or financial contribution** from the affected community but about **the degree of control and decision-making** that WE (as fieldworkers) relinquish to the people we work with.

Show the 'participation ladder' on the PowerPoint/flip chart and discuss the different levels of participation.

Hand out the participation exercise sheet and ask participants, in pairs, to see where each box fits onto the participation ladder. They may want to invent their own examples for the blank boxes. Feedback in plenary and discuss.
**20 minutes**

Show relevant key indicators of participation from Sphere and invite comments from the group. Ask them where the indicators sit on the participation ladder and explain that the Sphere standards are written as a minimum only – going above the standard is to be encouraged where feasible and appropriate.
**10 minutes**

Ask the group to think of some practical ways to promote participation and show the suggestions on the PowerPoint/flipchart.

Review key learning from the session and ask participants to think about the things they will do differently in order to enable people to participate. They should bring along some suggestions for the next review session.
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- People often have a variety of concepts of participation and what it means.
- Participation is based on the assumption that people have a right to control their own lives and be part of the process of change.
- Participation is ultimately about creating a situation where people can reflect, analyse, plan and take action having been given the knowledge to do so and at the same time drawing on existing skills and experience that are available both inside and outside their own community.
- The affected population will consist of many different individuals and groups who will have different perspectives and needs. Some marginalised or minority groups may be more vulnerable because their perspective may not be 'heard' and it may be difficult for them to access facilities and services. The hygiene promoter needs to continually be trying to access these different and varied perspectives e.g. of men and women, girls and boys, those who are elderly or who have disabilities, those belonging to minority clans, tribes or religions etc.
- Different levels of participation are possible at different stages of an emergency
- There is always some space for participation – even if it is only a basic attempt at consultation and the provision of information to the affected population

Supplementary Activities

1. Power Walk (see handout)

Explain to participants they are going to do an exercise called the *Power Walk*. Hand out one piece of paper containing a role to each participant. Say that they are not allowed to show or tell others what their role is.
Ask participants to stand in a line facing in the same direction. Make sure that there is enough space to allow them to take at least ten steps forward (this activity made need to be conducted outside)
Say that they must now act out the role of the person on their piece of paper. You are going to make a series of statements. If you think that the person in your role can answer yes to a statement, take one step forward. For example: I wear shoes.
Read out the statements one by one, allowing time for the characters to think and act.
After reading these statements, ask those who have taken the most steps forward who they are. Then ask those who have stayed behind or taken no steps at all who they are. How did they feel when they watched all the others going forward? Provoke a discussion on what they learn from this. Point out that the most important people to reach are precisely the ones who remain behind. Often we only talk to those who are at the front. Discuss how we can make sure that this does not happen.

Lessons from the power walk

- Who comes to the front in any participatory process in the community
- Who benefits from any projects
- The 'target group' will often not be reached because they remain hidden
- Those who are left behind become more and more frustrated
- Need to find methodologies to make sure that all participate.

2. Venn Diagram to identify Stakeholders

Divide participants into small groups. Ask each small group to construct a Venn diagram (provide handout as an additional explanation) representing the different sections of the community/groups/stakeholders in the existing WASH programme or overall emergency response. They should indicate the level of participation of each group and or their vulnerability by the size of the circle and the distance from the central circle indicating

the programme.

Ask one group to present their Venn diagram and discuss what the hygiene promoters can do to facilitate the participation of the various groups.

**Where can I find out more?**

Participatory Evaluation, Tools for Managing Change in Water and Sanitation, Narayan, D. (1993) World Bank

# Hygiene Promotion Skills

## Behaviour Change and Social Change

Aims:

**This session is designed to:**
Ensure that participants understand how behaviour and social change come about and how they can help to enable change in the current situation

Outcomes:

**By the end of the session participants will be able to:**
- Describe the factors influencing behaviour change
- Describe the process of social change
- Explain what can be done to enable change in the current situation

# 90 Minutes

**Resources/Handouts:**

Behaviour Change Models
Catalyse Model
Communication for Social Change and Hygiene Promotion
PowerPoint slides 19-22

Session Plan:

Introduction
Ask participants to brainstorm some key health behaviours and health messages - from either the current situation and/or their own experience and record these on the flip chart/board.

In pairs ask participants to think of an example of a health message that has helped them to change their behaviour and one that has not and briefly discuss this.
**5 minutes**

Ask participants what factors might encourage people to change their practices or behaviours?

Possible answers might include:

- Wish to live in an attractive and clean atmosphere
- Save money by spending less on medicine
- Feel respect from people
- Comfort
- Pleasant aroma
- Emotional experience (fear of getting sick, aversion to smell or infection etc.)
- In women: desire to be beautiful and be liked by men

- In men: desire to be strong and be liked by women
- Desire to have healthy, nice looking children who live to adulthood
- Harmony in the family
- Prosperity
- Dignity and self-respect

Explain that people will have different perspectives and different reasons that might motivate them to change. In an emergency people are often forced to change.
**5 minutes**

Ask participants if behaviour change can happen quickly and if they can think of examples of this. Examples might be:

- When user fees are abolished at the clinic (and drugs are available) an overnight increase in numbers is often observed
- When piped water is provided to people's homes – immediate increase in amount of water used
- Where people feel that the problem is very serious e.g. cholera outbreak
- Adverse publicity about a particular vaccine for children often leads people to boycott it very quickly

**5 minutes**

Explain that there are several models that have been designed over the years to explain how people change behaviour and what they need in order to do so. In this session they will look at one simple behaviour change model: The Health Action Model by John Hubley.

Distribute handout and give participants ten minutes to look through the handout and diagram of the Health Action (Hubley) model of behaviour change model. Ask if there are any questions.

Ask the group to think of examples from the current situation that relate to a specific component of the Hubley model.
**10 minutes**

Explain to the participants that behaviour change models tend to explore individual behaviour change and that the concept of social change examines how change comes about in a community or group working together and this is also very important. Social change is usually a model applied to longer-term programmes but has relevance to the emergency situation. The emergency itself can provide a catalyst for change and dialogue with those affected can help to initiate community action to address the problems. Provide the handout on social change and hygiene promotion and ask participants to try and find time to read this before the next review session/meeting.

Explain the concept of 'positive deviance' (people/families who manage to engage in 'healthy behaviours' despite the fact that they are also struggling with limited resources (a lack of resources is often cited as the main reason why people cannot practice healthy behaviours). Ask if they know of any examples of such families or individuals. It may be useful to try to understand these families better and find out what motivates them to use latrines or wash hands etc.

The last model/concept that might be of use is the Catalyse Model. This tries to simplify the approaches that can be used to stimulate individual and community level change. Show participants the Catalyse diagram and ask if there are any questions. Ask them to provide examples of how this diagram might relate to the current situation.
**15 minutes**

Divide participants into small groups and ask them use the Catalyse model provided to identify key actions for promoting change in the affected community. They should also bear in mind the Predisposing, Reinforcing and Enabling Factors of the Health Action model.

Ask each group to feedback and discuss and clarify their suggestions.
**25 minutes**

Review Key learning points by asking 5 key questions about the process of change in relation to the current water and sanitation programme e.g.

What factors may lead someone to start washing their hands?
How might you work with people to ensure that they use the latrines provided?
What factors enhance community level change?
Give 2 examples of predisposing factors that might help or hinder the process of change in a WASH programme.
Give 2 examples of enabling factors and 2 examples of reinforcing factors.
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- It is important to unpick the term behaviour change -people often assume that behaviour change takes a long time and isn't possible in an emergency but experience says otherwise
- The emphasis on action rather than behaviour change may be easier to accept – you are not necessarily looking for long term changes in an emergency but the short term mitigation of public health risks
- Behaviour change models can help to explain what is required for either action or long term behaviour change
- The Social Change model describes a dynamic process where community dialogue and collective action work together to produce community level change. The process starts with a "catalyst/stimulus" that can be external or internal to the community. This catalyst leads to dialogue within the community that when effective, leads to the resolution of a common problem[5].
- Interactive approaches may be more useful and effective than one way communication methods (message dissemination) in supporting behaviour change and action
- There is a trade off between reach and effectiveness such that the methods that allow you to reach people may not be as effective as those that encourage discussion and dialogue. Using a variety of approaches will ensure that at least

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

people receive information but interactive methods are probably more effective.

- There will always be some people who are ready to engage with taking action even early on in the emergency although many people will be grieving and mobilisation may be difficult at first. Showing support and empathy for individuals at this time can make the HP work easier as time progresses.
- It may be useful to provide large flip charts of the key models discussed and to use these to refer to during team meetings and future training sessions

# Understanding different perspectives[6]

Aims:

This session is designed to:
Enable participants to understand the importance of understanding a variety of perspectives

Outcomes:

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

- Describe why they need to examine other people's perspectives
- Explain to community mobilisers the importance of 'putting yourself in somebody else's shoes'

## 45 Minutes

Resources/Handouts:

A4 card with large number 3 for each group
Selection of pictures/photographs of people from different walks of life with different livelihoods etc. (include men, women, children, people with disabilities, elderly etc.)

Session Plan:

Introduce the session.
Divide participants into groups of 4 and ask them to sit around a real or imaginary desk so that there is someone on each side. Place a large number 3 on the table and ask each person in turn to describe what they see as shown below.

Each person will see something different - one will see a 3, another will see a letter M, another, a letter W another, a letter E. Repeat the question again and ask why do people see different things when the 'image' is the same?
**10 minutes**

Ask the group why do people have different points of view about the same subject e.g.

6 Adapted from Uganda CBHC (1991) Facilitator's Resource Manual Uganda (Unicef and World Neighbours)

hygiene? Ask the group where people get their point of view from. A person's viewpoint comes about as a result of many things: their experience, their education, the influence of their parents, neighbours, where they live, the resources they have etc.
**10 minutes**

Provide each group with a selection of pictures or photographs of different people from different walks of life and ask them to imagine how they feel about hygiene and sanitation. Allow the groups to discuss for a while and then ask for volunteers to introduce their 'character' to the rest of the group and then explain their viewpoint.
**15 minutes**

Ask the plenary group what we can learn from these exercises and ensure that they can explain the importance of 'seeing the world through other people's eyes' or 'stepping into their shoes' if we are to be in a better position to facilitate change. This is known as empathy and is a key skill of the hygiene promoter.
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- The importance of empathy has been touched on before but it is important to keep reminding participants of its importance.
- Hygiene promoters can easily slip into traditional ways of providing health education where the emphasis is on telling people what to do. By encouraging them to put themselves in other people's shoes they will become better at exploring alternative ways to communicate with people

# Using Visual Aids

Aims:

| This session is designed to: |
|---|
| Ensure that participants know how to use visual aids appropriately |

Outcomes:

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

- Explain the term visual literacy and why it is relevant to their work
- Describe how they can use and adapt visual aids in their work

# 90 Minutes

Resources/Handouts:

Example pictures (see PowerPoint slides 24-26 – these could be printed out or copied onto flipchart paper)
Guidelines for designing posters
Designing a leaflet
Assortment of leaflets and posters for each group to critique

Session Plan:

Ask participants to define Visual Literacy.

Present examples (e.g. as a handout) of some of the pictures that people often have difficulty in recognising (see PowerPoint).

Ask participants to identify what is in the picture and how it might be interpreted. Show research results on the presentation of common pictures

Explain how people have to 'learn' visual literacy and learn the conventions that the visually literate take for granted e.g. perspective. Visual literacy can be learnt quite quickly but pictures may need to be explained to people with no formal education.
**15 minutes**

In pairs ask participants to discuss how they would pre-test a visual aid and what the benefits of pre-testing might be. Ask for feedback from the group and discuss.

Explain that pre-testing is critical when using stand-alone materials but not as important when using visual aids in an interactive exercise to stimulate discussion. It is preferable to use materials that depict the people and context that you are working in but using materials from a different context may even reveal some very interesting findings for the facilitator – especially during the assessment stage of the programme.
**15 minutes**

Divide participants into small groups and provide each group with a set of pictures and ask them to identify potential problems with interpretation.
Discuss in plenary

**15 minutes**

Provide 2 groups with the guidelines for designing posters and some example posters and 2 groups with the handout on designing leaflets along with example leaflets. Ask them to critique the visual aids in the light of the written guidelines.
Feedback to the plenary group and discuss with reference to the current situation.
**30 minutes**

In pairs ask participants to identify two key learning points from the session and discuss these in plenary.
**15 minutes**

**Facilitators Notes/Key Learning Points:**

- People may not be familiar with pictorial conventions and may have to learn to 'read' pictures
- Conventions that are familiar in the West may not be understood by people from other cultures
- People can learn to 'read' pictures quite quickly and that is why interactive visual aids are more useful than stand alone visual aids – especially in an emergency when time for pre-testing may be limited
- If using stand alone pictures in leaflets or posters these will need to be piloted/pre-tested and should adhere to current guidelines
- Using pictures as discussion starters or in interactive ways reduces the need for pre-testing and community members can even prepare their own pictures for discussion

**Where can I find out more?**

Linney, B. Pictures, People and Power
Rohr-Rouendaal, P. Development drawings and How to use them

# Use of Other Promotional Methods and Communication Approaches

Aims:

**This session is designed to:**
Ensure that hygiene promoters are exposed to the range of different communication approaches and methods

Outcomes:

**By the end of the session participants will be able to:**
- Demonstrate how to facilitate drama/street theatre for hygiene promotion.
- Explain how PHAST, Child to Child and Social Marketing can inform hygiene promotion in emergencies.
- Describe how radio and other promotional methods can be used to best effect in an emergency

## 2 Hours 15 Minutes

Resources/Handouts:

- Locally appropriate costumes for street theatre (e.g. hats, sarongs etc.)
- A pair of hand puppets
- Overview of Social Marketing
- Overview of PHAST
- Overview of Child to Child
- Using role plays and drama
- PowerPoint slides 28-32

Session Plan:

Introduction to session aims and outcomes.

Ask participants to brainstorm different approaches or methods for communication in hygiene promotion. Possible answers might include:
- PHAST
- CHAST
- Child to Child
- Social Marketing
- Using radio and TV
- Using puppets
- Home to home visiting
- Drama
- PLA
- Games, competitions etc.

Explain that the term 'approach' will be used to denote a well defined framework and philosophy for carrying out hygiene promotion such as PHAST, Child to Child and Social Marketing whereas the term 'method' will be used to mean the actual activities that are

used such as drama, puppets, three pile sorting etc. In an acute emergency it may be difficult to apply a particular approach in its entirety because time is so limited but we can draw on the methods and to some extent the philosophy advocated by particular approaches.

Show flipchart or PowerPoint to distinguish approaches and methods.
**10 minutes**

Briefly explain about some of the different approaches (facilitators handouts are available in the Orientation Package) inviting participants to explain where possible and give examples from their own experience.
Ask participants what they think is feasible in this situation. Explain that we can adapt these approaches and use many of the methods and principles from them even if we can't use the whole approach as it is used in longer-term programmes. For example PHAST has been adapted for use in emergencies as Faster PHAST where only some of the steps are used, many of the methods that PHAST uses can be used independently as assessment or motivational tools. Child-to-Child activities can be used as well as the principle of working with children because they are major caretakers of younger children. Social Marketing methods such as the mass media are often used in emergencies and the principle of understanding the consumer's perspective that is paramount to enabling change to take place, remains an appropriate goal even in the emergency context.
**20 minutes**

Divide the participants into smaller groups and provide them with the Community Mobiliser training session on 'Using drama and street theatre'. Ask the groups to go through this and to practice the training session using their peers as community mobilisers. Participants should take it in turn to be facilitators.
Ask the groups to be prepared to present a brief excerpt from the training in plenary and invite comments from other groups.
**50 minutes**

Select two communication approaches e.g. child to child and social marketing - that you can adapt to the particular context and in two groups ask participants to find out as much as possible about these. They should put together a plan for how they will adapt the approaches and what specific methods they will use in the current context.
Ask each group to present their plan and to be prepared to respond to questions from the other group.
**40 minutes**

Draw out the key learning from the session and the practical actions that the hygiene promoters will apply in the field.
**15 minutes**

**Facilitators Notes/Key Learning Points:**

- It is helpful to try to identify which methods will be feasible in the specific context prior to the session and to base the session around planning these.
- It may not be possible to run a social marketing programme in the early stages of an emergency as this requires a significant amount of formative research. However, this may be possible in the later stages or where the infrastructure is already in place.

- Hygiene promoters can learn much from the approach of social marketing such as the importance of really understanding the consumer's perspective rather than just providing them with information from the 'expert's perspective.

**Where can I find out more?**

- Hygiene Promotion. A Manual for Relief & Development (implementation chapter)
- Health on Air. A Guide to Creative Radio for Development
- Behaviour Change Communication: A toolkit

# Role of the Hygiene Promoter

## Community Management of Facilities

**Aims:**

**This session is designed to:**
Ensure that hygiene promoters understand how to promote the community management of facilities.

**Outcomes:**

**By the end of the session participants will be able to:**
- Explain the importance of community management of WASH facilities
- Describe their role in promoting effective community management of facilities.

**Time:**

90 Minutes

**Resources/Handouts:**

Oxfam Briefing Document on Community Management
Bujumbura Case Study
Roles and Responsibilities of WASH Committees

**Session Plan:**

Introduction to session aims and outcomes.

Ask participants if people are used to community managed water and sanitation facilities and discuss some of the pros and cons of this.

Ask participants in pairs to discuss if community management is possible in the current situation and why it might be desirable. Invite feedback and discuss.
**10 minutes**

Read the following story to the participants:
**The Story of the Dam**
Once there was a village in rural Africa where the people had a problem with water. Every year the rains came and watered the fields but during the dry season the people had to walk very far to get water for their animals. There was a missionary living nearby and he decided to build a dam. He arranged for all the people to get together to build the wall, the women carrying stones and sand and the men making the concrete and digging. The missionary ordered all the materials from the capital and gave it to the village as a donation. The dam was soon finished and when the rains came, the dam filled and everyone was very happy. The years passed and people started cultivating vegetable gardens around the dam and selling the produce in the market. The village prospered.
The missionary retired and went back to his own country. Then after about 12 years, a

crack appeared in the dam and water started running out. The leaders in the village wrote a letter and took it to the local authorities. "please send this letter to the missionary," they said: "we need to tell him that his dam is broken and he must come and fix it"

Ask participants what can we learn from this story? What did the missionary do wrong? Ask them what happens in the current emergency situation? Is it similar? How do we encourage a sense of ownership even when we need to get things done in a hurry?
**15 minutes**

**Working with Committees**
Discuss the reasons why committees may be necessary – (to build a community's capacity to prioritise needs and take action, to manage and oversee the installation of wells, to ensure long term sustainability etc.?). Ask participants to consider if it is always necessary to set up committees. Brainstorm the kind of support that might be necessary when working with committees to ensure their long-term viability.

Divide the group into smaller groups and distribute copies of a case study such as the Bujumbura case study and give the groups ten minutes to read through. Ask them to consider the following questions and make seven recommendations for the setting up of committees. Feedback recommendations to plenary and discuss.

- What was the process for organising the committees? Do you think these were the right channels to use? Can you suggest any others?
- What were the criteria for a person to be selected as a committee member?
- Was there enough emphasis on representation?
- What were some of the problems with the structure of co-ordination for the committees? What could the solution be?
- Do you think the committees would be sustainable after the project was over?
- What were some of the activities that the committees were involved in?

**30 minutes**

**Financial Management (see facilitator's notes)**
Possible areas to cover: accountability, identifying costs, collection of payments, keeping money, fund administration, simple accounting, remuneration for maintenance work, opening a bank account. You might want to ask the advice and input of the project accountant when running these sessions.

Divide participants in to groups and ask them to imagine various scenarios that could go wrong when a committee is asked to manage its own money. How can you support the community in managing the money better?

Provide an example of a role-play that could be done with the community - a likely scenario might be to do with managing money. For example: A water and sanitation committee has recently been formed and it has been agreed in the community that every one will pay 200 shillings contribution every month to the upkeep of the hand pump. A treasurer has been chosen but he has no experience in keeping records. The treasurer goes from house to house with the Chairman or the Secretary but she takes

the money and puts it into a locked tin without making any records. Some people say they will pay half now and the rest in a week or two week's time. Subsequently the treasurer goes back to collect the remainder of the money but the people say they have already paid. The treasurer argues with them but he is not entirely sure who has paid and who has not. At a subsequent meeting, the committee members ask how much has been collected and the treasurer gets out the box and begins to count. Some members feel there should be more money and accuse the treasurer of taking some.

Ask participants:
How do you think the play ended? What do you think happened to the group? What do you think needs to be done in order to avoid this sort of problem?
**25 minutes**

Draw out the key action points for the hygiene promoters subsequent work in the field
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- Training in community management can take a long time and ongoing support needs to be provided to committees and/or user groups. Along with basic training on setting up a committee, sustainability and financial management it will also be important to look in detail at each specific water/sanitation system to discuss the best way it can be managed. Each situation will be different and the training offered to Hygiene Promoters and to committees will need to respond to the challenges of that particular situation.
- Practical training should also be provided on basic maintenance and repair – preferably early on in the programme - so that trainees can have time to practise their new-found skills.
- An example of a possible activity on financial management is given in the session plan but this may not be appropriate early on in the emergency – the session will need to be adapted to cover the most pertinent issues in each context.
- The committee should be setting an example to the community on the optimum use of facilities and so training sessions on sanitation, hygiene promotion, communication and mobilisation will also be relevant. If time permits, sessions on quality assurance would also be useful so that the committee and community members can monitor the construction of facilities. This would include common problems such as insufficient bags of cement used, inefficient drainage and adherence to safety protocols.
- Community management may not take place after construction of facilities due to the lack of sufficient community ownership and it is important involve the users as far as possible at all stages of the decision-making process when installing and managing facilities.
- Remember that communities should be encouraged to adopt a longer term problem-solving approach when thinking about the management of facilities, even if this is difficult in the early acute stages of an emergency.
- It may be useful to take into consideration the following when promoting community management of facilities:-
    - whether the community feels that the construction of facilities is what they need and want.
    - whether all community sections/groups have been consulted in plans to construct facilities, including the involvement of women.
    - whether the local government and leaders support the project.

- whether discussions on community management have taken place within the community, and between those implementing the community management of facilities, as well as those involved in hygiene promotion and engineering.
- planning for meetings to be held in places which are easy for people to get to, or where they may naturally gather e.g. water source.

The important issues to think about for long-term maintenance of facilities include:-

- how repairs will be managed
- who will do the repairs (and training required)
- who will pay for spare parts and where will they be obtained
- the establishment of water committees for water point maintenance.
- the introduction of user fees for facilities, and the subsequent need for financial accountability (and training required)

Formal agreements regarding the roles of different community members in maintenance are important, in particular the adaptation of such an agreement to suit the specific needs.

The important objectives and indicators for monitoring and evaluating community management include:-

- whether facilities are functioning.
- whether repairs of facilities take place regularly.
- whether those undertaking repairs have received adequate training.
- whether spare parts for facilities are available.
- whether community members are undertaking agreed tasks.
- whether water committees have been established.

**Where can I find out more?**

- Hygiene Promotion. A Practical Manual for Relief & Development pp10-11 & 252-257

# Further/Refresher Training Practice

Aims:

This session is designed to:
Provide further practice in training community groups

Outcomes:

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

- Describe what makes a good trainer
- Plan and adapt training sessions for community groups

# 6 hours

Resources/Handouts:

- WASH Cluster Hygiene Promotion Project: Training of Community Mobilisers
- Visual aids sets (see Visual Aids Library)

Session Plan:

Introduction to aims and outcomes.

Ask participants to read the Guidelines for training Community Mobilisers in the introduction section of the training package and in pairs to discuss 2-3 issues that they can remember from this.

In plenary ask the participants to suggest some of the important points again and clarify these where necessary. Explain that it is important that they find the time to familiarise themselves with the training package including the introduction.
**10 minutes**

Divide participants into pairs and allocate to each pair a different training session from the Training Package for Community Mobilisers. Ask them to practice facilitating the session using the accompanying materials.

In pairs they should aim to prepare each session and to present key excerpts from the session to the rest of the group. For example they should prepare the introduction of the session and activity as a role-play but could then shorten part of the session and simply explain what happens next resuming the role play at critical moments. Each facilitator should try to facilitate for a total of 5-10 minutes for the session. There will then be 10 minutes to discuss each group's mini training session.

Ask for comments from the rest of the group after each 'role play' ensuring that they focus on the positive points first. Make sure that each participant has some constructive feedback on how they can improve their facilitation skills.
**Preparation 1 hour**
**Presentation and Feedback approximately 30 minutes for each pair - maximum 5 hours**

Once each group has presented their training session and this has been discussed ask each group to write down two things they will do differently when they are next training and ask for some suggestions in plenary
**15 minutes**

**Facilitators Notes/Key Learning Points:**

- It is important that participants get a feel for how long some of the training methods may take, as well as which materials fit best with each method and how to involve those being trained.

# Introduction to Baseline Survey

Aims:

| This session is designed to:<br>Provide an introduction to carrying out a baseline survey |
|---|

Outcomes:

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

- Explain why a baseline survey is necessary
- Explain why it is necessary to collect both qualitative and quantitative data
- Explain the concept of sampling
- Explain how a baseline survey is carried out

90 Minutes

Resources/Handouts:

| Designing baseline study<br>PowerPoint Slides 3-6 |
|---|

Session Plan:

Briefly introduce the session

Ask the group what they understand by baseline data. Explain that sometimes the term is used to refer to the pre emergency setting but here it will concern the collection of data against which the progress of the Water, Sanitation and Hygiene Promotion programme can be measured: a baseline is a detailed assessment of the **current situation**. (Some information from prior to the emergency will be also be relevant e.g. mortality and morbidity rates).

Ask the group why they need to collect more information when an assessment has already been made? Explain that the initial rapid assessment will feed into the baseline but the assessment or baseline study they will be doing now will be more detailed and will try to provide more quantitative data to ensure that the programme can be monitored and evaluated effectively (the initial rapid assessment often relies predominantly on qualitative data and estimates of quantitative data).

Explain that although changes have already taken place so that the 'baseline' may be different from the immediate post emergency situation, this is unavoidable in an emergency and it is still important to collect a baseline to help to monitor progress. Show the timeline (see power point slide) illustrating when the baseline is carried out and clarify where necessary
**15 minutes**

Ask the group how they would collect quantitative data. Ask if any have had experience of carrying out a questionnaire survey and ask them to explain how they did this.

Ask for an explanation of sampling and why this is necessary when carrying out a questionnaire survey. Explain the difference in sampling for quantitative data collection and qualitative (random versus purposive sampling – see PowerPoint slides)
**15 minutes**

Ask why it is important or necessary to collect qualitative data also as part of the baseline (gives greater understanding of the problem, helps to define questions to ask in questionnaire survey, acts as a means of crosschecking information e.g. on hand washing)
**10 minutes**

Divide the participants into small groups and ask each group to plan how they would carry out a baseline survey in the current context to collect both quantitative and qualitative data. Ask them to list the necessary steps on flip chart paper.

Ask one group to feedback their plan to the large group and ask for questions, comments and additions from the other participants. Explain that it is necessary to be as practical as possible about the process of baseline data collection in an emergency. When planning the survey they must also consider how they will analyse the data and who will do this.
**40 minutes**

Provide handout on designing a baseline survey. Ensure that any misconceptions are clarified.
**10 minutes**

**Facilitators Notes/Key Learning Points:**

- This session provides an overview only of the baseline data collection process
- The meaning of baseline here refers to the current situation and practices with regard to water, sanitation and hygiene although it may be useful to understand the pre emergency context when doing an assessment e.g. are people used to using latrines or washing hands?
- This session will need to be modified according to the specific approach of the individual agency and it may be preferable to use the time to ensure that participants are familiar with a predetermined plan for baseline data collection
- Some newer technologies for collecting data such as handheld computers (PDAs) may be available in some agencies.
- It is vital to consider the issue of how data will be analysed when designing a baseline survey. Collation and analysis of data can take up a significant amount of time and resources.

**Where can I find out more?**

WASH Information Management Project

# Questionnaire Survey

Aims:

This session is designed to:
Ensure that participants are trained to carry out a questionnaire survey and that the questionnaire is piloted prior to use

Outcomes:

By the end of the session participants will be able to:
- Explain the importance of carrying out a questionnaire survey
- Randomly select households for administration of questionnaire
- Administer and complete questionnaire appropriately
- Collate and analyse data collected

## 2 days approx

Resources/Handouts:

Example Questionnaire
Guidance Notes for carrying out surveys
Clipboards, pencils, rubbers

Session Plan:

The session will need to cover:
- Familiarisation with questionnaire and how to ask questions (when to probe etc.)
- Importance of standardisation of approach when asking questions (asking the same question in different ways can elicit different responses in a questionnaire survey – unlike a focus group where this approach may be desirable)
- Data Collectors etiquette and behaviour with community
- Importance of random sampling and random sampling method
- Piloting of questionnaire and feedback on results – including verification of questionnaires (to ensure that these are filled in correctly, that necessary changes in questions or wording of questions are incorporated, that data collectors are confident to identify households and administer questionnaire – this should usually be done in pairs)
- Rapid input and collation of data using either excel programme (in data collection toolkit) or by using hand tabulation and collation
- Analysis of data - converting to percentages and interpretation of the findings
- How data will be used
- Feedback of data to community involved

Facilitators Notes/Key Learning Points:

- This session will need to be planned according to the specific methodology adopted by each agency but the above session plan gives an idea of what needs to be covered
- Unlike longer term programmes it is not possible to obtain all the necessary information before initiating an emergency response – the baseline will usually be

collected after the programme begins

- Initial assessment data should feed into the baseline study
- Carrying out a questionnaire survey may not always be appropriate if the situation is rapidly changing and people are on the move
- It is also not appropriate if you do not have time to train and support the survey team and analyse the data
- Questionnaires should be kept as short as possible and should be complemented with qualitative information
- Piloting the questionnaire, staff training and support are vital
- Programme staff should be involved in collating and analysing the data
- The outlined survey approach, presented here, represents an attempt to be as rigorous as possible given the constraints and is a 'good enough' technique

**Where can I find out more?**

WASH Information Management Project

# Oral Rehydration Therapy

Aims:

**This session is designed to:**
Ensure that hygiene promoters know how to manage diarrhoea including how to prepare and use oral rehydration solution made from oral rehydration sachets and salt and sugar solution (where appropriate).

Outcomes:

**By the end of the session participants will be able to:**
- Describe the signs and symptoms of dehydration
- Correctly demonstrate how to prepare and administer oral rehydration solution made from oral rehydration salts (sachets) and salt & sugar
- Explain how to manage diarrhoea

# 45 Minutes

Resources/Handouts:

- Picture of dehydrated baby (see Visual Aids Library)
- Wilted plant
- 'Oral rehydration salt sachets, boiled water, measuring utensils, bowl
- Items for making up oral rehydration solution - salt, sugar, spoon, water, bowl.
- 'F' Diagram

Session Plan:

Introduction to session aims and outcomes.

Ask participants what they already know about diarrhoea and how they usually manage diarrhoea at home. Ask them to brainstorm how to prevent diarrhoea. Remind participants of the important link between diarrhoea and malnutrition
**10 minutes**

Use a wilted plant or the diarrhoea doll (plastic bag filled with water with baby's face and body painted onto it) to demonstrate how fluid is lost through episodes of diarrhoea and why this can lead to death.

Demonstrate the preparation of oral rehydration solution (using sachets and salt and sugar where government approved).
**10 minutes**

Divide participants into 3 groups and give each group a task:
- *Group 1:* to prepare and undertake a demonstration of how to make up oral rehydration salts using packets. To make up a song about this.
- *Group 2:* to prepare and undertake a demonstration of how to make up oral rehydration solution using water, salt and sugar. To make up a song about this.
- *Group 3:* to imagine they have to explain to a mother how to manage diarrhoea

**10 minutes**

Ask each group to feedback to larger group and discuss and clarify any problems encountered. Provide handouts.
**15 minutes**

**Facilitators Notes/Key Learning Points:**

- Where there is a problem with specific diarrhoeal diseases such as cholera or dysentery, time will need to be made available to discuss these issues in more depth.
- Diarrhoea is defined as the passage of three or more watery stools in 24 hours. Dysentery is indicated by the passage of blood or mucus in the stools.
- Diarrhoea and dysentery are spread through the faecal oral route as shown in the 'F' diagram
- Diarrhoea can cause dehydration, which can be especially serious in children, the elderly and those who are malnourished and it is useful to know the symptoms of dehydration.
- It is important to understand that ORT will not necessarily stop the diarrhoea straight away but will replace the lost fluid and prevent serious complications of dehydration.
- Administer the solution in small amounts (a teaspoon at a time) if a baby or small child is vomiting. They will still keep down some of the fluid
- Demonstrate how to correctly make up ORS sachets and a home made oral rehydration solution using clean boiled water, salt and sugar (ensure that you promote the locally accepted quantities and measuring materials for home made solution e.g. the use of a clean soda bottle). The actual amount of salt and sugar may vary according to country, and it is important to refer to the national country guidelines. Some countries do not recommend promoting home made rehydration solution.
- It is also important to give other fluids and to continue feeding - including breast milk for babies
- Hygiene Promoters/community workers should encourage attendance at a health clinic if there are any signs of dehydration, if there is blood or mucus in the diarrhoea, or if diarrhoea continues for longer than 7 days.
- Diarrhoea can be prevented by the safe disposal of excreta, hand washing with soap after defaecation & before eating, by reducing flies, by drinking safe water, keeping the compound clean from animals and faeces, eating well cooked and clean food and breastfeeding babies and small children.
- Songs about making oral rehydration fluid using oral rehydration salts from packets and salt & sugar can help people to remember how to make it and administer it.

**Where can I find out more?**

- Hygiene Promotion: A Manual for Relief & Development pp 83-4, 233-236
- Where There is No Doctor (chapter on diarrhoea)

# Cholera Control Issues

**Aims:**

| **This session is designed to:**<br>Ensure that participants are familiar with the response required to an outbreak of cholera |
|---|

**Outcomes:**

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

- Explain the differences between cholera and diarrhoea
- Explain the term AWD
- Describe how to work effectively with others to control cholera

60 minutes

**Resources/Handouts:**

Cholera Toolkit
Cholera Fact sheet (from session on water and sanitation diseases)

**Session Plan:**

Review the signs and symptoms of cholera if previously covered in the session on water and sanitation by dividing the participants into small groups and asking them to imagine that there have been reports of cholera and that they are:

- Group 1: Community Members
- Group 2: Officials from the MoH
- Group 3: A local NGO

Ask them to devise a short role-play of their first reactions to the news and what they plan to do. Tell them that it is useful to include both good and bad reactions.

Ask each group to act out their short scenarios inviting the other groups to make notes but not to comment until all the groups have had a turn. Discuss the role-plays and help the groups to identify useful and harmful responses.
**45 minutes**

Clarify the situation in the current context and the response required by the hygiene promoters in terms of raising/renewing people's awareness of the risks and methods of prevention. Make sure that the hygiene promoters are clear on their specific role and how they will be supported i.e. through regular meetings, supervised fieldwork etc.

**Facilitators Notes/Key Learning Points:**

- Cholera is a severe intestinal infection spread by the faeco-oral route (see F diagram) that can lead to severe dehydration and death very quickly if treatment is not sought promptly. Symptoms usually include diarrhoea and vomiting.
- However, most people infected with Vibrio cholerae do not become ill, although

the bacterium is present in their faeces for 7-14 days. When illness does occur, more than 90% of episodes are of mild or moderate severity and are difficult to distinguish clinically from other types of acute diarrhoea. Less than 10% of ill persons develop typical cholera with signs of moderate or severe dehydration.

- Treatment of severe cases includes rehydration using intravenous fluids and ORT. Unlike most other diarrhoeas, antibiotics are also used.
- The term 'cholera' can be very sensitive for some governments as declaring an epidemic can threaten trade and tourism and undermine the economy
- Adults do not normally die from diarrhoea but cholera can cause severe and rapid dehydration. Cholera should be suspected from any adult death from diarrhoea
- However, adult deaths can also occur during outbreaks of dysentery and other diarrhoeal diseases and confirmation of cholera is only possible using laboratory examination of stool specimens. In the absence of confirmation it is better to use the term Acute Watery Diarrhoea or AWD.
- As with any emergency, collaboration and co-ordination are of the utmost importance
- A campaign response may be required to raise awareness in the community especially where there are regular outbreaks and people have become de-sensitised to ongoing message dissemination.
- All community members should be informed about the disease, students, mothers, workers, patients with other diseases. All possible media should be used: radio, TV, churches, mosques, rallies, public gatherings, posters, booklets, etc.
- The community should be informed that cholera is a highly communicable disease, caused by a microorganism and spread from one person to another through food, water and soiled hands and other items. An apparently healthy person can harbour cholera germs and transmit them to other people or contaminate food and water when hygienic conditions are defective. The germ is easily killed by heat (boiling water, cooking food) or by disinfectants such as chlorine. Washing hands with soap and water help get rid of germs on hands (WHO)

**Where can I find out more?**

WHO website: http://www.who.int/topics/cholera/en/

# Malaria Control Issues

Aims:

This session is designed to:
Ensure that participants are aware of what they can do to help control malaria

Outcomes:

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

- Describe malaria transmission risk in the context they are working in
- List the most effective means of prevention in the current context
- Describe how to work with communities to control cholera

## 3.5 Hours

Resources/Handouts:

Malaria Quiz
PowerPoint slides 8 and 9
Focus group discussion framework
RBM Information Sheet
Child to Child activity sheet on malaria

Session Plan:

**Introduction**
Ask participants to think of some of the reasons why emergencies make people more vulnerable to malaria. Some of the suggestions should include:

- breakdown of health services and national malaria control programmes
- limited access to populations at risk
- environmental factors such as flooding, drought
- weakened immunity due to malnutrition and multiple infections
- environmental deterioration that encourages vectors to breed and increases the exposure of the population at risk

**Exercise 1**
Ask participants to fill in the malaria quiz individually and then go through the answers with the whole group (make sure that you know the answers for your context before you start).
**1 hour**

Make sure that participants are all familiar with the signs and symptoms of malaria and when to seek treatment for themselves or their families.
**15 minutes**

**Exercise 2**
Divide participants into small groups and ask them to imagine they are conducting an assessment of malaria and what questions they would need to ask.

Feedback in plenary and correct any misconceptions.

**30 minutes**

Exercise 3
Divide participants into 2 large groups and ask for 2 volunteer facilitators for each group. Provide the facilitators with the focus group framework and ask them to conduct a focus group with the rest of the participants in order to understand their experience of malaria.
**30 minutes**

Allow each group the chance to reflect on their findings from the focus group and organise the data.
**15 minutes**

Discuss the findings and the process in plenary.
**15 minutes**

Exercise 4
Divide the participants into small groups and ask them to think of some of the important ways that HP teams can help to promote control of malaria in the affected community. Remind them to think of the different groups represented in the population.

Ask one group to feedback in plenary and ask for additional suggestions from the other groups.
**30 minutes total**

Outline the current or intended programme and what will be expected of the hygiene promoters.
**15 minutes**

Facilitators Notes/Key Learning Points:

- This session must be designed with the proposed intervention in mind and tailored to take account of what the participants already know. The quiz is designed to help assess their knowledge but a three pile sorting activity could also help to determine this.
- Hygiene promoters must co-ordinate with the MoH and health sector to ensure an effective malaria control intervention
- Early diagnosis and treatment is vital especially in children under five years and those with cerebral malaria
- If children aged between 0-59 months get malaria, they must be treated the same day that they begin feeling ill.
- Once the child no longer has malaria the mother must give the child good wholesome food for the next two weeks.
- Take all the treatment prescribed and do not stop mid course if symptoms improve.
- If bed nets (Insecticide treated nets - ITNs or preferably long lasting insecticide treated nets - LLINs) are to be used then families must be mobilised to use them correctly
- Where priorities need to be defined, those usually most at risk are pregnant women and children under five years
- If IRS Indoor residual spraying is to be carried out people must be consulted and provided with information about the process and safety issues

- A thorough social assessment of such issues as sleeping patterns, family dynamics and decision making should be undertaken to define the most appropriate approach to mobilisation
- Remember the important link between HIV/AIDS, TB and Malaria

**Where can I find out more?**

www.who.int/malaria/

**Notes/Suggestions to improve Future Training**

# Appendices:

## Job Descriptions

## WASH Cluster Generic Job Description: Hygiene Promotion Co-ordinator

| | |
|---|---|
| Job title: | **Hygiene Promotion Coordinator** |
| Reports to: | WASH Team Leader |
| Manages: | Hygiene Promoters and Community Mobilisers |

### Purpose:

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

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

### Key tasks and responsibilities:

#### Information management

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

#### Implementation

Ensure and oversee the following activities:

- Identification of key hygiene practices to be addressed and sectors of the population with whom to engage and develop an appropriate communications strategy to promote safe practices.

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

**Resources management**

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

**Programme approach**

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

**Person specification:**

1. Knowledge of public health and one or more other relevant area (e.g. health promotion, community development, education, community water supply).

2. At least two years of practical experience in developing countries in appropriate community health programmes in different contexts. Some of this time should have been in emergency relief programmes.

3. Good knowledge and experience of working with local partner agencies with a capacity to provide formal and informal training.
4. Experience and understanding of Hygiene Promotion and community mobilisation in relation to water and sanitation activities.
5. Understanding of international health and development and relief issues.
6. Sensitivity to the needs and priorities of disaster-affected populations.
7. Demonstrated experience of integrating gender and diversity issues into public health promotion.
8. Assessment, analytical, and planning skills.
9. Good oral and written reporting skills.
10. Diplomacy, tact, and negotiating skills.
11. Training/counterpart development skills.
12. Personnel management skills.
13. Good communication skills and ability to work well in a team.
14. Ability to work well under pressure and in response to changing needs.
15. Ability to travel at short notice and to work in difficult circumstances.
16. Good written and spoken skills in the language of the humanitarian operation.

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

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December 2007

# WASH cluster generic job description: Hygiene Promoter

| | |
|---|---|
| **Job title:** | **Hygiene Promoter** |
| **Reports to:** | Hygiene Promotion Coordinator |
| **Manages:** | Community Mobilisers |

**Purpose:**

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

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

**Key tasks and responsibilities:**

**Information management**

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

**Implementation**

- Promote safe WASH practices, including appropriate use and maintenance of WASH facilities and services.
- Ensure that action is taken to mitigate priority water and sanitation related health risks.
- Facilitate appropriate community involvement in the design and delivery of essential WASH services and facilities.
- Enable effective dialogue with the affected community to allow the agency to be held to account for the quality of the WASH programme.
- Help identify needs for non-food items relevant to hygiene, participate in the choice of items, targeting strategy, promotion of effective use, and post-distribution monitoring.

**Resources management**

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

**Programme approach**

- Supervise Hygiene Promotion activities in line with relevant standards, codes of conduct, and humanitarian principles.

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

**Person specification:**

1. Knowledge of one or more of the following: public health, health or Hygiene Promotion, community development, education, or community water supply and sanitation.

2. At least two years of practical experience in the country concerned, in relevant community development, health, WASH, or similar programmes.

3. Good knowledge and experience of working with local partner agencies.

4. Experience and understanding of Hygiene Promotion and community mobilisation in relation to water and sanitation activities.

5. Sensitivity to the needs and priorities of different sectors of a community.


6. Familiarity with the culture of the affected population, ability to develop respect from a wide range of people and strong ability to communicate effectively on hygiene matters.

7. Fluency in the language of the affected population and the international language used in the humanitarian operation.

8. Assessment, analytical, and planning skills.

9. Good oral and written reporting skills.

10. Diplomacy, tact, and negotiating skills.

11. Training/counterpart development skills.

12. Personnel management skills.

13. Ability to work well in a team in difficult circumstances.

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

# Terminology and Definitions[7]

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

Health Promotion **is the process of enabling people to increase control over, and to improve, their health. The Ottawa Charter[8](1986) defined five key principles of health promotion:**

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

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

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

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

**The difference between Hygiene Promotion and health promotion;** Hygiene Promotion is more specific and more targeted than health promotion. It focuses on the reduction – and ultimately the elimination – of diseases and deaths that originate from poor

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

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

hygiene conditions and practices. For example, good hygiene conditions and practices are enhanced when people can consume water that is safe, use sufficient amounts of water for personal and domestic cleanliness, and dispose of their solid and liquid wastes safely. A person may have good hygiene behaviour, but not be healthy for other reasons. Good or bad health is influenced by many factors, such as the environment (physical, social, and economic). For example, in social environments where people are marginalised because of their gender, economic status or religious affiliation, and have no influence whatsoever on decisions that affect their daily lives, they are likely to be prone to anxiety or depression, which can lead to mental problems.

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

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

**Behaviour change communication (BCC)** is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education, and communication (IEC) programmes to promote more tailored messages, greater dialogue, and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programmes to ensure sustainable change in attitudes and behaviour.[9]

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

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

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

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

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

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

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

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

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

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

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

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

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

**Outputs** refer to the specific deliverables or products of a water, sanitation, and hygiene programme. This could be the coverage of latrines, protected water sources, handwashing

facilities, community mobilisers, or household distributions of hygiene items. **Outcomes** refer to the expected consequence of having such outputs e.g. the use and maintenance of latrines and handwashing facilities or the effective use of hygiene items.

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

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

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

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

December 2007

# Part 2: Useful To Know Training for Hygiene Promoters

## Available Handouts

These handouts are taken or adapted from the following publications or resources:

1. O'Reilly, M. Walden, V. & Yetter, M. (2007) Humanitarian Programmes and HIV and AIDS A Practical approach to Mainstreaming Oxfam Publishing, Oxford
2. Ferron S. Morgan, J. & O'Reilly M. (2007) Hygiene Promotion: A Practical Manual for Relief & Development IT Publications, London
3. The National Institute of Diabetes and Digestive and Kidney Diseases Diarrhoea Factsheet
4. Figueroa, M.E., Lawrence Kincaid, D. Rani, M., Lewis, G. (2002) Communication for Social Change, Working Paper Series: The Rockefeller Foundation and Johns Hopkins University Center for Communication Programs
5. Linney,B. (1995) Pictures, people and power. Hong Kong: Macmillan.
6. LSHTM/WEDC (1998). Guidance Manual on Water Supply and Sanitation Programmes, Published by WEDC for DFID.
7. IFRC (various) Gender Checklist, ARCHI toolkits
8. Oxfam (various) Malaria Control Guidelines, PHP Training Manual and PHP Guidelines
9. Swithern, S. & Hastie, R. (2008) Improving the Safety of Civilians: A Protection Training Pack, Oxfam Publications, Oxford

Websites
http://www.pressureworks.org.uk/usefulstuff/how/leaflet.html
http://www.cartercenter.org/health/trachoma_education/leaflets.html
www.cdc.gov/hiv/resources/guidelines/herrg/pub-info_educational.htm
www.sphereproject.org
www.child-to-child.org
www.who.int/mediacentre/factsheets/en/

# Context

## Water & Sanitation Related Diseases

- Table of transmission of diseases
- Disease fact sheets
- WASH related diseases
- Pair wise Ranking Instructions

## The Sphere Project

Minimum standards for water, sanitation and hygiene promotion (*items (available from www.sphereproject.org )*
Minimum standards for shelter and non food items (*items (available from www.sphereproject.org )*

- Hygiene Promotion and Sphere

## Introduction to Gender

- Gender checklist

## Introduction to Protection

- Protection Handout

## Introduction to HIV/AIDS

- Hygiene Promotion and HIV/AIDS
- HIV transmission three pile sorting exercise

## Community Participation

- Gender and Community Participation Worksheet
- Participation Ladder Exercise
- Roles and Statements for the Power Walk (optional exercise)
- How to do a Venn Diagram (optional exercise)

# Transmission patterns and preventive measures

## For water- and sanitation-related diseases common in emergency situations

| Infection | Transmission pattern | Human excreta disposal | Solid waste dispo sal | Waste water disposal | Safe water chain | Hand-washing | Food hygie ne | Washing clothes and body |
|---|---|---|---|---|---|---|---|---|
| Various types of diarrhoea, dysentery, poliomyelitis, typhoid and paratyphoid, hepatitis A | From human faeces to mouth (faecal-oral) via multiple routes of faecal contaminated water, fingers and hands, food, soil and surfaces. Animal faeces may also contain diarrhoeal disease organisms. | ✓ | ✓ | | ✓ | ✓ | ✓ | |
| Roundworm (Ascariasis), Whipworm (Trichuriasis) | From faeces to mouth: Worm eggs in human faeces have to reach soil to develop into an infective stage before being ingested through raw food, dirty hands and playing with things that have been in contact with infected soil. Soil on feet and shoes can transport the eggs long distances. Animals eating human faeces pass on the eggs in their own faeces. | ✓ | ✓ | | | ✓ | ✓ | |
| Hookworm | From faeces to skin (especially feet): Worm eggs in the faeces have to reach moist soil, where they hatch into larvae which enter the skin of people's feet. | ✓ | | | | | | |
| Schistosomiasis (Bilharzia) | From faeces to urine to skin: Worm eggs in human faeces or urine have to reach water where they hatch and enter snails. In the snails they develop and are passed on as free swimming "cercariae" which penetrate the skin when people come into contact with infested waters. | ✓ | | | ✓ | | | |
| Scabies, RingwormYaws | From skin to skin: Both through direct skin contact and through sharing of clothes, bedclothes and towels. | | | | | | | ✓ |
| Trachoma, Conjunctivitis | From eyes to eyes: Both direct contact with the discharge from an infected eye and through contact with articles soiled by a discharge, such as towels, bedding, clothing, wash basins, washing water. Flies may also act as transmission agents. | | | | | | | ✓ |
| Louse-borne typhus, Louse-born relapsing fever | From person to person: Through bites of body lice which travel from person to person contact and through sharing clothes and bedclothes, particularly when underwear is not regularly washed. | | | | | | | ✓ |
| Malaria, Dengue fever, Yellow fever | From person to person through the bite of infected mosquitoes. The mosquito breeds in standing water. | | | ✓ | | | | |
| Leishmaniasis | From person to person through the bite of an infected phlebotomine sandflies. The sandflies breed in damp organic debris including excreta and solid waste. | ✓ | ✓ | | | | | |

Source: Ferron S. Morgan, J. & O'Reilly M. (2007) *Hygiene Promotion: A Practical Manual for Relief & Development* IT Publications, London (Adapted from Boot,M.T., and Cairncross, A., 1993 and Ministry of Health, Uganda (1998a and b)

# Faecal-Oral Diseases[10]

The diseases in this category are caused by faeces from a person infected with the disease entering the mouth of another person. Different faecal-oral diseases include diarrhoea (dysentery, cholera, giardia), typhoid and intestinal worms.

**Symptoms of diarrhoea**

Diarrhoea is the frequent passing of watery stools and there are many different types. It is one of the major causes of morbidity and mortality especially in refugee situations but even in non-emergency situations is responsible for a significant proportion of the burden of disease. Diarrhoea can be caused by bacteria, protozoa or viruses and these organisms may also cause other symptoms such as fever and vomiting. The passing of frequent stools can be seen as the body's normal response to rid it of the harmful disease causing organisms. If the fluid lost in the diarrhoea is not replaced, the person infected may become severely dehydrated. Dehydration can cause death, especially in the very young and old. People who are poorly nourished will also be more at risk from the effects of diarrhoea.

The organisms that cause diarrhoea are present in large numbers in the faeces and people are infected with these organisms through the mouth. These diseases are thus known as faecal-oral diseases. Even if only a few organisms are swallowed, these will multiply in the intestines and cause diarrhoea.

Even babies excrete disease causing organisms in their faeces. In fact, infants' faeces contain more disease causing organisms per gram than there are in adults' faeces. As babies and young children are more susceptible to these diseases, their faeces should be considered more dangerous than adults' faeces

There are a variety of organisms that cause diarrhoea: the following represent only some of them. With the majority of diarrhoeas it may not be possible to diagnose a particular cause.

**Dysentery**

Dysentery is a form of bloody diarrhoea transmitted through the faecal-oral route. When people become infected, they excrete large numbers of the infective organisms in their stools. If the germs from these stools come into contact with food, water or hands then other people can swallow the germs and become infected.

A person with dysentery passes faeces containing blood. This is accompanied by fever, vomiting and stomach pains. It is usually caused by an organism known as S*higella* which has a variety of different forms. ***Shigella* dysentery** is endemic in many countries in the tropics reaching its highest incidence in the rainy seasons.

The disease usually occurs in two phases - an initial phase with fever and watery stools that can be very serious and cause dehydration and delirium especially in children. The latter phase is accompanied with loose, frequent stools containing blood and mucus and may cause severe discomfort and pain.

The only proven way of preventing infection and transmission of all types of *Shigella* dysentery is handwashing with soap (and breast-feeding for infants). Methods for preventing other forms of diarrhoea are also likely to reduce the transmission of dysentery.

**Amoebic dysentery** is the type of diarrhoea or dysentery (diarrhoea with blood) caused by the protozoa called *Amoeba*. *Amoeba* may also cause abscesses in the liver, which can cause extreme pain in the right upper belly. Usually the diarrhoea comes and goes and there may even be

[10] Adapted from Hygiene Promotion Manual: From relief to development

constipation. There are cramps in the belly and the person experiences an urgent need to pass stools even when there is very little stool there. With amoebas there is usually no fever.

### Cholera

Cholera is caused by one particular type of bacteria called *Vibreo cholera.* Symptoms are usually mild but in a minority of cases there is a rapid onset of severe watery diarrhoea and vomiting and sometimes cramps in stomach, arms or legs. So much water and salts are lost from the body of a person with cholera that the person become thirsty, stops urinating, and quickly becomes weak and dehydrated. Dehydration can lead to circulatory collapse and death. To prevent dehydration, the person must drink at least the volume of fluid the body is losing. Drinking oral rehydration solution (ORS) will replace salts and sugars which have also been lost from the body. A vaccination against cholera is available but is not effective in controlling large outbreaks of cholera and is no longer recommended by the World Health Organisation.

**Special measures to prevent the spread of cholera during an outbreak include:**

- Try to identify the source of the cholera and whether particular areas or people are affected.
- Prevent use of contaminated water sources
- Intensify information campaign to promote hand washing, use of latrines and prompt identification and treatment (case finders may be necessary to identify patients on home visits)
- Establish emergency isolation centres for sick patients (special precautions for disinfection should be in operation here)
- Establish ORS centres to provide rehydration of less severe cases

**Management of cholera patients in an outbreak:**

- Help them to drink plenty of fluid (preferably ORS) to prevent the dehydration which kills
- Help them get medical attention immediately
- Dispose of faeces in a latrine
- Wash hands frequently and thoroughly with soap and water

### Typhoid

Typhoid is a faecal-oral disease causing loose stools and a gradually increasing fever often accompanied by a relatively slow pulse. People with typhoid fever usually feel very unwell with generalised aches and pains and loss of appetite. Delirium (not being able to think clearly or make sense) may also be present as the illness progresses. The organism that causes typhoid is known as *Salmonella typhi*. The illness may often cause death if not treated.

### Making oral rehydration solution

Drinking plenty of any drink available in the home will help to prevent dehydration.

Oral rehydration solution (ORS) is a special mixture of salts and sugars. When ORS solution is given to someone with dehydration, it will assist rehydration very quickly. ORS sachets are available for mixing with water. They can be obtained at health units, pharmacies and at other retail outlets.

To make ORS follow the instructions on the packet. Usually these are the instructions:
1. Add one sachet of ORS salts to one litre of drinking water,
2. Mix thoroughly,
3. Taste the drink to make sure it is less salty than tears.
4. Give a dehydrated person sips to drink every five minutes, day or night, until they begin to urinate normally.

If a person has diarrhoea and there is no ORS available, the person should drink plenty of other fluids such as water, porridge drinks, soups, coconut milk etc. to stop dehydration.

### Giardia

*Giardia* is a faecal-oral disease. The symptoms are foul-smelling yellow diarrhoea which has bubbles in it. If blood or mucus is present it is probably not *Giardia*. In addition the belly is swollen and uncomfortable and produces lots of gas. *Giardia* can clear up without medical treatment but if the diarrhoea goes on for more than ten days it is best to seek medical advice. Long-term infection with *Giardia* can cause significant weight loss.

### Hepatitis A

Hepatitis A is another faecal-oral disease. The disease causes acute inflammation of the liver. It usually starts with fever, chills, headaches and fatigue. A few days later there is often loss of appetite, vomiting, dark urine and light coloured faeces and jaundice of the skin or the outer coating of the eyeballs. In young children there may be few symptoms but in older people the jaundice may be severe and prolonged; complete liver failure may occur and the patient may lapse into a coma. There are other forms of hepatitis with similar symptoms but which are not transmitted through the faecal oral route but through blood and sexual contact.

### Roundworm

As their name suggests these worms are round and can be up to 30 centimetres in length. They live in the intestines and feed off whatever food is ingested. This may make the person feel very weak as he/she is not getting enough food to eat. The worms may also block the intestine and cause problems with defecation.

The roundworm eggs follow the faecal oral route of transmission usually through unclean fingers or unwashed fruit and raw vegetables. Raw fruit and vegetables may become contaminated when people with roundworm defecate on the ground near to where vegetables or fruit are growing. Because children often put their fingers and other objects in their mouths they are often more at risk.

### Whip worm

Whip worms are small thin worms and look like sewing threads. Infection occurs in a similar way to roundworm, but infection is less likely to be from eating contaminated fruit and raw vegetables as the eggs are more easily killed by drying or by direct sunlight.

### Pin worm

Pin worms are very small, thin worms. The worms live in the intestines and at night they emerge from the anus to lay eggs around the opening. Pin worms cause severe itching around the anus. Whenever the person scratches, the eggs will contaminate the fingers and they may re-infect the person if they then put their fingers in their mouth.

### Transmission and prevention of all faecal-oral diseases

The "5-Fs" diagram illustrates the main ways in which diarrhoea may be transmitted and the ways they can be prevented. It summarises the main ways in which faecal-oral diseases are spread – by faecal germs contaminating fields, fluids, fingers, flies or food, then eventually being swallowed. Most latrines will stop the 'fluids' and 'fields' transmission routes. Some of the more sophisticated latrines such as the ventilated improved pit (VIP) latrine and pour-flush latrine may also break the 'flies' route. Using a latrine does not prevent the contamination of hands and fingers. Good hygiene practices are needed for this, particularly the washing of hands with soap after contact with faeces (i.e. after defecation or after cleaning a child).

**Hygiene practices that prevent all faecal-oral diseases**

The magnitude of risk varies with different hygiene practices. Three practices are considered to be the most significant and cost-effective in preventing faecal-oral diseases. These are:

- Dispose of faeces safely. Use a latrine or bury faeces including young children's and babies'.
- Clean hands frequently with soap or ashes especially after defecation and after clearing up babies' faeces.

- Maintaining drinking water free from faecal contamination.

Other less important prevention methods are related to food hygiene:

- Wash hands with soap before preparing or eating food.
- Protect food from flies.
- Cook meals thoroughly.
- Wash raw vegetables and fruit in clean water before eating.

### Hookworm

Hookworms are not strictly a faecal oral disease, instead they are a faecal-soil related disease. It can be one of the most damaging diseases of childhood and thrives in overcrowded unsanitary conditions. Hookworms are small and red in colour. They live in the intestines and feed on the blood by hooking onto the wall of the gut. If there are many worms the person may become anaemic and feel very weak and tired. Hookworm eggs are excreted in the stools. Once outside the body they develop into tiny worms (larvae). If someone walks on the contaminated ground without any shoes, the worms will pierce the skin of the feet, enter the bloodstream and eventually find their way to the lungs where they develop and feed on blood. When they are mature, the worms are coughed up from the lungs and if the person swallows them in the sputum, they enter the intestine, lay their eggs and the new host then excretes their eggs and the life-cycle starts again.

**Prevention of Hookworm**

- Build and use latrines.
- Children should not walk around barefoot.

## Vector-Borne Diseases

Certain diseases are spread by insect vectors which live in, or breed near, water. This group includes such diseases as Malaria, Filariasis, Dengue fever, Yellow Fever, River Blindness, leishmaniasis, sleeping sickness and guinea worm infections. Refugees may be at particular risk because there may be diseases that they are not used to in the new area of settlement. They will therefore not have built up protection or immunity against these diseases.

### Malaria

Malaria is the single most important vector-borne disease. The malaria spreading mosquitoes are all types of *Anopheles mosquitoes* and can be distinguished from other mosquitoes because they rest at an angle. There are several species of *Anopheles* mosquitoes, most can breed in still, unpolluted water including swamps and containers. Until recently mosquitoes could not breed above 3000m altitude but recently have started to breed at higher altitudes. *Anopheles* feed on people at night. It is only the females that bite because they need a blood meal every 2-3 days to develop each batch of 100-200 eggs. When a mosquito bites its victim to suck blood, it first injects saliva to prevent the blood from clotting and blocking its mouth-parts. In malaria-infected mosquitoes, the saliva contains infective forms of the parasite (*Plasmodium).* Most *Anopheles* fly up to 2km from their breeding site to feed. The adults live for about 30 days and many are resistant to insecticides. Different types of Anopheles mosquitoes live in different habitats, for example *Anopheles gambiae* larvae prefer the sun or partial shade and do not like thick bush. *Anopheles funestus* and *Anopheles mucheti*, which can also spread malaria, may infest shaded waters such as lakes and swamps. *Anopheles bwambae* lives in hot salt springs in some places.

*Malaria increased significantly when Rwandans from malaria free highland areas were forced to flee into lowland areas in Zaire and Tanzania during 1994.*

**Control of Malaria**

Control of malaria and other mosquito borne infections is difficult and requires multiple measures. One of the most important measures may be the choice of settlement. Other measures that can be taken locally include:

- Removing anything that might collect stagnant water such as tin cans, broken bottles.
- Ensuring adequate drainage around shelters or houses and water collection points using ditches and soakaways.
- Cut grass and plants around the home or shelter where they may attract mosquitoes
- Covering water storage jars, rainwater tanks.
- Draining or filling in places where rain and washing water collects, including ponds or small puddles.
- Distributing bed nets.
- Planting of neem trees (*Azadriachta indica)* which repel mosquitoes.

Spraying the homes or water bodies in or around a camp or settlement may be an option but care must be taken to use trained personnel who are properly protected.

### Schistosomiasis (bilharzia)

Blood flukes (Bilharzia, Schistosomiasis) is an infection caused by a kind of worm that gets into the bloodstream. It is becoming an increasingly common disease. In addition to being painful, causing weakness and fever, the kidneys or liver may be badly damaged, which can eventually cause death. There are several types of blood flukes including:

- *Schistosoma haematobium* which can cause blood in urine and is spread through infected urine,
- *Schistosoma mansoni* which causes bloody diarrhoea and is spread through faeces.

Blood flukes are not spread directly from person to person. Part of their life must be spent inside a certain small water snail (*Bulinus* species or *Biophalaria* species*)*. An infected person urinates or defecates in water, passing the worm eggs into the water too. Worm eggs hatch and pass into the snails. Young stages of the worm leave the snail and then bury into the skin of a person who enters the water. In this way, someone who washes or swims in water where an infected person has urinated or defecated also becomes infected. To prevent blood flukes, the life cycle of the blood fluke must be disrupted.

**Prevention of Schistosomiasis**

Control and prevention of *Schistosomiasis* is difficult but measures include:

- Safe disposal of faeces and urine by all members of the community. (Even if one infected person urinates in snail infested water, those snails will continue to produce worms for a long period of time.)

- Avoid skin contact with contaminated water. This means avoiding swimming, washing, clothes washing, walking or playing in contaminated water.

- If contaminated water is collected all the worms will die within forty eight hours providing all the snails are removed and will then be safe for washing in.

### Hygiene-Related Skin and Eye Infections

These diseases are not caught by drinking or bathing in infected water but like the diarrhoeas and some of the worm infections they can be prevented by the use of an increased quantity of water for personal and household hygiene.

### Scabies

Scabies is a disease causing very itchy little bumps on the skin. The bumps can appear anywhere on the body but are most common between the fingers, on the wrists, around the waist, on the genitals and between the toes. The bumps are small mites living just under the skin which make it itch. Scratching the infected skin can help to spread the disease and may also lead to skin lesions that in turn can become infected with bacteria. Scabies is spread by touching the infected skin, clothes or bed-clothes of a person with scabies. The disease is very common in children and spreads most rapidly in overcrowded conditions.

**Prevention of Scabies**

- Bathe and change clothes regularly.
- Wash all clothes and bedding regularly and hang them in the sun.
- If possible, don't let untreated infected children have contact with uninfected children.

### Ringworm

Ringworm is caused by a fungal infection. It appears as small rings on the skin usually on the head, between the legs, between the toes, and under the nails. If it appears on the head it often causes the hair to fall out and the scalp develops round scaly patches. Finger and toe nails infected with ringworm become rough and thick. The disease is very common in children and spreads most rapidly in overcrowded conditions.

**Prevention of Ringworm**

- Bathe and wash clothes regularly.
- Do not let a child with ringworm sleep with others.

### Trachoma

Trachoma is a chronic eye infection that gets slowly worse. It may last for months or years and can cause blindness if not treated. Tracoma begins with red, watery eyes like conjunctivitis but after a month or more, small lumps develop inside the upper eyelids. These small lumps begin to disappear in a few years to leave scars which make the eyelids thick and may keep them from opening and closing all the way. The scarring may pull the eyelashes down into the eye, scratching the eye and causing blindness. Trachoma produces a discharge from the eyes and is usually spread when the discharge from an infected person comes into contact with another person by flies, contaminated fingers, cloths, towels or bedclothes. It is very common in dry, dusty areas where water is in short supply, particularly among young children.

**Prevention of Trachoma**

- Wash the face every day with soap and water.
- Keep flies away from the face.

### Conjunctivitis

Conjunctivitis is another eye disease. It causes the eyes to become red and watery. The eye becomes sore. The eyelids often stick together after sleep. It is especially common in children. It is easily spread from one person to another person by flies, fingers, cloths, towels or bedclothes that have been contaminated by the eyes of an infected person.

**Prevention of Conjunctivitis**

- Wash the face every day with soap and water.
- Keep flies away from the face.

### Typhus and Plague

Rats carry fleas which can spread diseases such as Thyphus. Typhus can also be spread by lice or ticks carried by other animals. Typhus begins like a bad cold and leads to fever and aches and

pains in the head and muscles. A rash appears after a few days, first in the armpits and then on the body, then the arms and legs. The rash looks like small bruises. The plague is also spread by rodents. The symptoms include high fever, headache, muscular pains, shaking chills, and often pain in the groin or armpit. The fatality rate for people with plague is between 60-65%.

**Prevention of Typhus and Plague**

- Bathe and wash clothes regularly. De-louse the whole family regularly.
- Hang clothes and bedding out in the sun frequently.
- Keep animals such as dogs out of dwellings.
- Discourage rats by burning or burying rubbish and protecting food supplies
- Kill rats. Set traps and then drown or burn dead rats.

Poison should be used only if strict controls are possible as some rodents may be a source of human food or poison may be allowed to contaminate other food for human consumption

# Diarrhoea Fact Sheet

(adapted from National Institute of Diabetes and Digestive and Kidney Diseases Factsheet)

## Definition of Diarrhoea

Diarrhoea--loose, watery stools occurring more than three times in one day--is a common problem that usually lasts a day or two and goes away on its own without any special treatment. However, prolonged diarrhoea can be a sign of other problems.

Diarrhoea can cause dehydration, which means the body lacks enough fluid to function properly. Dehydration is particularly dangerous in children and the elderly, and it must be treated promptly to avoid serious health problems. Dehydration is discussed below.

People of all ages can get diarrhoea but the under five years age group are most vulnerable to disease and death. It is unusual for an adult to die from simple diarrhoea. If an adult is reported to have died from diarrhoea then cholera should be suspected.
The average adult has a bout of diarrhoea about four times a year.

### What Causes Diarrhoea?

Diarrhoea may be caused by a temporary problem, like an infection, or a chronic problem, like an intestinal disease. A few of the more common causes of diarrhoea are

- Bacterial infections. Several types of bacteria, consumed through contaminated food or water, can cause diarrhoea. Common culprits include *Campylobacter, Salmonella, Shigella,* and *Escherichia coli.*
- Viral infections. Many viruses cause diarrhoea, including rotavirus, Norwalk virus, cytomegalovirus, herpes simplex virus, and viral hepatitis.
- Food intolerances. Some people are unable to digest a component of food, such as lactose, the sugar found in milk.
- Parasites. Parasites can enter the body through food or water and settle in the digestive system. Parasites that cause diarrhoea include *Giardia lamblia, Entamoeba histolytica,* and *Cryptosporidium.*
- Reaction to medicines, such as antibiotics, blood pressure medications, and antacids containing magnesium.
- Intestinal diseases, like inflammatory bowel disease or celiac disease.
- Functional bowel disorders, such as irritable bowel syndrome, in which the intestines do not work normally.

Some people develop diarrhoea after stomach surgery or removal of the gallbladder. The reason may be a change in how quickly food moves through the digestive system after stomach surgery or an increase in bile in the colon that can occur after gallbladder surgery.

In many cases, the cause of diarrhoea cannot be found. As long as diarrhoea goes away on its own, an extensive search for the cause is not usually necessary.

People who visit foreign countries are at risk for traveller's diarrhoea, which is caused by eating food or drinking water contaminated with bacteria, viruses, or, sometimes, parasites. Traveller's diarrhoea is a particular problem for people visiting developing countries. Visitors to the United States, Canada, most European countries, Japan, Australia, and New Zealand do not face much risk for traveller's diarrhoea.

### What Are the Symptoms?

Diarrhoea may be accompanied by cramping abdominal pain, bloating, nausea, or an urgent need to use the bathroom. Depending on the cause, a person may have a fever or bloody stools.

Diarrhoea can be either acute or chronic. The acute form, which lasts less than 3 weeks, is usually related to a bacterial, viral, or parasitic infection. Chronic diarrhoea lasts more than 3 weeks and is usually related to functional disorders like irritable bowel syndrome or diseases like celiac disease or inflammatory bowel disease.

### Diarrhoea in Children

Children can have acute (short-term) or chronic (long-term) forms of diarrhoea. Causes include bacteria, viruses, parasites, medications, functional disorders, and food sensitivities. Infection with the rotavirus is the most common cause of acute childhood diarrhoea. Rotavirus diarrhoea usually resolves in 5 to 8 days.

Medications to treat diarrhoea in adults can be dangerous to children and should be given only under a doctor's guidance.

Diarrhoea can be dangerous in newborns and infants. In small children, severe diarrhoea lasting just a day or two can lead to dehydration. Because a child can die from dehydration within a few days, the main treatment for diarrhoea in children is rehydration. Rehydration is discussed below.

**Take your child to the doctor if any of the following symptoms appear:**

- Stools containing blood or pus, or black stools
- Temperature above 101.4 degrees Fahrenheit
- No improvement after 24 hours
- Signs of dehydration (see below)

### What Is Dehydration?

**General signs of dehydration include:**

- Thirst
- Less frequent urination
- Dry skin
- Fatigue
- Light-headedness
- Dark coloured urine

**Signs of dehydration in children include:**

- Dry mouth and tongue
- No tears when crying
- No wet diapers for 3 hours or more
- Sunken abdomen, eyes, or cheeks
- High fever
- Listlessness or irritability
- Skin that does not flatten when pinched and released

If you suspect that you or your child is dehydrated, call the doctor immediately. Severe dehydration may require hospitalisation.

### When Should a Doctor Be Consulted?

Although usually not harmful, diarrhoea can become dangerous or signal a more serious problem.

You should see the doctor if:

- You have diarrhoea for more than 3 days.
- You have severe pain in the abdomen or rectum.
- You have a fever of 102 degrees Fahrenheit or higher.
- You see blood in your stool or have black, tarry stools.
- You have signs of dehydration.

If your child has diarrhoea, do not hesitate to call the doctor for advice. Diarrhoea can be dangerous in children if too much fluid is lost and not replaced quickly.

**What Tests Might the Doctor Do?**

**Diagnostic tests to find the cause of diarrhoea include the following:**

- **Medical history and physical examination.** The doctor will need to know about your eating habits and medication use and will examine you for signs of illness.
- **Stool culture.** Lab technicians analyse a sample of stool to check for bacteria, parasites, or other signs of disease or infection.
- **Blood tests.** Blood tests can be helpful in ruling out certain diseases.
- **Fasting tests.** To find out if a food intolerance or allergy is causing the diarrhoea, the doctor may ask you to avoid lactose (found in milk products), carbohydrates, wheat, or other foods to see whether the diarrhoea responds to a change in diet.
- **Sigmoidoscopy.** For this test, the doctor uses a special instrument to look at the inside of the rectum and lower part of the colon.
- **Colonoscopy.** This test is similar to sigmoidoscopy, but the doctor looks at the entire colon.

**What Is the Treatment?**

In most cases, replacing lost fluid to prevent dehydration is the only treatment necessary. (See "Preventing Dehydration" below.) Medicines that stop diarrhoea may be helpful in some cases, but they are not recommended for people whose diarrhoea is from a bacterial infection or parasite--stopping the diarrhoea traps the organism in the intestines, prolonging the problem. Instead, doctors usually prescribe antibiotics. Viral causes are either treated with medication or left to run their course, depending on the severity and type of the virus.

**Preventing Dehydration**

Dehydration occurs when the body has lost too much fluid and electrolytes (the salts potassium and sodium). The fluid and electrolytes lost during diarrhoea need to be replaced promptly--the body cannot function properly without them. Dehydration is particularly dangerous for children, who can die from it within a matter of days.

Although water is extremely important in preventing dehydration, it does not contain electrolytes. To maintain electrolyte levels, you could have broth or soups, which contain sodium, and fruit juices, soft fruits, or vegetables, which contain potassium.

For children, doctors often recommend a special rehydration solution that contains the nutrients they need. You can buy this solution in the grocery store without a prescription. Examples include Pedialyte, Ceralyte, and Infalyte.

**Tips About Food**

Until diarrhoea subsides, try to avoid milk products and foods that are greasy, high-fiber, or very sweet. These foods tend to aggravate diarrhoea.

As you improve, you can add soft, bland foods to your diet, including bananas, plain rice, boiled potatoes, toast, crackers, cooked carrots, and baked chicken without the skin or fat. For children, the paediatrician may recommend what is called the BRAT diet: bananas, rice, applesauce, and toast.

**Preventing Traveller's Diarrhoea**

Traveller's diarrhoea happens when you consume food or water contaminated with bacteria, viruses, or parasites. You can take the following precautions to prevent traveller's diarrhoea when you go abroad:

- Do not drink any tap water, not even when brushing your teeth.
- Do not drink unpasteurised milk or dairy products.
- Do not use ice made from tap water.
- Avoid all raw fruits and vegetables (including lettuce and fruit salad) unless they can be peeled and you peel them yourself.
- Do not eat raw or rare meat and fish.
- Do not eat meat or shellfish that is not hot when served to you.
- Do not eat food from street vendors.

You can safely drink bottled water (if you are the one to break the seal), carbonated soft drinks, and hot drinks like coffee or tea.

Depending on where you are going and how long you are staying, your doctor may recommend that you take antibiotics before leaving to protect you from possible infection.

**Points To Remember**

- Diarrhoea is a common problem that usually resolves on its own.
- Diarrhoea is dangerous if a person becomes dehydrated.
- Causes include viral, bacterial, or parasitic infections; food intolerance; reactions to medicine; intestinal diseases; and functional bowel disorders.
- Treatment involves replacing lost fluids and electrolytes. Depending on the cause of the problem, a person might also need medication to stop the diarrhoea or treat an infection. Children may need an oral rehydration solution to replace lost fluids and electrolytes.
- Call the doctor if a person with diarrhoea has severe pain in the abdomen or rectum, a fever of 38 degrees centigrade or higher, blood in the stool, signs of dehydration, or diarrhoea for more than 3 days.

# WHO Cholera Fact Sheet[11]

Cholera is an acute intestinal infection caused by the bacterium *Vibrio cholerae.* It has a short incubation period, from less than one day to five days, and produces an enterotoxin that causes a copious, painless, watery diarrhoea that can quickly lead to severe dehydration and death if treatment is not promptly given. Vomiting also occurs in most patients.

Most persons infected with *V. cholerae* do not become ill, although the bacterium is present in their faeces for 7-14 days. When illness does occur, more than 90% of episodes are of mild or moderate severity and are difficult to distinguish clinically from other types of acute diarrhoea. Less than 10% of ill persons develop typical cholera with signs of moderate or severe dehydration.

## Background

The vibrio responsible for the seventh pandemic, now in progress, is known as *V. cholerae* O1, biotype El Tor. The current seventh pandemic began in 1961 when the vibrio first appeared as a cause of epidemic cholera in Celebes (Sulawesi), Indonesia. The disease then spread rapidly to other countries of eastern Asia and reached Bangladesh in 1963, India in 1964, and the USSR, Iran and Iraq in 1965-1966.

In 1970 cholera invaded West Africa, which had not experienced the disease for more than 100 years. The disease quickly spread to a number of countries and eventually became endemic in most of the continent. In 1991 cholera struck Latin America, where it had also been absent for more than a century. Within the year it spread to 11 countries, and subsequently throughout the continent.

Until 1992, only *V. cholerae* serogroup O1 caused epidemic cholera. Some other serogroups could cause sporadic cases of diarrhoea, but not epidemic cholera. Late that year, however, large outbreaks of cholera began in India and Bangladesh that were caused by a previously unrecognized serogroup of *V. cholerae*, designated O139, synonym Bengal. Isolation of this vibrio has now been reported from 11 countries in South-East Asia. It is still unclear whether *V. cholerae* O139 will extend to other regions, and careful epidemiological monitoring of the situation is being maintained.

## Transmission

Cholera is spread by contaminated water and food. Sudden large outbreaks are usually caused by a contaminated water supply. Only rarely is cholera transmitted by direct person-to-person contact. In highly endemic areas, it is mainly a disease of young children, although breastfeeding infants are rarely affected.

Vibrio cholerae is often found in the aquatic environment and is part of the normal flora of brackish water and estuaries. It is often associated with algal blooms (plankton), which are influenced by the temperature of the water. Human beings are also one of the reservoirs of the pathogenic form of *Vibrio cholerae.*

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[11] Taken from http://www.who.int/mediacentre/factsheets/en/

## Treatment

When cholera occurs in an unprepared community, case-fatality rates may be as high as 50% -- usually because there are no facilities for treatment, or because treatment is given too late. In contrast, a well-organized response in a country with a well established diarrhoeal disease control programme can limit the case-fatality rate to less than 1%.

Most cases of diarrhoea caused by *V. cholerae* can be treated adequately by giving a solution of oral rehydration salts (the WHO/UNICEF standard sachet). During an epidemic, 80-90% of diarrhoea patients can be treated by oral rehydration alone, but patients who become severely dehydrated must be given intravenous fluids.

In severe cases, an effective antibiotic can reduce the volume and duration of diarrhoea and the period of vibrio excretion. Tetracycline is the usual antibiotic of choice, but resistance to it is increasing. Other antibiotics that are effective when *V. cholerae* are sensitive to them include cotrimoxazole, erythromycin, doxycycline, chloramphenicol and furazolidone.

## Epidemic control and preventive measures

When cholera appears in a community it is essential to ensure three things: hygienic disposal of human faeces, an adequate supply of safe drinking water, and good food hygiene. Effective food hygiene measures include cooking food thoroughly and eating it while still hot; preventing cooked foods from being contaminated by contact with raw foods, including water and ice, contaminated surfaces or flies; and avoiding raw fruits or vegetables unless they are first peeled. Washing hands after defecation, and particularly before contact with food or drinking water, is equally important.

Routine treatment of a community with antibiotics, or "mass chemoprophylaxis", has no effect on the spread of cholera, nor does restricting travel and trade between countries or between different regions of a country. Setting up a *cordon sanitaire* at frontiers uses personnel and resources that should be devoted to effective control measures, and hampers collaboration between institutions and countries that should unite their efforts to combat cholera.

Limited stocks of two oral cholera vaccines that provide high-level protection for several months against cholera caused by *V. cholerae* O1 have recently become available in a few countries. Both are suitable for use by travellers but they have not yet been used on a large scale for public health purposes. Use of this vaccine to prevent or control cholera outbreaks is not recommended because it may give a false sense of security to vaccinated subjects and to health authorities, who may then neglect more effective measures.

In 1973 the WHO World Health Assembly deleted from the International Health Regulations the requirement for presentation of a cholera vaccination certificate. Today, no country requires proof of cholera vaccination as a condition for entry, and the International Certificate of Vaccination no longer provides a specific space for recording cholera vaccinations.

## Trade in food products coming from cholera-infected regions

The publication "Guidelines for Cholera Control", available through WHO's Distribution and Sales Unit, states the following:

"Vibrio cholerae 01 can survive on a variety of foodstuffs for up to five days at ambient temperature and up to 10 days at 5-10 degrees Celsius. The organism can also survive freezing. Low temperatures, however, limit proliferation of the organism and thus may prevent the level of contamination from reaching an infective dose.

"The cholera vibrio is sensitive to acidity and drying, and commercially prepared acidic (ph 4.5 or less) or dried foods are therefore without risk. Gamma irradiation and temperatures above 70 degrees Celsius also destroy the vibrio and foods processed by these methods, according to the standards of the Codex Alimentarius.

"The foods that cause greatest concern to importing countries are seafood and vegetables that may be consumed raw. However, only rare cases of cholera have occurred as a result of eating food, usually seafood, transported across international borders by individuals.

"...Indeed, although individual cases and clusters of cases have been reported, WHO has not documented a significant outbreak of cholera resulting from commercially imported food."

In summary, although there is a theoretical risk of cholera transmission with international food trade, the weight of evidence suggests that this risk is very small and can normally be dealt with by means other than an embargo on importation.

WHO believes that the best way to deal with food imports from cholera-affected areas is for importing countries to agree, with food exporters, on good hygienic practices which need to be followed during food handling and processing to prevent, eliminate or minimize the risk of any potential contamination; and to set up arrangements to obtain assurance that these measures are adequately carried out.

At present, WHO has no information that food commercially imported from affected countries has been implicated in outbreaks of cholera in importing countries. The isolated cases of cholera, which have been related to imported food, have been associated with food which had been in the possession of individual travellers. Therefore, it may be concluded that food produced under good manufacturing practices poses only a negligible risk for cholera transmission. Consequently, WHO believes that food import restrictions, based on the sole fact that cholera is epidemic or endemic in a country, are not justified.

# WHO Hepatitis A Factsheet[12]

## KEY FACTS

- Hepatitis A is a viral liver disease that can cause mild to severe illness.
- It is spread by faecal-oral (or stool to mouth) transmission when a person ingests food or drink contaminated by an infected person's stool.
- The disease is closely associated with poor sanitation and a lack of personal hygiene habits, such as hand washing.
- An estimated 1.4 million cases of hepatitis A occur annually.
- Epidemics can be explosive in growth and cause significant economic losses: 300 000 were affected in one Shanghai outbreak in 1988.
- Improved sanitation and the Hepatitis A vaccine are the most effective ways to combat the disease.

Hepatitis A is a liver infection caused by the hepatitis A virus (HAV). The virus is spread when an uninfected (or unvaccinated) person eats or drinks something contaminated by the stool of an HAV-infected person: this is called faecal-oral transmission. The disease is closely associated with inadequate sanitation and poor personal hygiene. Unlike hepatitis B and C, hepatitis A infection does not cause chronic liver disease and is rarely fatal, but it can cause debilitating symptoms.

Hepatitis A occurs sporadically and in epidemics worldwide, with a tendency for cyclic recurrences. Worldwide, HAV infections account for an estimated 1.4 million cases annually. Epidemics related to contaminated food or water can erupt explosively, such as an epidemic in Shanghai in 1988 that affected about 300 000 people.

The disease can wreak significant economic and social consequences in communities. It can take weeks or months for people recovering from the illness to return to work, school or daily life. The impact on food establishments identified with the virus, and local productivity in general, can be substantial.

## Symptoms

The symptoms of hepatitis A range from mild to severe, and can include fever, malaise, loss of appetite, diarrhoea, nausea, abdominal discomfort, dark-coloured urine and jaundice (a yellowing of the skin and whites of the eyes). Not everyone who is infected will have all of the symptoms. Adults have signs and symptoms of illness more often than children, and the severity of disease and mortality increases in older age groups. Infected children under six years of age do not usually experience noticeable symptoms, and only 10% develop jaundice. Among older children and adults, infection usually causes more severe symptoms, with jaundice occurring in more than 70% of cases. Most people recover in several weeks - or sometimes months - without complications.

## Who is at risk?

Anyone who has not had been infected previously or been vaccinated can contract hepatitis A. People who live in places with poor sanitation are at higher risk. In areas where the virus is widespread, most HAV infections occur during early childhood. Other risk factors for the virus include injecting drugs, living in a household with an infected person, or being a sexual partner of someone with acute HAV infection.

## Transmission

HAV is usually spread from person to person when an uninfected person ingests food or beverages that have been contaminated with the stool of a person with the virus. Bloodborne transmission of HAV occurs, but is much less common. Waterborne outbreaks, though infrequent, are usually associated with sewage-contaminated or inadequately treated water. Casual contact among people does not spread the virus.

## Treatment

[12] Taken from http://www.who.int/mediacentre/factsheets/en/

There is no specific treatment for hepatitis A. Recovery from symptoms following infection may be slow and take several weeks or months. Therapy is aimed at maintaining comfort and adequate nutritional balance, including replacement of fluids that are lost from vomiting and diarrhoea.

### Prevention

Improved sanitation and Hepatitis A immunization are the most effective ways to combat the disease.
Adequate supplies of safe-drinking water and proper disposal of sewage within communities, combined with personal hygiene practices, such as regular hand washing, reduce the spread of HAV.
Several hepatitis A vaccines are available internationally. All are similar in terms of how well they protect people from the virus and their side-effects. No vaccine is licensed for children younger than one year of age.
Nearly 100% of people will develop protective levels of antibodies to the virus within one month after a single dose of the vaccine. Even after virus exposure, one dose of the vaccine within two weeks of contact with the virus has protective effects. Still, manufacturers recommend two vaccine doses to ensure longer-term protection of about 5 to 8 years after vaccination. Millions of people have been immunized with no serious adverse events. The vaccine can be given as part of regular childhood immunizations programmes and with vaccines commonly given for travel.

### Where is the disease found?

Geographic areas can be characterized as having high, intermediate or low levels of HAV infection.

- High: In developing countries with very poor sanitary conditions and hygienic practices, the lifetime risk of infection is greater than 90%. Most infections occur in early childhood and those infected do not experience any noticeable symptoms. Epidemics are uncommon because older children and adults are generally immune. Disease rates in these areas are low and outbreaks are rare.
- Intermediate: In developing countries, countries with transitional economies and regions where sanitary conditions are variable, children escape infection in early childhood. Ironically, these improved economic and sanitary conditions may lead to higher disease rates, as infections occur in older age groups, and large outbreaks can occur.
- Low: In developed countries with good sanitary and hygienic conditions infection rates are low. Disease may occur among adolescents and adults in high-risk groups, such as injecting-drug users, homosexual men, persons travelling to high-risk areas, and in isolated populations, e.g. closed religious communities.

### Immunization efforts

Planning for large-scale immunization programmes should involve careful economic evaluations and consider alternative or additional prevention methods, such as better sanitation and health education for improved hygiene.

Whether or not to include the vaccine in routine childhood immunizations depends on the local context, including the level of risk for children. Several countries, including Argentina, China, Israel and the United States have introduced the vaccine in routine childhood immunizations. Other countries recommend the vaccine for persons at increased risk of hepatitis A, including travellers to countries where the virus is endemic, men who have sex with men, or persons with chronic liver disease (because of their increased risk of serious complications if they acquire HAV infection).

Recommendations for hepatitis A vaccination in outbreaks should also be site-specific, including the feasibility of rapidly implementing a widespread immunization campaign. Vaccination to control community-wide outbreaks is most successful in small communities, when the campaign is started early and when high coverage of multiple age groups is achieved. Vaccination efforts should be supplemented by health education to improve sanitation and hygiene practices.

# WHO Hepatitis E Fact Sheet[13]

Hepatitis is a general term meaning inflammation of the liver. Hepatitis is a disease that can be caused by a variety of different viruses such as hepatitis A, B, C, D and E. Since the development of jaundice is a characteristic feature of liver disease, a correct diagnosis can only be made by testing patients' sera for the presence of specific viral antigens and/or anti-viral antibodies.

Hepatitis E (HEV) was not recognized as a distinct human disease until 1980. Hepatitis E is caused by infection with the hepatitis E virus, a non-enveloped, positive-sense, single-stranded RNA virus. Although man is considered the natural host for HEV, antibodies to HEV or closely related viruses have been detected in primates and several other animal species.

**How is HEV transmitted?**

HEV is transmitted via the faecal-oral route. Hepatitis E is a waterborne disease, and contaminated water or food supplies have been implicated in major outbreaks. Consumption of faecally contaminated drinking water has given rise to epidemics, and the ingestion of raw or uncooked shellfish has been the source of sporadic cases in endemic areas. There is a possibility of zoonotic spread of the virus, since several non-human primates, pigs, cows, sheep, goats and rodents are susceptible to infection. The risk factors for HEV infection are related poor sanitation in large areas of the world, and HEV shedding in faeces. Person-to-person transmission is uncommon. There is no evidence for sexual transmission or for transmission by transfusion.

**Where is HEV a problem?**

The highest rates of infection occur in regions where low standards of sanitation promote the transmission of the virus. Epidemics of hepatitis E have been reported in Central and South-East Asia, North and West Africa, and in Mexico, especially where faecal contamination of drinking water is common. However, sporadic cases of hepatitis E have also been reported elsewhere and serological surveys suggest a global distribution of strains of hepatitis E of low pathogenicity.

**When is a HEV infection life-threatening?**

In general, hepatitis E is a self-limiting viral infection followed by recovery. Prolonged viraemia or faecal shedding are unusual and chronic infection does not occur.
Occasionally, a fulminant form of hepatitis develops, with overall patient population mortality rates ranging between 0.5% - 4.0%. Fulminate hepatitis occurs more frequently in pregnancy and regularly induces a mortality rate of 20% among pregnant women in the 3rd trimester.

## The disease

The incubation period following exposure to HEV ranges from 3 to 8 weeks, with a mean of 40 days. The period of communicability is unknown. There are no chronic infections reported. Hepatitis E virus causes acute sporadic and epidemic viral hepatitis. Symptomatic HEV infection is most common in young adults aged 15-40 years. Although HEV infection is frequent in children, it is mostly asymptomatic or causes a very mild illness without jaundice (anicteric) that goes undiagnosed. Typical signs and symptoms of hepatitis include jaundice (yellow discoloration of the skin and sclera of the eyes, dark urine and pale stools), anorexia (loss of appetite), an enlarged, tender liver (hepatomegaly), abdominal pain and tenderness, nausea and vomiting, and fever, although the disease may range in severity from subclinical to fulminant.

## Diagnosis

Since cases of hepatitis E are not clinically distinguishable from other types of acute viral hepatitis, diagnosis is made by blood tests which detect elevated antibody levels of specific antibodies to hepatitis E in the body or by reverse transcriptase polymerase chain reaction (RT-PCR).

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[13] Taken from http://www.who.int/mediacentre/factsheets/en/

Unfortunately, such tests are not widely available. Hepatitis E should be suspected in outbreaks of waterborne hepatitis occurring in developing countries, especially if the disease is more severe in pregnant women, or if hepatitis A has been excluded. If laboratory tests are not available, epidemiological evidence can help in establishing a diagnosis.

### Surveillance and control

Surveillance and control procedures should include provision of safe drinking water and proper disposal of sanitary waste monitoring disease incidence determination of source of infection and mode of transmission by epidemiological investigation detection of outbreaks spread containment

### Vaccines

At present, no commercially available vaccines exist for the prevention of hepatitis E. However, several studies for the development of an effective vaccine against hepatitis E are in progress.

### Prevention

As almost all HEV infections are spread by the faecal-oral route, good personal hygiene, high quality standards for public water supplies and proper disposal of sanitary waste have resulted in a low prevalence of HEV infections in many well developed societies.
For travellers to highly endemic areas, the usual elementary food hygiene precautions are recommended. These include avoiding drinking water and/or ice of unknown purity and not eating uncooked shellfish, uncooked fruit or vegetables that are not peeled or prepared by the traveller.

### Treatment

Hepatitis E is a viral disease, and as such, antibiotics are of no value in the treatment of the infection. There is no hyper-immune E globulin available for pre- or post-exposure prophylaxis. HEV infections are usually self-limited, and hospitalisation is generally not required. No available therapy is capable of altering the course of acute infection. As no specific therapy is capable of altering the course of acute hepatitis E infection, prevention is the most effective approach against the disease. Hospitalisation is required for fulminant hepatitis and should be considered for infected pregnant women.

*Guidelines for epidemic measures*

- Determination of the mode of transmission.
- Identification of the population exposed to increased risk of infection.
- Elimination of a common source of infection.
- Improvement of sanitary and hygienic practices to eliminate faecal contamination of food and water.

# Dengue and dengue haemorrhagic fever[14]

Dengue is a mosquito-borne infection which in recent years has become a major international public health concern. Dengue is found in tropical and sub-tropical regions around the world, predominantly in urban and semi-urban areas.

Dengue haemorrhagic fever (DHF), a potentially lethal complication, was first recognized in the 1950s during the dengue epidemics in the Philippines and Thailand, but today DHF affects most Asian countries and has become a leading cause of hospitalisation and death among children in several of them.

There are four distinct, but closely related, viruses that cause dengue. Recovery from infection by one provides lifelong immunity against that serotype but confers only partial and transient protection against subsequent infection by the other three. There is good evidence that sequential infection increases the risk of more serious disease resulting in DHF.

### Prevalence

The global prevalence of dengue has grown dramatically in recent decades. The disease is now endemic in more than 100 countries in Africa, the Americas, the Eastern Mediterranean, South-east Asia and the Western Pacific. South-east Asia and the Western Pacific are most seriously affected. Before 1970 only nine countries had experienced DHF epidemics, a number that had increased more than four-fold by 1995.

Some 2500 million people -- two fifths of the world's population -- are now at risk from dengue. WHO currently estimates there may be 50 million cases of dengue infection worldwide every year.

In 2001 alone, there were more than 609 000 reported cases of dengue in the Americas, of which 15 000 cases were DHF. This is greater than double the number of dengue cases which were recorded in the same region in 1995.

Not only is the number of cases increasing as the disease is spreading to new areas, but explosive outbreaks are occurring. In 2001, Brazil reported over 390 000 cases including more than 670 cases of DHF.

Some other statistics:

- During epidemics of dengue, attack rates among susceptibles are often 40 -- 50%, but may reach 80 -- 90%.
- An estimated 500 000 cases of DHF require hospitalisation each year, of whom a very large proportion are children. At least 2.5% of cases die, although case fatality could be twice as high.
- Without proper treatment, DHF case fatality rates can exceed 20%. With modern intensive supportive therapy, such rates can be reduced to less than 1%.

The spread of dengue is attributed to expanding geographic distribution of the four dengue viruses and of their mosquito vectors, the most important of which is the predominantly urban species *Aedes aegypti*. A rapid rise in urban populations is bringing ever greater numbers of people into contact with this vector, especially in areas that are favourable for mosquito breeding, e.g. where household water storage is common and where solid waste disposal services are inadequate.

### Transmission

Dengue viruses are transmitted to humans through the bites of infective female *Aedes* mosquitoes. Mosquitoes generally acquire the virus while feeding on the blood of an infected person. After virus incubation for 8-10 days, an infected mosquito is capable, during probing and blood feeding, of transmitting the virus, to susceptible individuals for the rest of its life. Infected female mosquitoes may also transmit the virus to their offspring by transovarial (via the eggs) transmission, but the role of this in sustaining transmission of virus to humans has not yet been delineated.
Humans are the main amplifying host of the virus, although studies have shown that in some parts of the world monkeys may become infected and perhaps serve as a source of virus for uninfected mosquitoes. The virus circulates in the blood of infected humans for two to seven days, at approximately the same time as they have fever; *Aedes* mosquitoes may acquire the virus when they feed on an individual during this period.

[14] Taken from http://www.who.int/mediacentre/factsheets/en/

**Characteristics**
Dengue fever is a severe, flu-like illness that affects infants, young children and adults, but seldom causes death. The clinical features of dengue fever vary according to the age of the patient. Infants and young children may have a non-specific febrile illness with rash. Older children and adults may have either a mild febrile syndrome or the classical incapacitating disease with abrupt onset and high fever, severe headache, pain behind the eyes, muscle and joint pains, and rash.
Dengue haemorrhagic fever is a potentially deadly complication that is characterized by high fever, haemorrhagic phenomena--often with enlargement of the liver--and in severe cases, circulatory failure. The illness commonly begins with a sudden rise in temperature accompanied by facial flush and other non-specific constitutional symptoms of dengue fever. The fever usually continues for two to seven days and can be as high as 40-41°C, possibly with febrile convulsions and haemorrhagic phenomena. In moderate DHF cases, all signs and symptoms abate after the fever subsides. In severe cases, the patient's condition may suddenly deteriorate after a few days of fever; the temperature drops, followed by signs of circulatory failure, and the patient may rapidly go into a critical state of shock and die within 12-24 hours, or quickly recover following appropriate volume replacement therapy.

**Treatment**
There is no specific treatment for dengue fever. However, careful clinical management by experienced physicians and nurses frequently saves the lives of DHF patients. With appropriate intensive supportive therapy, mortality may be reduced to less than 1%. Maintenance of the circulating fluid volume is the central feature of DHF case management.

**Immunization**
Vaccine development for dengue and DHF is difficult because any of four different viruses may cause disease, and because protection against only one or two dengue viruses could actually increase the risk of more serious disease. Nonetheless, progress is being made in the development of vaccines that may protect against all four dengue viruses. Such products may become available for public health use within several years.

**Prevention and control**
At present, the only method of controlling or preventing dengue and DHF is to combat the vector mosquitoes. In Asia and the Americas, *Aedes aegypti* breeds primarily in man-made containers like earthenware jars, metal drums and concrete cisterns used for domestic water storage, as well as discarded plastic food containers, used automobile tyres and other items that collect rainwater. In Africa it also breeds extensively in natural habitats such as tree holes and leaf axils.
In recent years, *Aedes albopictus*, a secondary dengue vector in Asia, has become established in: the United States, several Latin American and Caribbean countries, in parts of Europe and in one African country. The rapid geographic spread of this species has been largely attributed to the international trade in used tyres.

Vector control is implemented using environmental management and chemical methods. Proper solid waste disposal and improved water storage practices, including covering containers to prevent access by egg laying female mosquitoes are among methods that are encouraged through community-based programmes.

The application of appropriate insecticides to larval habitats, particularly those which are considered useful by the householders, e.g. water storage vessels, prevent mosquito breeding for several weeks but must be re-applied periodically. Small, mosquito-eating fish and copepods (tiny crustaceans) have also been used with some success. During outbreaks, emergency control measures may also include the application of insecticides as space sprays to kill adult mosquitoes using portable or truck-mounted machines or even aircraft. However, the killing effect is only transient, variable in its effectiveness because the aerosol droplets may not penetrate indoors to microhabitats where adult mosquitoes are sequestered, and the procedure is costly and operationally very demanding. Regular monitoring of the vectors' susceptibility to the most widely used insecticides is necessary to ensure the appropriate choice of chemicals. Active monitoring and surveillance of the natural mosquito population should accompany control efforts in order to determine the impact of the programme.

# WHO Malaria Factsheet[15]

Malaria, the world's most important parasitic infectious disease, is transmitted by mosquitoes that breed in fresh or occasionally brackish water.

### The disease and how it affects people

The symptoms of malaria include fever, chills, headache, muscle aches, tiredness, nausea and vomiting, diarrhoea, anaemia, and jaundice (yellow colouring of the skin and eyes). Convulsions, coma, severe anaemia and kidney failure can also occur. The severity and range of symptoms depend on the specific type of malaria. In certain types, the infection can remain inactive for up to five years and then recur. In areas with intense malaria transmission, people can develop protective immunity after repeated infections. Without prompt and effective treatment, malaria can evolve into a severe cerebral form followed by death. Malaria is among the five leading causes of death in under-5-year-old children in Africa.

### The cause

Malaria is caused by four species of Plasmodium parasites (P. falciparum, P. vivax, P. ovale, P. malariae). People get malaria after being bitten by a malaria-infected Anopheles mosquito. Some female mosquitoes take their blood-meal at dusk and early evening, but others bite during the night or in the early hours of the morning. When a mosquito bites an infected person, it ingests malaria parasites with the blood. During a period of 8 to 35 days (depending on the ambient temperature), the parasite develops in the mosquito. The infective form (sporozoite) ends up in the salivary glands and is injected into the new human host at subsequent blood-meals. In the human host, the sporozoites migrate to the liver, multiply inside liver cells, and spread into the bloodstream. The liver phase can last between 8 days and several months, depending on the malaria species. Their growth and multiplication takes place inside red blood cells. Clinical symptoms occur when the red blood cells break up. If this happens in large numbers, the person experiences the characteristic intermittent fevers of the disease. The released parasites invade other blood cells. Most people begin feeling sick 10 days to 4 weeks after being infected.

### Distribution

Today, malaria occurs mostly in tropical and subtropical countries, particularly in Africa south of the Sahara, South-East Asia, and the forest fringe zones in South America. The ecology of the disease is closely associated with the availability of water, as the larval stage of mosquitoes develops in different kinds of water bodies. The mosquito species vary considerably in their water-ecological requirements, (sun-lit or shaded, with or without aquatic vegetation, stagnant or slowly streaming, fresh or brackish) and this affects the disease ecology. Climate change (global warming) appears to be moving the altitude limits of malaria to higher elevations, for example in the East African highlands and Madagascar. The construction of irrigation systems and reservoirs in some parts of the world can have a dramatic impact on malaria distribution and on the intensity of its transmission.

### Scope of the Problem

WHO estimates 300-500 million cases of malaria, with over one million deaths each year.
The main burden of malaria (more than 90%) is in Africa south of the Sahara with an estimated annual number of deaths over 1 million. Two thirds of the remaining burden hits six countries: Brazil, Colombia, India, Solomon Islands, Sri Lanka and Viet Nam. In many parts the natural habitat sustains intense malaria transmission; in others, water resources development (irrigation, dams, urban water supply) has exacerbated the transmission intensity and caused the distribution of the disease to spread. In yet others, for example the Central Asian republics of the CIS, malaria has returned as a result of a breakdown in water management and maintenance problems of local irrigation systems.

### Interventions

WHO's Strategy for Malaria Control, which forms the basis of the Roll Back Malaria initiative, identifies four main interventions:

- Reducing mortality, particularly among children, by early case-detection and prompt treatment with effective anti-malarial drugs
- Promoting the use of insecticide-treated bed nets, especially by children and pregnant women
- Prevention of malaria in pregnancy by applying intermittent preventive therapy
- Ensuring early detection and control of malaria epidemics, especially in emergency situations.
- Where appropriate, countries and communities are being encouraged to reduce mosquito breeding sites by filling in and draining water bodies and through other environmental management schemes.

[15] Taken from http://www.who.int/mediacentre/factsheets/en/

# Scabies disease fact sheet[16]

Scabies is a contagious skin infection that spreads rapidly in crowded conditions and is found worldwide. Personal hygiene is an important preventive measure and access to adequate water supply is important in control.

## The disease and its effect on people

The principal sign of the disease is a pimple-like rash that is most commonly found on the hands, especially the webbing between the fingers, the skin folds of the wrist, elbow or knee, the penis, the breast or the shoulder. Infestation often causes intense itching all over the body, especially at night. Scratching of itchy areas results in sores that may become infected by bacteria. A more severe form of scabies, known as Norwegian scabies, is more common among people with weakened immune systems. In this form of the disease, vesicles are present along with thick crusts over the skin. The itching in this type of scabies may be less severe or totally absent.

## Cause

Scabies infestation is caused by the microscopic mite *Sarcoptes scabei*. The fertilized female mite burrows into the skin, depositing eggs in the tunnel behind her. After the eggs are hatched, larvae migrate to the skin surface and eventually change into the adult form. Mating occurs on the skin surface. An adult mite can live up to about a month on a person. Once away from the human body, mites only survive 48-72 hours. The characteristic itchy rash of scabies is an allergic response to the mite. Individuals who are infested with scabies for the first time typically experience symptoms after 4 to 6 weeks. With subsequent infestation, symptoms appear within days.

Scabies spreads principally by direct skin-to-skin contact and to a lesser extent through contact with infested garments and bedclothes. Environments that are particularly vulnerable to the spread of scabies include hospitals, childcare facilities and any crowded living conditions. Infestation is easily passed between sexual partners.

## Distribution of the disease

Scabies mites are found worldwide, affecting all socioeconomic classes and in all climates. Epidemics have been linked to poverty, poor water-supply, sanitation and overcrowding.

## Scale of the problem

There are about 300 million cases of scabies in the world each year.

## Interventions

Improved personal hygiene plays an important part in the prevention and control of scabies and depends on access to adequate water-supply. Treatment of patients is with acaricide ointments preceded by a hot bath with liberal use of soap. Infested clothing should be sterilized or washed in hot soapy water. Bedding, mattresses, sheets and clothes may require dusting with acaricides.

Several recent studies have demonstrated that an oral dose of ivermectin is extremely effective in curing scabies. The mass distribution of ivermectin organized by WHO for the control of onchocerciasis and lymphatic filariasis (in this case associated with albendazole) could have an important impact on scabies.

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[16] Prepared for World Water Day. Reviewed by staff and experts from the cluster on Communicable Diseases (CDS) and the Water, Sanitation and Health Unit (WSH), World Health Organization (WHO)

# How to do matrix and pair wise ranking

Matrix and pair wise ranking can be used to prioritise problems or compare preferences: for example to compare the perceived effectiveness of different treatments for diarrhoea or for establishing which health problems are the most common or serious. Again, this is most effectively done in small groups.

- Ask participants to brainstorm the issues in the camp or settlement that you are going to compare, for example "Which diseases are people in the community most worried about getting?"

- Decide on symbols or pictures to represent these issues. Place one set of these in a row along the top and another in a column along the side to form the matrix (as in the diagram).

- For each square in the matrix, ask participants whether the symbol at the top of the row is more important or less important than the one at the left of the row. Stop when each symbol has been compared with each of the others. (Only the top half of the matrix will be filled in). Keep a tally of each choice in the relevant box.

- When the participant has made his/her choices try to get them to give the reasons why they were chosen.

- The scores can then be added up to find which issue is the most important. In this example, people were most worried about contracting dysentery.

- This should be followed by further discussion on the outcome of the scoring exercise and what can be done about the problem. The findings should be included in the project records.

# Hygiene Promotion and Sphere
(www.sphereproject.org)

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

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

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

## Sphere and WASH

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

### Sphere and Hygiene Promotion

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

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

**Hygiene Promotion standard 1:** programme design and implementation
All facilities and resources provided reflect the vulnerabilities, needs, and preferences of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate.

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

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

Guidance notes

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

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

**3. Reaching all sections of the population:** Hygiene Promotion programmes need to be carried out with all groups of the population by facilitators who can access, and have the skills to work with, different groups (for example, in some cultures it is not acceptable for

women to speak to unknown men). Materials should be designed so that messages reach members of the population who are illiterate. Participatory materials and methods that are culturally appropriate offer useful opportunities for groups to plan and monitor their own hygiene improvements. As a rough guide, in a camp scenario there should be two hygiene promoters/community mobilisers per 1,000 members of the target population. For information on hygiene items, see non-food items standard 2.

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

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

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

For further information see www.sphereproject.org December 2007

# Gender roles

The purpose of this exercise is to encourage discussion about the roles of men and women with a view to enabling women to be more involved in the planning and decision-making for interventions associated with water, sanitation and hygiene.

By the end of the session participants should be able to list the different activities ascribed to men and women in their specific culture and context and explain how women might be more involved in a water and sanitation programme.

- Divide participants into groups of about six people. If the session has invited both men and women, ensure that there is an equal mix of both in the groups.

- Provide each group with a set of activity cards. Ask the groups to sort the cards into three groups according to those activities that are usually performed by men, those usually performed by women, and those usually performed by men and women to the same extent.

- Explain to the groups that the exercise is designed to encourage discussion and differences of opinion, and that the pictures should be used constructively to gain insights into how the different roles of men and women are viewed in a specific culture and context.

- Encourage further discussion by asking the groups to consider what knowledge is necessary in order to perform each task and what decisions must be made before each task can be performed.

- Ask each group to also decide how men and women can become more equal partners in a water and sanitation programme – considering such issues as access to paid employment, maintenance and care of facilities etc.

- Ask for feedback in plenary and try to encourage consensus on any contentious issues.

# Gender Checklist for WASH Programming

(adapted from IFRC Gender Checklist)

<u>General data</u>

- Total number of family's data disaggregated by age and sex.
- Number of families headed by females, and number by males.
- Child headed families.
- Number of unaccompanied boys and girls, elderly, disabled.

<u>Water collection, transportation and allocation at HH level</u>

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

<u>Access to and control over water sources</u>

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

<u>Gender division of time-use in the household</u>

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

<u>Technical options / O&M</u>

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

<u>Privacy and security</u>

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

<u>Sanitary habits of women and girl</u>

- What is appropriate to discuss; what types of materials are appropriate to distribute; how are children faeces dealt with?
- What are the cultural assumptions with regard to water and sanitation activities during pregnancy, during menstruation, anal cleaning, etc?

Cultural issues

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

Traditional gender roles and power structure

- How do women perceive themselves in traditional roles and active participation? How much of this can be changed and how much can not be changed?
- Who decides how much money should be spent on water?

## Suggestions for improving Gender Awareness

### Community consultation

- Ensure recruitment of men and women on the team
- Ensure that women are available to talk to women and men to men in the assessment (especially when discussing sanitation and personal hygiene)
- Work separately with women and men's groups, where necessary, to counter exclusion and prejudice related to water, sanitation and hygiene practices.
- Women and men need to be consulted about convenient times and locations for meetings and they need time to be given time to re-organize their schedules.
- Involve both men and women in discussions on water and sanitation, including personal hygiene habits, general health and the needs and fears of children (do not just focus on women)
- Conduct consultations in a secure setting where all individuals (including women and girls) feel safe to provide information and participate in discussion and decision making.
- Include questions on cultural and ethnic beliefs on water usage, responsibilities and sanitation practices.

### Link to hardware / Community training

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

### Social research

- Through interviews with key informants, try to understand the power and social relations in the target communities and examine the roles, responsibilities,

processes and workloads of children, women and men, the rich and the poor in terms of labour in their homes, hygiene practices and water use and management.
- Determine how women's and men's participation and skills acquisition influence power dynamics at the household level. Be aware of possible increases in domestic tensions and provide basic conflict resolution and support where possible.

## Gender sensitization

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

# Protection Handout[17]

## Protection is about improving the safety of civilians

Where there is a **threat** and people are **vulnerable** they are at **risk**.
The more time people face the **threat**, the higher the **risk**.

## Threat + Vulnerability x Time = RISK

| **Example:**<br>A woman goes out of her village to collect water. A man blocks her way and threatens her with violence.<br>The actions of the man are the threat.<br>The woman may be vulnerable because she is a woman, or from a certain ethnic group, and also because she has no water source in her village.<br>The more times she has to go and collect water the greater the risk to her. |
|---|

## Threats include:

- **Violence –** deliberate killing, wounding, torture; cruel, inhuman and degrading treatment; sexual violence including rape; the fear of any of these.
- **Coercion –** (forcing someone to do something against their will) – forced prostitution, sexual slavery, sexual exploitation, forced or compulsory labour, forced displacement or return, restriction of movement, prevention of return, forced recruitment, being forced to commit acts of violence against others.
- **Deliberate Deprivation –** destruction of homes, wells and clinics; preventing access to land or markets; preventing deliver of relief supplies; deliberate discrimination in getting jobs, education, land or services; illegal 'taxes' or tolls.

## Reducing Risk

Non-governmental Organizations (NGOs) try to reduce risk by reducing the threat, reducing the vulnerability and reducing the time people face the threat.

### NGOs work in co-ordination with others to do some or all of these actions:

## To reduce the threat

- **Advocacy:** convincing those with power to protect people or getting others to put pressure on them to protect people
- **Capacity-building:** supporting the authorities to protect civilians
- **Presence:** using physical presence to deter attacks on civilians

## To reduce vulnerability

- **Assistance:** directly providing services or goods so that people can avoid threats
- **Voice:** helping people to negotiate their own safety
- **Information:** providing impartial information to help people make informed decisions about their safety

[17] Taken from: Improving the Safety of Civilians: A Protection Training Pack OXFAM

# Hygiene Promotion and HIV and AIDS

AIDS is not a water-related disease and HIV is not spread via contaminated water or poor hygiene, however, HIV/AIDS can be considered as a global emergency and emergency contexts can often make people more vulnerable to HIV infection and / or to deterioration in their HIV status. The following – often interrelated factors may be typical in situations of political instability, war or conflict – and can play an important part in increasing the risks of HIV:

- Displacement
- Economic vulnerability
- Sexual and gender based violence
- Lack of health infrastructure
- Breakdown of social structures
- Human rights abuses
- Gender discrimination etc.

If adequate attention is not paid to the risks that HIV poses, a WASH intervention may at worst contribute to increased risk and at best fail to meet the needs of the affected population.

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

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

The key questions to ask initially are: what is the HIV prevalence in the area of origin (of displaced people), what is the HIV prevalence in the area of stay (host population/non-displaced population), what is the likely duration of the emergency and hence the sustained vulnerability of the affected community and how are men, women and children vulnerable in this current situation. You will need to try and understand how the programme might affect the prevalence of HIV and AIDS, what the needs of people living with HIV and AIDS (PLWHA) are, and what your programme can do to mitigate the impact of HIV and AIDS.

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

- train water and sanitation committees so that they understand HIV issues and the needs of those affected or infected in terms of sanitation and access to water
- be prepared for 'drop-outs' as illness may be an issue for committee members too
- consider the 'out-of-sight' needs of chronically ill and bedridden people
- consider lower pump handles and 5-litre jerry cans for children's use
- consider the design of facilities in order to make collecting water less arduous e.g. foot pumps may be easier to manage than hand pumps
- consider ramps instead of steps and a bar to hold when squatting
- consider the sanitation and water needs of those who may be bedridden

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

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

Adapted from *Humanitarian Programmes and HIV and AIDS,* Oxfam GB, 2007
For further information see:
http://publications.oxfam.org.uk/oxfam/display.asp?K=9780855985622

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

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

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

A PowerPoint presentation is also available to support training and awareness raising.
http://www.irc.nl/content/download/4199/48511/file/TOP2HIV_AIDS05.pdf

July 08

# HIV/AIDS Transmission Routes

**(A variation on three-pile sorting)**

The purpose of this exercise is to encourage participants to discuss how HIV/AIDS is transmitted and to allow facilitators to explore what they already know about HIV/AIDS.
It provides a useful way to introduce the topic and to subsequently discuss the links with a WASH programme.

By the end of the session participants should be able to list the main ways that HIV/AIDS is transmitted and suggest ways that they can protect themselves. They should also be able to explain what the WASH project can do to respond to the threat of this disease.

- This exercise can be done with small groups of about 6/7 people to enable everyone to participate.

- Divide participants into small groups and provide each group with the set of picture cards provided.

- Ask the group to sort the pictures into three piles according to whether they think the pictures show high risk, low risk or ambiguous risk (either they are unsure or there are elements of both high and low risk) practices that contribute or otherwise to the spread of HIV/AIDS.

- Encourage as much discussion as possible. The facilitator can help to clarify any points of contention with the small groups.

- In plenary ask each group to suggest one or two cards that show how HIV is transmitted and to explain if this happens in their community. Ask the whole group to contest anything they don't agree with and clarify any misconceptions. Ask participants what might be done to prevent transmission? Challenge participants if their suggestions do not seem to be realistic.

- Ensure that each group explains the content of the 'third' pile of ambiguous pictures and that the issues identified are clarified where necessary.

- Ask the group to think of the relevance that the discussion has for them and their families and why they might be at greater risk of HIV/AIDS in the current situation.

- Ask the group what relevance HIV/AIDS has for the project they are working on e.g. are there people with HIV/AIDS within the affected population? How can they ensure that women feel safe in accessing the latrines and water points? How can they encourage greater awareness of the risks?

# Community Participation and Gender Worksheet

**(taken from Gender Perspectives: a gender training pack of the International Federation of the Red Cross)**

Consider the profiles of the following individuals all of whom have been forced to leave their home country as a result of recent clashes between government forces and the guerrilla groups that are opposed to the country's military regime.

*A 25-year old man*
A teacher. Has just lost his wife and son who died when their house was torched during a raid by government forces trying to flush out guerrillas. He was working late on some exam papers at the school when the incident occurred. He is accompanied by his 3 year old daughter who survived the fire although sustained burns which are now infected.

*A 15-year old girl*
Has lost her whole family as a result of recent clashes. They were shot dead in front of her when they were shopping in the market. She fled with her neighbours.

*A 50-year old woman*
In good health. A midwife. Was attending a birth in a nearby town when the attack took place. She fled with everyone else. She has no idea if her husband and 2 sons know where she is.

*A 12-year old boy, mentally-disabled*
Apparently unaccompanied. He cannot explain how he got to the camp.

*A pregnant woman in her thirties with 3 other children*
Her husband, a military officer, has "disappeared". She made the decision to flee when her children became the target of bullying at their local school. She was trained as a type-setter for a newspaper but hasn't used these skills since starting a family.

*A 70-year old man*
Widower whose grown-up family has been living in a neighbouring country for 20 odd years. He's lost touch with them. He supplements his meagre pension by selling the eggs his chickens lay and doing some ad hoc book-keeping although his eye-sight is failing. He fled with his neighbours.

## Your task

1. What are the immediate and long-term needs of each of the individuals in the case study?

In your group prepare a table outlining what your group believes are the immediate and the long term needs for each individual in the case study, as well as what you think their fears may be.

| | Immediate needs | Long-term needs | Fears |
|---|---|---|---|
| 25 year old man - teacher. | | | |
| 15 year old girl. | | | |
| 50 year old woman - midwife. | | | |
| 12 year old boy, mentally-disabled. | | | |
| Pregnant woman in her thirties with 3 other children. | | | |
| 70 year old man. | | | |

2. What role could gender analysis play in an assessment of refugee needs?

# Participation Ladder Exercise

| The Community does what I want it to do |
|---|

| I make the decisions but I ask for representation – the community has no power |
|---|

| I make the final decisions but the community participates in the project |
|---|

| I ask for people's views but I decide on methods for information gathering. No sharing of decision making |
|---|

| There is shared decision making but I am still in control |
|---|

| The community shares in developing action plans. There is two-way information sharing and participation is seen as a right |
|---|

| The community decides, sets the agenda and retains control – they may ask for outside assistance |
|---|

# Roles and Statements for the Power walk

**Roles for the power walk**

- Village shopkeeper (male)
- Head teacher (female)
- Unemployed young man aged 18
- Married girl of 16 years
- Village chair (man)
- Unaccompanied girl aged 13
- Unaccompanied boy aged 14
- Local sheikh/pastor/priest
- Grandmother caretaker of chidren
- Commercial farmer (male)
- Medical assistant (male)
- TBA (Traditional Birth Attendant)
- Chair of social services committee (female)
- Barmaid (etc. depending on the nature of the communities in that area)
- Leader of youth wing of ruling party (man aged 38)
- Leader of youth CBO (girl aged 16)
- Female petty trader at the village market
- Local councillor (man aged 50)
- Domestic worker of local councillor – girl aged 16
- Secondary school girl, daughter of local councillor
- Secondary school boy, son of TBA

**Statements for the power walk (prior to emergency)**

- I have been or expect to go to secondary school
- I will be invited to meet any important visitor from outside
- I can afford to go to a private hospital
- I can get easy access to condoms
- I can easily get a loan for an income generating activity
- I usually read a newspaper regularly
- I usually access to a television.
- I usually eat at least two meals a day for the whole year
- I have inherited/expect to inherit land from my parents
- I have relatives in town who send support
- I usually get new clothes for Christmas/Idd
- I wear shoes

**Statements relating to the current situation**

- I have received an adequate distribution of food
- I am able to purchase or exchange items in return for additional food items
- I receive some monetary support from my family (those unaffected by the emergency)
- I have access to a clean latrine
- I have enough water collection and storage containers
- I may be able to get a paid job with one of the NGOs
- I know what to do to manage diarrhea (in myself or my children) in the current situation
- I feel relatively safe walking around the camp/settlement
- I will not feel pressurized to earn money from sex work in this situation

# How to do Venn diagrams[18]

Venn diagrams can be used to explore perceived relationships between different things. Circles of different sizes are drawn to represent different structures or organizations.

These circles are drawn so that they overlap, depending on the degree of contact that the structures have with each other. For example, they can be drawn to represent different stakeholders and their relationships within a community or a project. A Venn diagram can be done in a public setting but it works better as an activity with a small group.

- Explain to the participants that the purpose of the activity is to explore how the settlement works in terms of who makes the decisions and how organizations and/or groups relate to one another.

- Suggest that the participants first experiment with different sized circles and how they relate to one another. For example, ask them to consider the following structures: host government, international agencies, non-governmental organisations, community leaders, teachers, traditional healers, medical services, refugees as a whole group, elders, children, female heads of household, educated élite, community health workers, host population.

- Ask them how these structures are interrelated and the degree of influence that one has over another.

- The findings should be included in the project records.

[18] Taken from Hygiene Promotion, A Practical Manual for relief and development.

# Available Handouts:

## Hygiene Promotion Skills

### Behaviour Change and Social Change

- Behaviour Change Models
- Catalyse Model
- Communication for Social Change and Hygiene Promotion

### Using Visual Aids

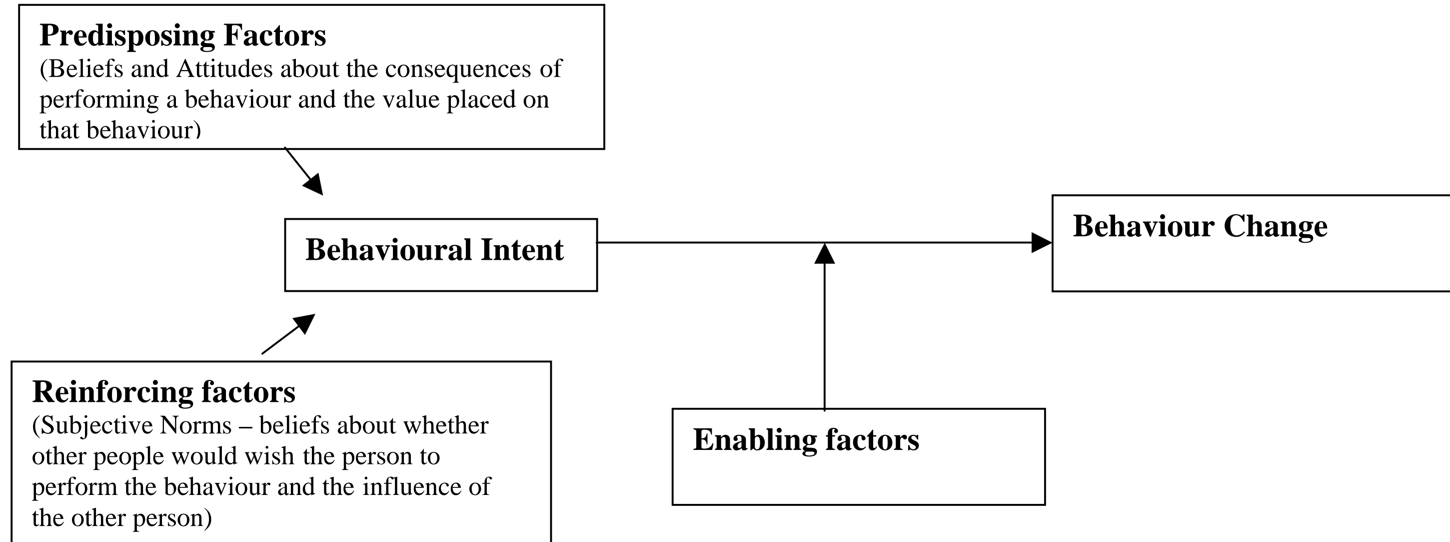
- Guidelines for designing posters
- Designing a leaflet

### Use of Other Promotional Approaches & Communication Methods

- Overview of Social Marketing
- Overview of PHAST
- Overview of Child to Child
- Using role plays and drama

# Behaviour Change Models

A simple model based on the work by Green and Kreuter (1991) and described by Hubley (1993) is shown below. This is known as the BASNEF Model.




**Predisposing factors** are knowledge, attitudes, beliefs, values, and perceptions that hinder or facilitate the motivation to change. **Enabling factors** are the skills, resources, or barriers that can help or hinder the desired behavioural changes. These allow a motivation to be realized. They may include availability, accessibility, affordability of health care or water and sanitation facilities and may also take into account the barriers to action. Enabling factors may also include new skills. These factors often become the target of health promotion. **Reinforcing factors** are the rewards received by the learner for the adoption of a behaviour. They are those consequences of action that determine whether the actor receives positive or negative feedback for that action. Such factors may include the physical consequences of an action, social support, peer influence or advice by health workers. Social benefits and social reinforcements can also be reinforcing factors. **Behavioural Intent** is the final step prior to action. This is influenced by one's attitude towards the behaviour and by the perception of what others think. In addition self-efficacy or the sense of being able to achieve something is also important.

All these factors collectively influence behaviour. There is not just one that causes the behaviour but rather a culmination of all of them. All three factors must be in alignment for the behaviour to persist. Direct communication to the target population strengthens the predisposing factors. Indirect communication to parents, peers and teachers strengthens reinforcing factors. Community organization strengthens enabling factors.

**Beliefs, Values, and Attitudes**
A belief is a conviction that an object or idea is real. The Health Belief Model (another model of behaviour change proposed by Becker et al 1994) is constructed on the premise of beliefs. A person must believe that his life is in jeopardy, perceive the seriousness of the condition, assess that the benefits outweigh the risks or inconveniences, and then be cued to action in order to change behaviour. Fear can also be a motivating factor for change. Values give us our understanding of right and wrong and a basis for justifying moral or ethical premises for actions. Recognition of values conflicts can be a motivation for change. Attitudes are a constant feeling toward something, and evaluation is the inherent structure of an attitude. Understanding how beliefs, values and attitudes relate to behaviour can help us understand the learning process. Attitudes and their potential relationship to behaviour have been studied extensively but in general, there is not a consistent relationship between the two. This may be because situational factors also exert such a powerful influence on behaviour.

The BASNEF Model and Hygiene Promotion Actions

| | Influences | Actions needed |
|---|---|---|
| Beliefs & Attitudes (Individual) | Culture, values, traditions, mass media, education, experiences | Communication programmes to modify beliefs and values and to motivate individuals |
| Subjective Norms (Community) | Family, community, social network, culture, social change, power structure, peer pressure | Communication directed at persons in family and community who have influence. Motivation of communities. |
| Enabling Factors (Intersectoral) | Income/poverty, sanitation services, women's status, inequalities, employment, agriculture | Provision of facilities in an emergency. Programmes to improve income, sanitation provision, situation of women, shelter, skills training |

According to this model, an individual will take up a new practice when he or she believes that the practice has sufficient benefits – health, economic or otherwise – and considers these benefits important. He or she may then develop a positive attitude to the change. Positive or negative influences, or subjective norms, from others in the person's environment who are important to him or her, will also influence their decision to try the new practice. Skills, time and means ("enabling factors") are also required to take up the practice.

If a new practice is then actually found to have immediate benefits – a cleaner environment, less hardship, recognition from respected others – it is most likely to be continued. Improved health is seldom such an immediate benefit. It is therefore often not a major reason why the new practice is adopted, although when asked, people will often give this reason as they know that this is the expected answer. Usually there are other factors involved that will trigger the community members to actually adopt good hygiene behaviours and practices. It is important that for each group that you work with, you identify what it is that 'triggers' them.

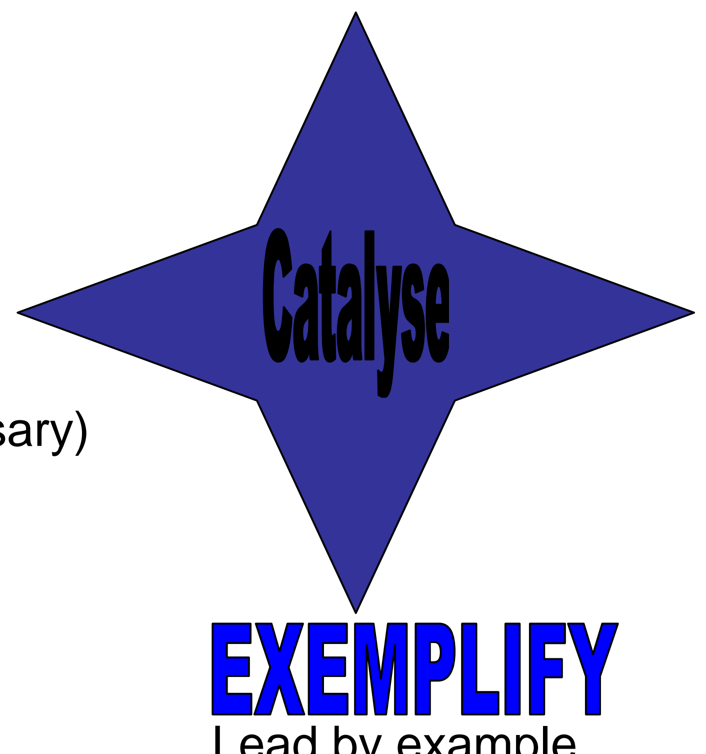
Just asking people to change their behaviour or providing them with information is not enough. Achieving hygiene and sanitation attitude and behaviour change, among individuals and communities, depends to a large extent on the ability of the community workers to understand that people's beliefs and the enabling factors are as important factors to deal with as are providing information and knowledge. Discussions about how to ensure that all the BASNEF factors are addressed can be done by using appropriate participatory visualisation tools. The use of such tools makes it possible to discuss sensitive issues and ensures that even those who are not fully literate can participate effectively in the discussions.

Other behaviour change models also point out the importance of 'Maintenance' of the behaviour in order to prevent relapse. Behaviour change may become a habit an practised without consciously thinking about it but will often need reinforcing to prevent relapse into older practices especially when people change their circumstances or the context in which they live.

In an emergency it may be easier to motivate people to adopt positive hygiene behaviours because:

- people have been forced to change their hygiene routines anyway
- they may feel themselves to be more at risk
- funding is often available to provide people with the necessary water and sanitation facilities

Catalyse Model




**Adapted from Defra 2005**

# Communication for Social Change[19]

Communication for Social Change (CFSC) describes a process where "community dialogue" and "collective action" work together to produce social change that benefits to the whole community.

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

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

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

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

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

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

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

### The 10 steps of community dialogue are:

1. **Recognition of a Problem.**
2. **Identification and Involvement of Leaders and Stakeholders.**

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

3. Clarification of Perceptions.
4. Expression of Individual and Shared Needs.
5. Vision of the Future.
6. Assessment of Current Status.
7. Setting Objectives.
8. Options for Action.
9. Consensus on Action.
10. Action Plan. .

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

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

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

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

# Guidelines for Developing Posters[20]

Posters are a means of providing limited information and reminding people about specific issues such as hand washing or how to make up ORS. However, they do have their limitations and may be used simply as decorative items rather than as a means of motivating change. Care must be taken that the hygiene promoters' time is not taken up with developing a poster at the cost of more effective means of mobilisation. Alternative ideas for interactive methods of hygiene promotion are given in this DVD.

- Consider the public information objective of your poster. Is it to inform, demonstrate, persuade, or remind?
- Who is the target audience? Where can they be reached? Are there any target audience preferences for types of materials (e.g., non-print for low-literacy audiences, fotonovelas for Latinas)?
- What is the specific message of your poster? Are you trying to provide information about a particular skill e.g. making ORS or encouraging people to use latrines to dispose of infant's excreta?
- Posters should convey one simple, clear message. Use words from the audience's local language, and avoid being too technical.
- Use familiar images and simple illustrations. Images, colours, and symbols should be appropriate and logically organized.
- Stylised drawing or shaded drawings can be difficult to understand
- Take care with conventions such as cartoons with thought bubbles, maps, graphs or diagrams
- Avoid using symbols – crosses, arrows, ticks, skull and crossbones etc. unless you are sure other people attach the same meaning as you do
- Be careful when showing only part of a person's body as this may lead to misunderstanding.
- Text and illustrations should be balanced. Use a typestyle or font that can be read from a distance of at least two meters.
- Design posters with ample white space for easy readability.
- Posters must be pre-tested to ensure their cultural relevance (see section on pre-testing).

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20 Adapted from CDC HIV health education and risk reduction guidelines
Hwww.cdc.gov/hiv/resources/guidelines/herrg/pub-info_educational.htmH
Linney,B. (1995) Pictures, people and power. Hong Kong: Macmillan.

# Designing a Leaflet[21]

Leaflets are used mainly to deliver information and are distributed to people to use as a reference. This allows them to decide when and where they study the information. It will take time to develop a well-designed leaflet and in the early stages of an emergency, dialogue with the affected community should not be undermined by diverting key resources into the design of leaflets and posters – especially where there are low levels of literacy. There are many alternative ways to convey key information to a population, especially one that has been traumatised and alternative suggestions on how to do this are provided on the DVD.

## The process

**Identify your target group and usual channels of communication**
What language do they use? What is the literacy level of the population? What channels of communication do they use and what do they trust? Are leaflets a suitable mode of communication? Try to answer the questions below with reference to this group.

**Make an outline for the information**
Unlike posters, leaflets contain multiple messages and technical ideas that need to be organized in a logical fashion. An easy way to create an outline for a leaflet is to consider possible questions the target audience might ask to learn more:

- What is the problem?
- What is the magnitude of the problem?
- What does one need to know about it?
- Who does it affect?
- How can the problem be solved?
- Why should one want to change his or her behaviour or practices?
- What can people do to prevent the problem or to protect themselves?
- What will happen if the problem is not solved?
- Are there resources available to help? Where can they be found?
- Where can you find more information?

**Make a draft copy of the leaflet and pre-test**
In an emergency, it may be difficult to carry out a detailed pre testing of the materials you design but some level of pre testing for all 'stand alone' materials (e.g. posters and leaflets) should be attempted (see section on pre-testing). Information does not have to be presented in a conventional leaflet and it might be more effective to provide stickers for buckets, water tanks, latrine covers or school notebooks.

**The important point to remember with a leaflet is not to cram it with text**. People won't read it.

Your text should be:

- Persuasive, interesting to read, and catchy and memorable.
- Written in clear, simple language of the region or target cultural group
- Written in large typeset that is easy to read

Use short paragraphs and mark them with headings. Use bullet-pointed lists which are easy to read. You can pull out single lines and highlight them in a different font size or colour to make a strong point.

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[21] Adapted from information from the following websites:
Hhttp://www.pressureworks.org.uk/usefulstuff/how/leaflet.html
Hhttp://www.cartercenter.org/health/trachoma_education/leaflets.html

**Monitor the effect of the leaflet**
If leaflets have been distributed, it is important to understand if they have been read and understood and also if people have used the information in any way. Try to incorporate monitoring of the leaflets into your monitoring plan for a few weeks after the distribution.

## Designing the leaflet

**The size**
The size and shape of the leaflet is an important factor in its success and it will need to be a convenient size to fit easily into a bag or pocket. Most leaflets are created as folded sheets of A4 (e.g. A4 is the size of the paper you usually use in a printer. If you fold A4 in half the size will be A5 and if you fold this in half again it will be A6.)

**Picture and layout design**
Try to identify pictures that help you to get your message across. Make sure you use copyright free pictures or that you have permission to use and reproduce the pictures. To get an idea of the layout, draw a rough sketch of:

- Where blocks of text will go
- Where headings will go
- Where pictures will go
- Colours for the text and background

An example leaflet could be laid out as outlined below:

**Front Cover**: a single, powerful statement and a hard-hitting graphic to support the leaflet's title.
**Page 2:** outline the problem: for instance, the situation against which you are campaigning.
**Page 3:** explain what you are trying to do about the situation on page two - and how, when and where.
**Back Cover**: provide information about your organisation. Include contact details for people who want to know more or want to get involved.

**Printing**
Any small printer will print, cut and fold your leaflets and may even help you with the design and it is probably better to get a professional to do this.

- All printers will cut your leaflet to size, so you must leave a "bleed margin". This is a space of 2mm around the edge of your design that can be lost in the cutting. Don't run any text into this space.
- If the quality of an image is too low, its corners will "pixelate" and go jagged. Your images should be saved as 300 dpi and preferably stored as JPG or TIF files.
- If your paper is too thin, heavy colours from one side of the paper will leak through to the other.

# PHAST (Participatory Hygiene and Sanitation Transformation)[22]

**GENERAL DESCRIPTION:**

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

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

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

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

**KEY CONSIDERATIONS:**

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

**ADVANTAGES:**

- The objective of PHAST is not only to teach hygiene and sanitation concepts (where needed) but, more importantly, to enable people to overcome constraints to change. It aims to do this by involving all members of society in a participatory process involving: assessing their own knowledge base; investigating their own environmental situation; visualizing a future scenario; analyzing constraints to change; planning for change; and finally implementing change.
- The participatory approach helps people to feel more confident about themselves and their ability to take action and make improvements in their communities. Feelings of

[22] Adapted from IRC information sheets

empowerment and personal growth are as important as the physical changes, such as cleaning up the environment or building latrines.
- Each step of PHAST contains between one and four easy-to-follow activities and also instructions on how to facilitate each activity.

DISADVANTAGES:

- The participatory process will work only if there exists: respect for people's knowledge and ideas, with clear recognition of their individual and collective inputs; faith in the creative potential of people and in the synergy of the participatory process; a minimum of structure, a maximum of participation; loyalty to the group; and a commitment to creating opportunities for people to express themselves.
- PHAST relies heavily on the training of extension workers and on the development of graphic materials that need to be modified and adapted- therefore, if neither of these aspects is done well there can be efficacy problems.
- PHAST mentions that completing all steps can take anywhere from 2-6 months.

LIKELY SCENARIOS:

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

PHAST IN EMERGENCIES

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

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

**Step 1: Problem identification**
**Step 2: Problem analysis**
**Step 3: Selecting options for solutions**

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

EVIDENCE BASE

PHAST was extensively piloted in four African countries (Kenya, Botswana, Uganda and Zimbabwe) during 1993.
A randomized controlled trial was carried out in the Kyrgyz Republic in 2003 and showed a 68% reduction in Giardia in school children.
An evaluation of a PHAST program in Malawi (DeGabriele, 2004) showed that PHAST was being used as a hygiene promotion tool but not as a community development tool.

KEY TECHNICAL REFERENCES:

http://www.who.int/water_sanitation_health/hygiene/envsan/phastep/en/index.html

# Social Marketing[23]

## What is social marketing?

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

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

## The key components of social marketing are:

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

## What are the basic characteristics of social marketing?

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

| The four Ps of social marketing | Examples |
|---|---|
| **Product**<br>Decide on the product, its form, format, and presentation in terms of packaging and characteristics | The marketed product can be:<br>• physical item e.g. a VIP latrines, SanPlats; or a<br>• practice or behaviour: wash hands after using latrines; or an<br>• idea: clean environment, good sanitation for health |
| **Price**<br>Decide on what the consumer would be willing to pay, both in terms of direct and indirect costs and perceptions of benefits: make the product worth getting | The price can be :<br>• monetary or direct costs: cost of products (with or without subsidies), social cost<br>• opportunity/indirect costs: time lost from other activities, missed opportunities, transport, loss in production or income<br>• psychological or physical costs: stress in changing behaviour, effort involved in maintaining latrine or obtaining additional water required |
| **Place**<br>Where will the product be available to consumers, including where is it displayed or demonstrated? | The place is every location where the product will be available, e.g. at tea shops, religious buildings, at clinics, pharmacies, clubs and local businesses |

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

| Promotion<br>How will the consumers know the product exists, its benefits, costs, and where and how to get it? | Promotion relates to the ways of delivery of the information about the product.<br>For example this can be done through television, radio, newspapers, posters, billboards, banners, folk singers or dramatists, public rallies, interpersonal/counselling<br>Because of its visibility, this element is often mistakenly thought of as comprising the whole of social marketing |
|---|---|

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

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

## Evidence Base:

Schellenberg et al (2001) used large-scale social marketing of treated bednets in rural Tanzania. The approach increased the number of infants sleeping under treated bednets from 10% at baseline to over 50% three years later with an associated 27% increase in child survival among 1mth-4yr olds.
Olembo et al (2004) promoted the CDC Safe Water Systems using social marketing in Zambia. The program showed a rise in point of use chlorination of water from 13.5% in 2001 to 42% in 2004

## How can the social marketing approach contribute to hygiene promotion in an emergency?

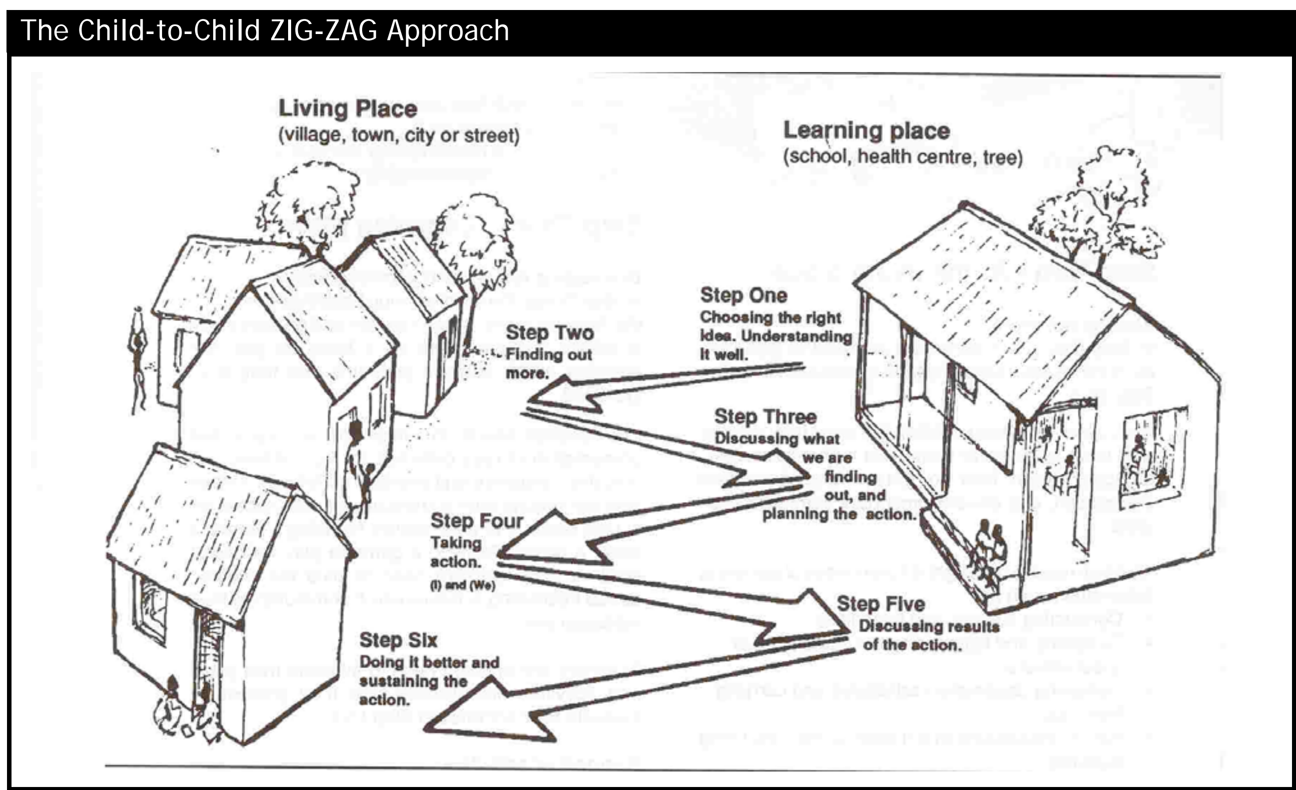
Undertaking a social marketing programme in an emergency is not usually possible, as a significant amount of time is required to research and understand the problem and identify an appropriate strategy. However, the emphasis on understanding the 'consumer's' viewpoint, creating a demand for water, sanitation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

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

# Child To Child[24]

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

The Child-to-Child ZIG-ZAG Approach




## Starting the project

- Gathering the children

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

- Choosing activities

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

Important for the health of the children and their communities
Easy enough for children to understand
Simple for children to do well
Interesting and fun!

- Getting Going

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

[24] Source: Oxfam and Child to Child Trust: *www.**child-to-child**.org*

## Step 1

Introduce `The Idea' and help children to understand it better. For example caring for children with diarrhoea:

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

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

## Step 2

Getting the children to find out more:
The children can find out things among other children, among parents and among others in the camp.
For example: the number of children in the group or family who have ad diarrhoea and how it affected them

## Step 3

Discussing what the children found out and planning activities that will help:
Discuss possible action, find out who else can help the children with practical actions, and make a plan of action
For example: what can 'I' do to prevent diarrhoea
what can 'we' do if another child is affected
what can we do to teach others about the dangers

## Step 4

Taking Action:
Do practical activities at home. Share new ideas and messages with members of the family and friends. Do activities in the camp
For example: making, mixing and tasting a special rehydration drink (ORS)
Giving the special drink to children who have diarrhoea
Checking that people know about dehydration from diarrhoea

## Step 5

Discussing the results of the activities and asking, "How did we do?"
Test knowledge and skills of children in the group and of others in the camp
Observe attitudes and practices of adults and children
For example: how many of us now know how to make the special drink?
how many have passed on the ideas to others?

## Step 6

Doing the activities better next time!

## Some Examples: Clean Safe Water

## Step 1 The Idea

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

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

First ask the children to make up a story about the first picture, describing who, when, where, what, and why. Ask if the water from the pump is clean?
Then show picture 2 and explain that this is one of the first women's children drinking water she brought home from the pump. Ask what could have happened between the first and second picture to make the water become dirty? Have the children continue with the story.
Next show picture 3 and explain that this is one of the second women's children drinking water she brought home from the pump. Ask what has this women done to keep her water clean? Have the children finish the story.

## Step 2 Finding out more

Have the children make a water map of the camp or community. Go and see the sources of water in the area. Which are clean and well looked after? Which are dirty? Draw the map on a piece of paper.
Find out about how people store water in their homes. Do they put it into a clean, covered container? Do they use a separate container, e.g., a cup, gourd or ladle to get water out of the storage container? Make a chart like this and record the information.

| Water Storage Containers | | | | | |
|---|---|---|---|---|---|
| House | 1 | 2 | 3 | 4 | 5 |
| Clean | * | | * | | |
| Covered | | * | * | | |
| Ladle | | | * | | * |

## Step 3 Discussing and planning to take action

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

## Step 4 Taking Action

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

## Step 5 Discussing the results

Ask the children how well they thought their activities were carried out. Did they encounter any unexpected problems? If so, discuss these and look for alternative solutions. Ask the children what effect their play and/or poster had on the knowledge and practice of other children, families and the population as a whole. How will they know in the longer term?
Tell the children to plan on observing the water sources and drawing new maps on a regular basis and keeping a record of the information. Do household surveys using the same time schedule and record if any positive changes have been made in the practices of storing water.

## Step 6 Doing It Better Next Time

Tell the children to think about their play and/or poster. What could have been better? How could the message have been clearer? Practice the play again and/or paint the poster with brighter colours, etc. and do them again to reinforce the health message for the population. Ask

the children to think of ways of keeping water clean that can be made long term and a feature of everyday life.

**Working with Schools**

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

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

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

It may be possible to have the whole school a living example of child to child in action. Staff and children agree a set of rules to live by, for example:

In a child-to-child school, we should all know…
In a child-to-child school, we practice…………
In a child to child school, we spread these ideas………….

**From Child to Child: In Mozambique, Good Hygiene Begins at School**

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

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

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

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

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

And the students' exemplary behaviour is catching on, as parents are listening to their children and practicing better hygiene at home. After seeing the changes in their children's schools, parents have begun to press local authorities to provide better hygiene education and services in all schools. Meanwhile, UNICEF is working closely with the Ministry of Education to see how this program can be replicated elsewhere.

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

**Source: UNICEF/WES**

# Role play, drama, street theatre and puppet shows

**Role Play**
*Role-play* is the use of drama in which people act out situations for themselves in order to acquire communication and problem-solving skills and understand situations more fully. Role-plays can help us learn more about people, their motivations and their behaviours.

Role-plays can vary in length from ten minutes to a whole day. Participants try to imagine themselves in the roles of other people and respond to a situation as they think their character would do. This can help them to understand other people's views and to anticipate how they might respond in a similar situation. When performed in front of a group, role-play can encourage discussion and can lead to working out solutions to a particular dilemma.

The purpose of the role play should be carefully explained at the beginning of the session to help overcome possible reluctance or feelings of embarrassment. At the end of the session each of the participants should be debriefed and helped to disengage from their role characters. This can be done by asking each participant in turn to introduce themselves again and to share their feelings about their roles and the role-play. If this is not done, uncomfortable feelings brought out by the roles and between the actors may cause problems later.

**Street-theatre/drama**
Street-theatre has its roots in story telling and can be used as a learning tool and as a way of passing on hygiene messages. Street theatre is short, lively and spontaneous and is flexible enough to allow audience participation. Equipment for street-theatre is minimal and productions can be put on anywhere and literally in the street. Street theatre can be carried out as dramas with actors or with puppets acting out the scenes. Some suggestions for things you can and can't do effectively with street theatre are listed below. Street-theatre has been carried out in a number of settings, including refugee camps to promote safe water use and the maintenance of water-points.

**Do's and don'ts for street-theatre dramas**
**Do's**
Men dressed as women.
Comic village stereotypes, e.g. drunkards, 'lads', obsequious servants, simpletons, beggars, traditional healers, dishonest merchants, religious leaders.

- Exaggerated characterization.
- Villain/hero conflicts ('goodies' and 'baddies').
- Macabre incidents, e.g. ghosts returning, death, white sheets.
- Dance and song.
- Asking the audience questions (Where is she?) and getting them to reply (She's behind you!).
- A few simple messages.
- Frequent repetition of the messages.
- Messages made clear through actions rather than words.
- Audience participation (asking members of the audience to come into the performance area and join in with certain tasks).
- Spontaneous and lively with a minimum of characters and props.

**Don'ts**

- Long gaps between scenes.
- Fast speech.
- More than one person speaking at one time.
- Scenes involving sitting or lying down.
- Long speeches or dialogues without action.
- Lecturing one actor by another.
- One actor playing different roles that may be confused, e.g. dishonest pharmacist and doctor.
- Complicated plots and detailed scripts.

## How to do street theatre - drama

The purpose of this exercise is to promote better hygiene practices in an entertaining way.

- Brainstorm what makes a good show

The facilitator can suggest these if the participants do not:
Humour (jokes, men dressed as women, stereotype characters)
Drama (hero/villain style, ghosts, death)
Action (lots of movement, not much sitting/lying down)
Interesting dialogue/story (clear slow speech, one actor speaking at one time, no long speech by one actor)
Involving the audience involved (pantomime style etc.)
Local reference (relevant comments to the audience)
Getting the message across.

- Talk through the "Do's and Don'ts for Street Theatre Drama"
- Warm-up

(It may be awkward doing warm-ups but the drama is much better if you have a warm up first)

Try standing in a circle and making animal noises (dog, cat, chicken, cow etc.) Then try acting out stereotype characters (angry wife, drunk husband, beggar, mayor.)

- Decide with the participants the message to be promoted in the community. Then allocate titles to groups.

- Explain that the plays should be 5 to 10 minutes long and will be done outside in the street or around water points. Allow 1-2 hours to work out roles and for preparation of plays and making/gathering of props.

- Ask each group to perform their dramas in turn.

- After each play give feedback on what worked and what did not work. The first to feedback should be the group itself, then other groups can feedback. Facilitators should feed back last.

- The logistics and arrangements for the performance of the drama(s) in the community setting must be discussed and planned.

- THEN PRACTICE AGAIN ... and perform!

**When preparing plays for public performance:**

- Organise people to help seat the crowd in readiness for the performance. Play music while the crowd gathers and is seated.
- Announce the start and ask for applause. Wait for crowd laughter to die down before continuing speech. Don't rush the performance.
- Ask questions of the crowd at the end of the show and repeat correct answers. Ask for applause for each correct response. At the end, thank the crowd and ask them to disperse.

## *Making puppets*

- Simple puppets can be made from mounting cardboard cut out figures on sticks or painting features onto wooden spoons, cardboard tubes or paper bags. (Glove puppets are easy to make and effective to perform with as they are able to pick things up.)
- To make the body, fold a long piece of paper and put your second finger on the fold like this. Draw round you hand and forearm as far down as your elbow, leaving a margin to make a template as shown in the picture. Cut the template along the drawn line, unfold it and pin it to a double layer of cloth. Cut the cloth out and sew it up, leaving the bottom and the neck open. Turn it right side out. Hands and the head can be attached to the body. The puppeteer's fingers must still be able to reach to the top of the puppet's hands.

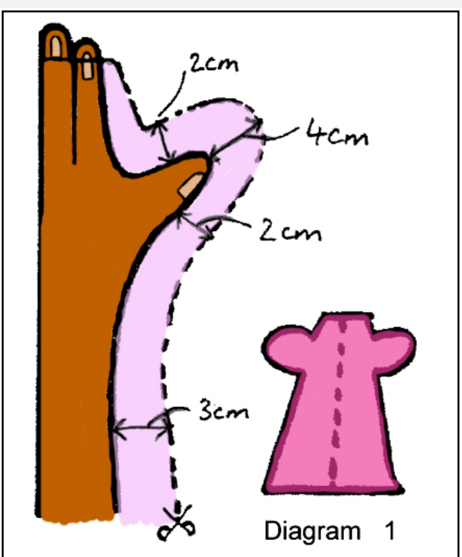


Diagram 1

- To make a puppet head, take thin foam, (0.5cm) and dye in a solution of water and brown poster paint or strong black tea. Squeeze out the water and dry. Cut a head shape out of double thickness foam, sew these pieces together and stuff with kapok/wadding/cotton wool. Make a cardboard tube, wide enough for two fingers and insert it into the neck. Make sure that you sew through the card as well as the cloth when attaching the body to the head. Sew on foam ears and stick on a foam nose. Draw features with marker pens. Make hair by attaching strands of wool, or with marker pens.

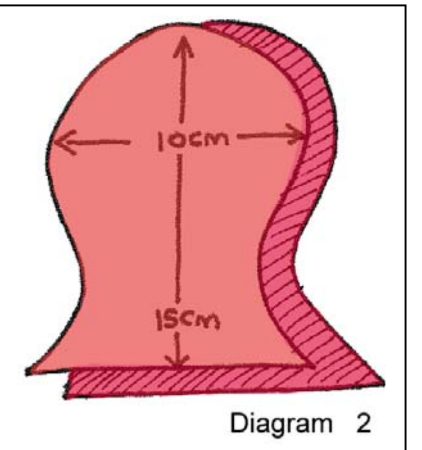
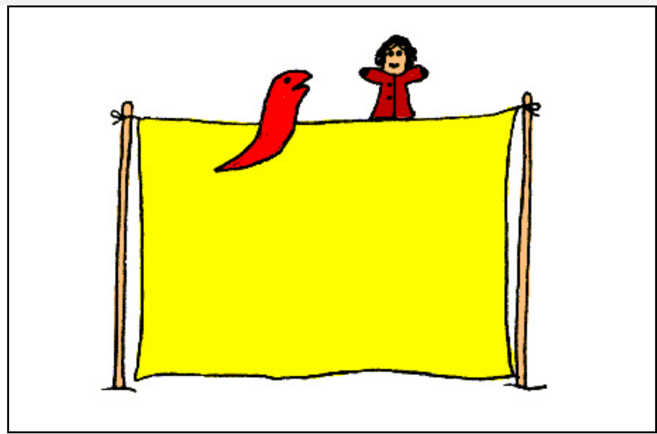


Diagram 2

- To make a portable screen, a length of cloth can be attached to two sticks and supported by people or roped to chairs.



**Puppet shows**
Puppets can be used to give theatre performances or with small groups to encourage discussion. They are especially helpful for communicating with small children as they will often talk directly to a puppet although they may be too shy to talk to an unfamiliar adult. Puppets are also able to do things that actors or ordinary people physically or culturally cannot do.

**Do's and don'ts for puppet shows**
**Do's**
- Short simple plots.
- Stock characters, e.g. traditional healer, beggar, villain.
- Speaking animal characters, e.g. fly, worm, louse.
- Interaction between puppets, e.g. beating, carrying, embracing, (especially those interactions that human actors cannot do).
- Swift changes between scenes.
- Very loud, slow speech.
- One character speaking at one time – the puppet should move or nod when speaking.
- Music and dance.
- Comic sound effects e.g. baby going to the toilet.
- Character moving when speaking.

**Don'ts**
- Long monologues by single puppet.
- Messages conveyed through words alone rather than words and actions.
- Puppets asking the audience questions during the show.

# Available Handouts:

## Role of the Hygiene Promoter

### Community Management of Facilities

- Oxfam Briefing Document on Community Management
- Bujumbura Case Study
- Roles and Responsibilities of WASH Committees

### Introduction to Baseline Survey

- Designing baseline study

### Questionnaire Survey

- Example Questionnaire
- Guidance Notes for carrying out surveys

### Oral Rehydration Therapy

- 'F' Diagram (see Part 1: Key actions to prevent diarrhoea)
- Instructions for management of diarrhoea (see Part 1: Key actions to prevent diarrhoea)

### Cholera Control Issues

- Cholera Toolkit
- Cholera Fact sheet (from session on water and sanitation diseases)

### Malaria Control Issues

- Malaria Quiz
- Focus group discussion framework
- Malaria Fact Sheet (see Part 2 Water and Sanitation Related Diseases)

RBM Information Sheet (see www.rbm.who.int/multimedia/rbminfosheets )

# Community Management Briefing document[25]

## Sustainable Water Supply & Community Management in Emergencies

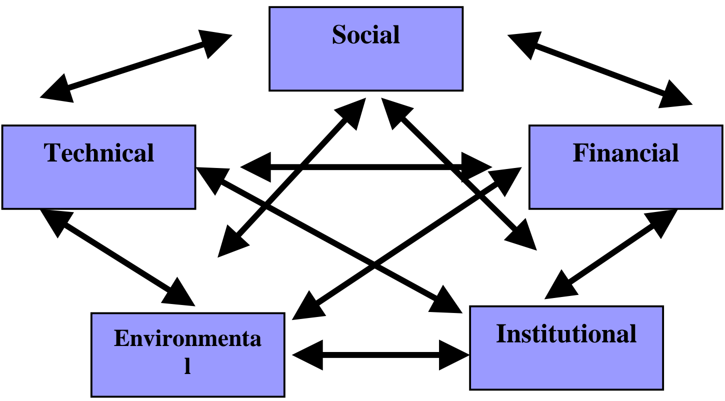
This briefing paper is intended as an overview of current thinking in providing sustainable water supplies to rural communities within the context of emergency interventions. The extent to which it is possible to achieve sustainability in emergency interventions has not been investigated in any depth and this briefing paper therefore relies on research from longer-term development and a common sense application to the emergency context.

In the last decade, the move to promote community management of water supplies within the development context has gathered momentum. Given the breakdown in government services common to many complex emergency situations as well as Oxfam's emphasis on promoting community participation and empowerment, this approach has been adopted by most humanitarian interventions in one form or another. In recent years, however, it has been acknowledged that community management approaches 'have not been noticeably better at sustaining systems than those that went before' (Schouten & Moriarty 2003). This is not to say that community management is an inappropriate approach – given its goal of making communities stronger and more cohesive and the weaknesses in many existing government systems, especially in complex emergencies. What is critical, however, is a more detailed understanding of the criteria and conditions necessary for a sustainable intervention and the application of these criteria to Oxfam's programmes. In the emergency context it may be necessary to accept the concept of 'sustainable enough' where whatever is possible is put in place but with the knowledge that probably more will be required once the situation stabilizes.

### What is Sustainability?

Sustainability can be understood to mean the lasting provision of improved water supply service such that the community will never have to revert to a lower level of service in terms of quantity and quality. Ideally, sustainability would also comprise the replacement or upgrading of facilities as necessary.

Ensuring a sustainable water supply is not the primary objective of an emergency intervention and this may explain why the issue has received so little attention in the past. However, it would seem irresponsible to implement systems and ignore the potential that these systems have to improve the quality of life for people beyond the crisis period, especially as we know that in many situations there is protracted conflict and disruption that leaves people living in an almost permanent state of vulnerability. Whilst the extent to which systems can be made sustainable in short term emergency programmes is not yet clear, it should be remembered that in many countries Oxfam has a relatively long term emergency engagement with specific regions and even communities.
Sustainability can be seen as comprising five interconnected elements as shown in the diagram below:




[25] Draft Oxfam Briefing Paper 2005

In any programme, each of these factors needs to be assessed to understand how to maximize the potential for sustainability.

### Local and National Government

In the past, community management has often been promoted to the exclusion of government involvement but it should be accepted that sustainability is unlikely unless the government is a central part of the process. Research to date shows that ongoing institutional support is required for sustainable rural water supply services. Governments are in the best position to take on this role although there may be other organizations (such as local NGOs or faith based organisations) and the private sector that are also able to take on some of the responsibility. Institutional and policy frameworks are required to ensure that community management is supported and legitimized. Regulation of private enterprises undertaking maintenance will also be required. Legal ownership of water supplies may be a more important factor than contributions made to initial costs in determining people's 'sense of ownership' and therefore motivation to ensure facilities are cared for and maintained. The enforcement of rules regarding the management of water supplies and the ability to bring defaulters to justice is also seen as crucial to the success of community management. In the emergency context, every effort must be made to ensure that the links are made with local and national government and where possible that government capacity to support long-term maintenance is strengthened.

### Community Management

According to Schouten and Moriarty (2003), four factors must be present to determine whether a community is managing a system: control, ownership, operation and management and contribution to costs. Control and ownership are the defining factors and the key to successful community management. Control refers to the 'ability to make strategic decisions about how a system is designed, implemented and managed; to select service levels, set tariffs and if desired employ someone else to look after the operation and management.' (ibid). The carrying out of operation and maintenance tasks, as suggested by the Village Level Operation and Maintenance (VLOM) approach is not essential to the concept of community management as others can undertake these activities with the community managing the process.

Meeting these criteria may not always be possible in the initial emergency intervention but as the situation stabilises, greater control by the community may be possible. However, it is a misconception (and one still widely held) that communities are capable of autonomously managing their own water supplies

It must be remembered that the community is not an homogenous entity but is made up of men and women with different levels of wealth and education. There may be social divisions in terms of religion, caste, ethnic group or class. Gender inequity may also militate against a sense of shared ownership. In emergency situations, social organization may be disrupted even more when people are living in camps. There will be those who want to participate and those who want the benefits but who do not want to pay the price. Leadership will be strong in some communities and weak in others. Understanding these factors and ensuring that they are taken into account in project planning is vital.

Capacity building and support will almost certainly be required and ideally should be sustained after the end of the project. A two-day workshop to train committee members is insufficient and it is often unrealistic to simply hand over facilities to a community when they are not fully prepared to meet the challenges of operating and maintaining the system on their own. Unrealistic demands are often made of communities such as the regular payment and depositing of maintenance fees when in reality people are often only willing to contribute when the system stops functioning. A one off payment may be preferable, that coincides with the time that people are most likely to have money such as harvest time. In addition incentives are usually

expected for committee members and pump attendants/operators and these will need to be considered and budgeted for.

Given the diverse nature of communities and situations there is not a standard model or package that can be applied to ensuring adequate maintenance or community management. Each situation must be assessed individually to take into account the specific needs of the situation and to ensure dialogue and collaboration with existing service providers. It should be borne in mind that what people want is a functioning, reliable and affordable system and not just the promise of control and ownership in the guise of a water committee.

## Alternative Models of Service Provision

Reed & Harvey (2004) outline three models of service provision currently in existence: Village Level Operation and Maintenance (VLOM), Public Private Operation and Maintenance (PPOM) and Private Ownership, Operation and Maintenance (POOM).

The VLOM approach is the original community management model and has developed over time. It may take various forms such as the training of community volunteers (hand pump attendants) to carry out maintenance and simple repairs or the training of a number of area pump mechanics who are called on if a problem arises. However both approaches need significant support from outside if they are to work as it is unrealistic to expect that community members can be trained to undertake major repairs or that they will continue to work without some form of reimbursement.

The PPOM approach does not rule out community management as the community can still own the facility and make decisions about its management but operation and maintenance are carried out by an external agency. Examples of Public Private Operation and Maintenance (PPOM) include the following:

Total Warranty Scheme: The pump manufacturer takes on the responsibility of supporting and training local enterprises to carry out maintenance and of supplying spare parts. The users pay an annual contract fee to the local enterprises. This has been piloted by the company Vergnet in Mauretania and several French speaking West African countries.

Water Assurance Scheme (WAS): This is similar to the Total Warranty Scheme but covers all types of technology rather than just handpumps and the emphasis is on the ongoing provision of safe, adequate and accessible water. Communities pay an annual sum to a private company that provides a maintenance and water monitoring service as well as a repair service for as long as the premium is paid.
In both the above examples, an established private sector is required and an adequate density of systems is required to make it financially viable for small enterprises. The government's role is in regulating the service.

Private Ownership, Operation and Maintenance (POOM) often understandably results in high levels of sustainability where the owner is making a profit from the sale of water and therefore has a strong incentive to repair the pumps whenever a breakdown occurs. Payment may be given in cash or kind. In some instances, it may be appropriate to rehabilitate such a system in an emergency but guarantees of future access for the beneficiary population will need to be assured and contracts drawn up to this effect (Oxfam Haiti can provide examples of this).

The hand pump leasing scheme provides another model of private ownership. The hand pump leasing scheme allows the community to own the borehole or well but to lease the hand pump from an external agency (such as the local water authority) for a fixed fee. Maintenance of the hand pump is then carried out by the agency.

### Spare Parts Supply

The initial choice of technology can be seen as the crucial factor in achieving sustainability and locally produced pumps and spare parts is the ideal choice. However, in the emergency context it may only be possible to procure high quality pumps elsewhere and this may subsequently mean that the supply of spare parts is compromised. Even in longer term situations the supply of spare parts remains problematic and is rarely a cost effective venture for small businesses due to the low pump density and low turnover of stock. It is important to understand the government policy on maintenance of hand pumps, including the provision of spare parts. The provision of a stock of spare parts should always be considered and budgeted for to at least ensure short term sustainability.

### Advocacy

A key aspect of ensuring more sustainable water supplies in emergencies is advocating with governments and other organizations for attention to this issue. It is only recently that the need for ongoing support for community management is being recognized and raising awareness amongst other stakeholders (including donors) in a water and sanitation project is vital if progress is to made.

### Guidelines for Oxfam Staff

Whilst the type of situation that Oxfam responds to is very varied, it may be helpful to think in terms of the acute versus the chronic situation. Below are some of the general issues that it is important to consider. In the acute situation there may not be enough time initially to assess in detail or implement all of the following factors as work may need to begin immediately. However, an assessment should take place as work is proceeding and changes in design should follow where possible.

- A more detailed assessment of external conditions is important- ensure access to government guidelines and plans for maintenance and the supply of spare parts.
- Avoid using a blueprint approach but ensure discussions with communities to provide some level of choice of technology and service provision where possible **(community maps can be a good starting point)**
- In the acute situation, concentrate on ensuring representation from key men and women in the community, identifying those who are vulnerable and on trying to make sure that the government ministries are involved.
- Do not automatically set up water committees - explore existing structures and mechanisms first and work through these where possible and appropriate.
- A community planning group may be more suitable than a committee in a short term situation and may help to encourage a sense of ownership that government programmes can later build upon.
- Emphasis should be placed on making men, women and children aware of their responsibilities with regard to the new facilities and that they will need to consider how they will be maintained in the future **(use critical incident pictures)**
- The importance of promoting linkages between the project and relevant government sectors cannot be over stressed. This does not just mean working with the water board or equivalent but involving all those long term structures that might support sustainability e.g. health department, welfare department, local NGOs or church groups etc.
- A stakeholder meeting could offer a valuable opportunity to ensure that people have the time to discuss key issues such as technology choice and maintenance prior to the project
- Consider both willingness **and** ability to pay now and in the future when the situation has stabilized
- Consider how the poorest and most vulnerable will be catered for now and in future e.g. through subsidies or free access.
- Ensure an adequate assessment of livelihoods and implications for water provision (water requirements for livestock may be high but livestock owners may have greater capacity to pay for maintenance).

- In an area where there is a high or increasing incidence of HIV/AIDS, the choice of technology will require particular care to ensure that it is easy to use. The distance between water sources and households will also need to be assessed and the minimum standard may need to be adjusted.
- Explore existing structures that may offer long-term support within local government and community e.g. faith based organizations or indigenous NGOs **(Venn diagrams are a useful way to explore these relationships).**
- Select training sessions as appropriate and adapt rather than provide a uniform training – concentrate on ensuring that people (men, women and children) understand the issues and practical implications with regard to maintenance and facilitate them to make their own plans - ensure that the wider community is brought into this process through structured community meetings.
- Do not leave training until the end of the programme – allocate resources to ensure this is done as early as possible
- If the situation permits initiate/support/facilitate meetings between local and national government representatives to discuss policy and strategy - (make provision for this in budgets).
- The setting of tariffs and payment schedules should be done with key representatives from the community (community leaders, women, vulnerable groups etc.) and must take into account the amount and timing of payment as well as additional requirements such as incentives for committee members and pump attendants.
- The provision of 'seed funds' to small local enterprises to encourage the supply of spare parts does not appear to be an effective intervention because of the low turnover of spare parts but in the emergency context it may be useful to provide 'seed' spare parts to the Ministry of Health or Water Department so that these items are accessible for at least a few years after the project end.
- Ensure that monitoring systems that consider sustainability are in place to identify problems at the earliest opportunity e.g. functioning of committee/user group, government support, knowledge and practice of hand pump attendants (if trained), groundwater levels, water quality etc. Indicators that define clearly such concepts as 'functioning of group' will need to be chosen. A **'spidergram matrix'** can help to tease out the important elements of such concepts. All stakeholders have a role to play in monitoring but the involvement of the water department or equivalent is particularly important. Community members/groups should also be encouraged to monitor these issues as a means of raising awareness about sustainability. Mock breakdowns could be staged to assess if people know what to do.

# Bujumbura Case Study[26]

Oxfam GB implemented an emergency public health project for displaced people in Bujumbura Rural Province in north-western Burundi. The project sought a reduction in diarrhoeal and vector-borne diseases through two integrated components: technical improvement such as water point rehabilitation, production of portable latrines slabs ("san-plats"), and residual spraying; and health promotion activities organised and carried out through volunteer committees.

**Establishing Committees**

The process of setting up committees followed several steps:

- meetings with commune administrators to present the project;
- meetings with the administrator's representatives and community elders in each site to present the idea of the committees;
- meetings with prospective committee members to discuss the kind of work they would be doing, the voluntary nature of the work, and the issues we would be addressing.

In recruiting committee members, we aimed to have each site represented by at least one man and one woman; we also hoped to find people who were dynamic, respected by the community, and interested in public health issues. A capacity inventory was carried out to learn about skills and preferences among committee members regarding different aspects of health promotion.

Additionally one man and one woman for every 100 households was identified and trained to be community animator. These were energetic men and women who could organise action to address public health issues and who would support the committee volunteers in implementing health promotion and community mobilisation activities.

Originally, the animators were conceived of as a group separate from the more management-orientated committee members. As time went by however, the distinction between committee members and animators became irrelevant: everyone participated in decision making as well as promotion activities.

The idea behind Oxfam's work with committee members and animators was that:

- working with natural helpers, i.e., community members whom others consult for advice and who are already involved in helping their community develop as apart of their everyday life, would be more effective than working on our own;
- focusing on action that the community could take to improve public health would be more effective than increasing knowledge about public health risks.

This led to a standard way of operating: first to discuss and analyse a public health problem, such as diarrhoea, where all participants, including the Oxfam Public Health promotion staff, could share knowledge and correct misconceptions. Then to plan what action(s) could address the problem, such as digging latrine pits and installing sanplats, as well as planning the promotion of these activities that would have to take place in the community. Finally to review the activities carried out by the committee and the community, resolving problems, and celebrating successes. Thus learning took place through doing, and discussions always had a practical objective in mind.

This approach seemed to work well: the committee members and the animators felt respected and included in the process. One valuable aspect of the approach was respecting the voluntary nature of their time and work: I felt that we did not overburden them with demands, and they

[26] Taken from Oxfam PHP Training Manual 2000

responded by working hard in the small amount of time they did have. The group dynamics within the committees was frequently monitored and adjustments when needed. The Oxfam office staff found ways to recognise their accomplishments by giving committee members gifts such as t-shirts (with the phrase "Working Together for Hygiene" on them), cooking pots, hoes, and seeds. The voluntary nature of the committees proved to be sustainable over the ten months of the project. However, the gifts given by Oxfam were crucial to maintaining their commitment, so it could be seen that we were paying the committees in some way.

The Ministry of Health (MOH) has a theoretical structure of health promoters and community health workers in each commune, and the committees should have been linked to that structure. However, we discovered that the structure did not exist to any great extent, and it was more important to establish the committees and begin addressing urgent public health issues in the camps.

**Activities:**

Diarrhoeal diseases were the most prevalent health problem in the camps, and there were a fairly wide range of conditions that could foster their transmission; thus, action to prevent and treat diarrhoea made up most of our promotion efforts. Over the course of the project the committee members and animators:

- Developed and presented a marionette show, sketches, songs, and dances related to general hygiene issues. Everyone involved quickly embraced the use of creative promotion techniques, which made the whole project much more interesting and fun. However, we did not do a very good job of documenting the use of these techniques.
- Created lists of all the households in the camp to organise distributions. Doing this and carrying out the distributions proved to be a relatively easy and empowering task that helped establish trust and credibility. However there was a danger that it would create a parallel bureaucracy in the committees.
- Introduced and distributed 2,000 sanplats, and promoted their correct installation and use. In most sites, the sanplats were properly installed and maintained, and all were carried back and reinstalled when people went home. The weakest point was the use of lids, which appeared spotty at best.
- Organised varied health promotion activities at primary schools. Used a set of drawings showing different hygiene conditions and asked students to sort them into safe or dangerous categories and then discussed the results. Songs and sketches were created and performed by the students.
- Female committee members volunteered for an oral rehydration project, where they received training at their closest health centre and distributed ORS donated by NGOs on an emergency basis. The ORS activity was an exciting initiative as it created direct links between the committees and the existing health care structure, but it will require a lot of attention to make sure that the health centres continue giving the donated ORS to the women.
- Distributed Hygiene-related non-food items including water containers, soap and chamber pots. Overall, the water containers were appropriate, but the extent to which they were properly used is not clear. The soap was a very welcome item, although we had to specifically ask people to reserve one piece per household for hand washing as most was used for washing clothes. The chamber pots were not appropriate at all: most seemed to have been sold or were not being used by the end of the project.

# Example Roles and Responsibilities of Water Committee Members

Both women and men should be included on the committee – preferably equal numbers of both and the members should be chosen with the agreement of community members.

**CHAIRMAN**

Responsible for overall functioning of Committee/User association

**Key Tasks**

Organise regular meetings between committee members to ensure problems are addressed and finances accounted for
To organise meetings when necessary with committee members and other stakeholders e.g. community meeting to address specific problems to do with water, sanitation and hygiene
To act as a catalyst for change in community with respect to hygiene issues, setting a good example of hygiene practice
To organise manpower for specific tasks associated with maintenance of the water source, where necessary (e.g. cleaning surroundings, repairing fence etc.)
To support other committee members in order to ensure effective running of the committee
To act as additional signatory for the withdrawal of money from account

**TREASURER**

Responsible for managing and accounting for finances

*Key Tasks*

To organise and supervise the collection of funds
To manage and account for collected funds by keeping accurate records and depositing money in bank
To act as main signatory for the withdrawal of money from bank account
To purchase spare parts with collected funds
To substitute for the Chairman in case of absence
To act as a catalyst for change in community with respect to hygiene issues, setting a good example of hygiene practice

**SECRETARY**

Responsible for keeping records of action points from meetings

*Key Tasks*

To keep a written or mental note of issues identified in committee meetings and to ensure that action points are clearly defined after each meeting
To support the Treasurer in the collection and managing of funds
To regularly visit the water point to identify problems and report back to committee members
To provide support where necessary to the Water Point Attendant
To act as an additional signature for the withdrawal of funds from the bank account
To act as a catalyst for change in community with respect to hygiene issues, setting a good example of hygiene practice

**WATER POINT ATTENDANT**

Responsible for day-to-day running of the water point system
**Key Tasks**
To perform regular maintenance tasks on water point where necessary
To repair breakdowns where possible or seek help from government technicians
To assist other committee members in the purchase of spare parts
To report major breakdowns as early as possible to the government authorities
To act as a catalyst for change in community with respect to hygiene issues, setting a good example of hygiene practice

# Designing the baseline study

Once the immediate needs and interventions have been identified, it will be necessary to gather more in depth information to inform the future design of the programme and to provide a baseline for monitoring and evaluation. The 'baseline'27 survey provides a detailed assessment of sanitation and hygiene practices. It should draw on both qualitative data (obtained from focus group discussions, three pile sorting exercises etc.) and quantitative data obtained from a random sample of the population, usually using a questionnaire. The data and analysis obtained from the rapid assessment should feed into the baseline survey.

Before embarking on the baseline study consider the following issues:

- Identify stakeholders
- What is the main reason for doing the study?
- What questions do you want to be able to answer later?
- Hence, what questions do you want to answer now?
- What evidence would be needed to answer these questions?
- Who/where would you get this evidence from?
- What methods would you use?
- Who would do the work?
- What training is required
- What resources are required?
- What is the time-scale?

## Qualitative Baseline Data

Example Qualitative Baseline Data Survey Plan

| Settlement | Population | Specific Characteristics | Data Collectors[28] | Data Collection Methods |
|---|---|---|---|---|
| 1 | 1800 | Muslim Village: subsistence farming | Hygiene Promoters x 2 (Volunteers x 4) | Exploratory Walk<br>FGD (women) x 1<br>FGD (men) x 1<br>Pocket Chart Voting (mixed group of volunteers) |
| 2 | 4350 | Periurban community: mixed Muslim, Hindu and Christian | Hygiene Promoters x 2 (Volunteers x 10) | Interviews with key informants<br>FGD (Christian women x 1)<br>FGD (Muslim women x |

[27] In an emergency situation some interventions need to start immediately and therefore the survey will not always reflect the original baseline conditions. A baseline survey can also be taken to mean a much broader assessment of the context but these guidance notes emphasise the use of the baseline for monitoring and evaluation of the MSM intervention.

[28] The number of hygiene promoters and volunteers covering each area is dependent on the situation. For the data collection exercise some of the hygiene promoters may need to cover more than one area.

| | | | | |
|---|---|---|---|---|
| | | | | 1)<br>FGD (Hindu Men x 1)<br>Exploratory Walk |
| 3 | 3400 | Predominantly Muslim fishing community | Hygiene Promoters x 2 (Volunteers x 8) | Interviews with key informants<br>Exploratory Walk<br>FGD (women) x 2<br>FGD (men) x 1<br>Mapping Muslim men |
| 4 | 8350 | Urban area: mixed community, Muslim and Hindu – some Christian, different wealth groups | Hygiene Promoters x 4 (Volunteers x 20) | Interviews with key informants Exploratory Walk<br>FGD (Hindu women) x 2<br>FGD (Muslim women x 1)<br>FGD (Hindu men x 1)<br>Mapping Hindu women ( |
| 5 | 2400 | Predominantly Hindu village – different caste groups | Hygiene Promoters x 2 (Volunteers x 6) | FGD (Hindu women) x 1<br>FGD (Muslim women x 1)<br>FGD (Hindu men x 1) |
| 6 | 6300 | Small town mixed Hindu, Muslim and Christian | Hygiene Promoters x 4 (Volunteers x 12) | Interviews with key informants<br>Exploratory Walk<br>FGD (Hindu women) x 1<br>FGD (Muslim women x 2)<br>FGD (Hindu men) x 1<br>Mapping (Hindu women) |
| 7 | 15470 | Camp – mixed population | Hygiene Promoters x 6 (Volunteers x 40) | Interviews with key informants<br>Exploratory Walk<br>FGD (Hindu women) x 2<br>FGD (Muslim women x 1)<br>FGD (Muslim men x1)<br>FGD (Christian women x 1)<br>3 pile sorting (Muslim women)<br>3 pile sorting (children 5- 8 years) |
| Total | 42070 | | | |

## Quantitative Baseline Data

This is usually gathered using a questionnaire. A random sample of the population is selected to represent the whole population.

*Example of Activity Chart/Gantt Chart for conducting Questionnaire survey*[29]

| Activity | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 | Day 8 | Day 9 | Day 10 | Day 11 | Day 12 | Day 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prepare questionnaire | ■ | | | | | | | | | | | | |
| Translate (if necessary) | | ■ | ■ | | | | | | | | | | |
| Prepare sampling frame | | ■ | ■ | | | | | | | | | | |
| Train survey team | | | | ■ | ■ | ■ | | | | | | | |
| Pre-test questionnaire | | | | | ■ | | | | | | | | |
| Amend questionnaire | | | | | | ■ | | | | | | | |
| Data collection | | | | | | | ■ | ■ | ■ | ■ | | | |
| Data collation | | | | | | | | | | ■ | ■ | | |
| Data analysis | | | | | | | | | | | | ■ | |
| Report writing | | | | | | | | | | | | | ■ |

### *Use of findings*

To inform indicators/ set targets within the logframe (i.e. this is an intrinsic part of the monitoring system)

Once you have completed the analysis, it is good practice to try to discuss the results with the community. Feedback to the community should help to identify subsequent community and agency actions

[29] The preparation and execution of the questionnaire survey will need to be carried out simultaneously with other hygiene promotion activities and should not require the cessation of these other activities for the full thirteen days.

# Example Water, Sanitation and Hygiene Survey Questionnaire

| Name of Interviewer | |
|---|---|
| Date of Interview | |
| Location | |
| Questionnaire No. | |

***Ensure that you define the person that you want to interview e.g. Women with Children 5 years old and under.***

*We are assessing the health and environmental status of your community. We are therefore asking you to participate by answering a few basic questions. The entire exercise will only take a short time. Your answers will be confidential. You have a right to accept to participate or not. Would you like to help us in answering these questions?*

| **DEMOGRAPHICS** | | | | |
|---|---|---|---|---|
| 1 | Name of village (from which the household originates) | | | |
| 2 | Total number in household | Adult Male | < 5 Male | 5-15 Male |
| | | Adult Female | <5 Female | 5-15 Female |
| 3 | Female headed or male headed | Female | Male | |
| 4 | How many people in your family can read and write? | Female | Male | |

| **WATER** | | | | |
|---|---|---|---|---|
| 5 | Where do you get your drinking water from?[30] | TUBEWELL/BOREHOLE | | |
| | | PROTECTED DUG WELL | | |
| | | PUBLIC TAP/STANDPIPE | | |
| | | UNPROTECTED DUG WELL | | |
| | | PROTECTED SPRING | | |
| | | UNPROTECTED SPRING. | | |
| | | RAIN WATER COLLECTION | | |
| | | SURFACE WATER (RIVER /POND/LAKE/DAM/ | | |
| | | STREAM/CANAL/IRRIGATION CHANNELS | | |
| | | TANKER | | |
| | | OTHER (SPECIFY) | | |
| 6 | How long did you have to wait to collect water this morning? | < 15 MINUTES | | |
| | | 15 MINUTES TO 30 MINUTES | | |
| | | > 30 MINUTES | | |
| 7 | How many containers for water collection do you have? | 2 or less | | |
| | | 3 | | |
| | | 4 | | |
| | | >4 (please specify) | | |
| 8 | How many containers do you use every day for your whole family | | | **Calculate total number of litres** |
| 9 | Do you have a separate container for storing drinking water? | YES | NARROW NECKED/COVERED | |
| | | YES | UNCOVERED | |
| | | YES | CLEAN | |

[30] You may want to ask this question twice to record answers for the wet and dry seasons if people have been in the location for some time.

| | | | |
|---|---|---|---|
| | | NO | |
| 10 | Can you show me how you take water from that container if you want a drink? | USES A CLEAN UTENSIL | |
| | | USES HAND | |
| | | USES DIRTY UTENSIL | |
| | | CONTAINER HAS A TAP | |
| | | OTHER (PLEASE SPECIFY) | |
| 11 | Do you treat the water you use for drinking? | BOILING | |
| | | CLOTH FILTER | |
| | | CHLORINE | |
| | | OTHER (PLEASE SPECIFY) | |

| HYGIENE AND SANITATION | | | |
|---|---|---|---|
| 12 | When do you think are the important times to wash your hands?<br><br>(DO NOT READ THE ANSWERS, ASK TO BE SPECIFIC, ENCOURAGE FURTHER ANSWERS ONCE ONLY AND CHECK ALL THAT APPLY) | AFTER GOING TO THE TOILET | |
| | | BEFORE EATING | |
| | | AFTER HANDLING CHILDREN'S EXCRETA | |
| | | BEFORE PREPARING FOOD | |
| | | AFTER TENDING TO THE ANIMALS | |
| | | OTHER (PLEASE SPECIFY) | |
| 13 | With what do you wash your hands?<br><br>(DO NOT READ THE ANSWERS, ASK TO BE SPECIFIC, ENCOURAGE FURTHER ANSWERS ONCE ONLY AND CHECK ALL THAT APPLY) | ONLY WATER | |
| | | SOAP | |
| | | ASH | |
| | | OTHER (PLEASE SPECIFY) | |
| 14 | Where do women in your family defaecate? | LATRINE | |
| | | BUSH | |
| | | RIVER | |
| | | OTHER (PLEASE SPECIFY) | |
| 15 | Where do men in your family defaecate? | LATRINE | |
| | | BUSH | |
| | | RIVER | |
| | | OTHER (PLEASE SPECIFY) | |
| 16 | The last time [*name of child under five*] passed stools, where did he/she defecate? | USED LATRINE | |
| | | USED POTTY | |
| | | USED WASHABLE DIAPERS | |
| | | WENT IN HOUSE/YARD | |
| | | WENT OUTSIDE THE PREMISES | |
| | | WENT IN HIS/HER CLOTHS | |
| | | OTHER (PLEASE SPECIFY) | |
| 17 | The last time [*name of child under five*] passed stools, where were the faeces disposed of? | DROPPED INTO LATRINE | |
| | | RINSED/WASHED AWAY | |
| | | WATER DISCARDED INTO TOILET FACILITY | |
| | | WATER DISCARDED OUTSIDE | |
| | | SOME WHERE IN YARD | |
| | | DID NOTHING/LEFT IT THERE | |
| | | BURIED | |
| | | OTHER (PLEASE SPECIFY) | |

| MANAGEMENT OF DIARRHOEA | | | |
|---|---|---|---|
| 18 | Has anyone in your household had diarrhoea (more than 3 loose stools a day) over the past two weeks? | YES | |
| | | NO | |
| 19 | If yes, who was it? | MAN | |
| | | WOMAN | |
| | | CHILD UNDER FIVE YEARS | |
| 20 | How can you prevent diarrhoea? | | |

| | List ways | | |
|---|---|---|---|
| 21 | The last time (name child) had diarrhoea, what did you do to treat him/her?<br><br>(ASK THE QUESTION AND PAUSE THEN PROBE, YOU CAN THEN ASK EACH QUESTION IN TURN) | WENT TO THE CLINIC | |
| | | GAVE ORS | |
| | | MADE SALT SUGAR SOLUTION AT HOME | |
| | | GAVE EXTRA LIQUIDS | |
| | | GAVE SOLIDS | |
| | | GAVE BREASTMILK | |
| | | GAVE TABLETS (PLEASE SPECIFY) | |
| | | OTHER (PLEASE SPECIFY) | |
| 22 | Can you tell me how to make sugar and salt solution? | CORRECT PROPORTIONS<br>(insert country specific details) | |
| | | INCORRECT PROPORTIONS | |

OBSERVATIONS ARE OFTEN BEST DONE AT THE END OF THE INTERVIEW. PLACE THE RELEVANT QUESTIONS AND OBSERVATIONS AT THE END OF THE QUESTIONNAIRE IF NEEDED.

| OBSERVATIONS | | | |
|---|---|---|---|
| 1 | Are there flies in the house | NO | |
| | | MANY | |
| | | FEW | |
| 2 | Is there rubbish lying around either in or near the house? | YES | |
| | | NO | |
| 3 | Is left over food covered? | YES | |
| | | NO | |
| 4 | Is there a household drying rack for utensils? | YES | |
| | | NO | |
| 5 | Are there faeces seen lying around the outside of house? | YES | |
| | | NO | |
| 6 | Ask to wash your hands – were you offered soap | YES | |
| | | NO | |
| 7 | Are animals kept close to the house? (within the compound) | YES | |
| | | NO | |

| MALARIA | | | |
|---|---|---|---|
| 1 | Have you or any of your children under five suffered from malaria in the past three months? | YES | |
| | | NO (GO TO QUESTION 3) | |
| 2 | If yes, did they receive treatment? | CLINIC/HOSPITAL | |
| | | PHARMACY | |
| | | LOCAL HERBALIST/TRADITIONAL HEALER | |
| | | NO TREATMENT (GO TO QUESTION 3) | |
| | | OTHER (PLEASE SPECIFY) | |
| 3 | If they received treatment was it | WITHIN 2 DAYS | |
| | | AFTER 2 DAYS | |
| 4 | How do you prevent malaria? | SLEEPING UNDER A NET | |
| | | COILS | |
| | | LOTIONS/BODY SPRAYS | |
| | | OTHER (PLEASE SPECIFY) | |
| 5 | Did your child under five (name) sleep under a treated bed net last night? | YES | |
| | | NO | |

Remember to thank the person being interviewed for her time and tell her that you hope to provide feedback on the results as soon as possible. These results will be anonymous and no one will know what specific answers she gave.

# Guidance Notes for Questionnaire Survey

## Interview Etiquette

- Dress appropriately.
- Present official document/certificate from organization or project if necessary.
- Be punctual (if appointments have been made).
- Do not enter the house unless you are invited.
- If you remain outside, do not ask for a chair; sit on the porch, steps, etc.
- Tell people how long the questionnaire will take.
- Do not accept lunch (unless it would be rude to refuse).
- Do not give gifts to interviewees.
- Thank interviewees at the end.

## Choosing Sample and individual households

- Do not choose samples exclusively from particular groups, such as children coming to clinics.
- Do not ask mothers to bring their children to a central point in the community, because some of them will not come; you will not be able to find out how many failed to appear and how different they may be from those who came.
- Do not use samples chosen at will by the interviewer, field supervisor or field director.
- Do not restrict your sample to families living in easily accessible households, such as those close to a main road or near a village centre; families living in less accessible areas may be poorer and less healthy.
- Do not omit households where no one is at home the first time you call. Find out if the household is inhabited, and revisit at a later time.

**Source: UNICEF MICS Survey – choosing a sample**

## Asking Questions

- Introduce yourself to the householder and explain what you want to do
- Make sure that you interview the 'right' person in the household i.e. the person who has been designated as the key informant for this particular survey e.g. mother with children under five
- Do not confuse the respondent by asking two questions at once, such as, 'How many children under the age of five are there and do any of them use the latrine?' Instead, ask two separate questions: 'Can you give me the names and ages of each child in the household?" Then, for each child ask 'where does (Name) usually defaecate?'

# Cholera control - Toolkit for Red Cross Volunteers[31]

*Key Messages*

- Cholera is a dangerous diarrhoeal disease that causes severe dehydration (body dry) if not treated immediately.
- Cholera like diarrhoea is caused by a germ that is found in the stools (pupu) of an infected person.
- Cholera like diarrhoea is spread through drinking water and food contaminated by stools.
- Cholera and diarrhoea can also be transmitted by dirty hands and flies.
- Dehydration, if not treated immediately, can rapidly lead to death.
- Persons with diarrhoea should drink more liquids and be referred to a health facility.
- Breastfeeding must continue in case of diarrhoea in a baby.
- Cholera and diarrhoea can be prevented. Wash hands, boil water, eat hot food.

*What you should know about cholera and diarrhoea and its control in the community*

- Once cholera or diarrhoea is introduced into a community, everyone must practice good hygiene to prevent its spread.
- If cholera or diarrhoea is in the community, go house-to-house in your assigned area to find cases of diarrhoea. Immediately refer them to a health facility or health worker.
- Tell suspect cases of diarrhoea or cholera to drink more liquids, take ORS (oral rehydration solution) if available and seek medical attention immediately.
- ORS is a small sachet of powder which is available at health facilities and pharmacies. It is mixed in a litre of clean water. Adults should drink at least 1 glass (100 ml) of this solution after each stool, children under five ½ a glass and babies should be given continual sips from a spoon (breast feeding must continue as well as the ORS).

*What you need to do in your community*

- Work with the local health workers and community leaders who are trying to control the cholera outbreak.
- Know where the health facility is located in your area and where oral Rehydration solution (ORS) sachets are available.
- You may be needed for COMMUNITY ACTION such as clean up campaigns to reduce flies, for disinfection of wells or for public information in marketplaces, schools, churches etc. on the dangers of cholera and how to prevent it. Your health workers will advise you on these actions.
- You may be needed for HOUSE TO HOUSE ACTION to search for cases and refer them to a health facility and to give the family information on prevention and treatment of cholera.
- Revisit all these families as often as necessary to ensure that new cases are not occurring and that families are practicing good prevention (see below for prevention steps).

*Know the signs of cholera, these include:*

- Continuous watery diarrhoea
- Vomiting
- Rapid dehydration with:
- Sunken eyes
- Dry lips, mouth and tongue
- Thirstiness
- General weakness and sometimes, cramps
- Sunken fontanelle (Open Mole) in babies

[31] Taken from IFRC ARCHI toolkits

*Volunteer's checklist*

- Have you consulted and planned with the local health workers and community leaders in your area?
- Do you clearly know what you will be doing? Community action or house to house promotion?
- Do you know what the community thinks (attitudes and knowledge) about diarrhoea and cholera and how you will explain to them its prevention and treatment?
- If community action is needed, are you working as a team with the health authorities? Do you have the necessary supplies and equipment (megaphone, bleach for wells, pamphlets)?
- If you are doing house-to-house visits, do you know your assigned area and the number of houses you will need to visit? Do you know how often you must visit all these households?
- Do you know where to refer people with diarrhoea? Do you know where to get ORS sachets?

*Measuring your success*

- All suspect cases of diarrhoea in your assigned households are immediately referred.
- All cases of diarrhoea are taking more liquids and mothers continue breastfeeding and go immediately to a health facility.
- Because of good information and early medical treatment, there will be no cholera deaths in the households under your responsibility.

*Keeping records and reporting on your volunteer work*

The number of days you volunteered for cholera control ______

The number of households in your assigned area ______

The number of people in these households ______

*Indicate the number of people visited and the number of diarrhoea cases referred during each round of your house-to-house visits*

First round of visits: ______ people visited, ______ persons referred

Second round of visits: _____ people visited, _____ persons referred

Third round of visits: _____ people visited, _____ persons referred

*Other key messages for families you visit:*

- Cholera is an intestinal infection and the germ is found in stools and diarrhoea.
- Cholera can be prevented by:
    - Drinking safe water
    - water that has been boiled at least 1 minute
    - keep water in a clean container with a cover
    - Eating hot and cooked food
    - Avoid, in times of an epidemic, eating seafood, fish and raw food (fruits and vegetables can be contaminated). Don't eat fruit or vegetables that you have not peeled or washed yourself.
    - Wash your hands with soap or ashes after using the latrine and before eating.
    - Food preparers should wash their hands before touching or preparing food
    - Protect food from flies, keep food covered before serving

# Malaria Quiz Questions[32]

1. Malaria is transmitted by a male anopheles mosquito True☐ False☐

2. How many different types of malaria are there?

3. What is the organism that causes malaria?

4. Vertical malaria control programmes are a new approach to malaria control
True☐ False☐

5. In 1998 WHO introduced a new strategy to address the problem of malaria – what is this new strategy called?

6. Pregnant women should take malaria prophylaxis during the whole of their pregnancy
True☐ False☐

7. Cerebral malaria only affects young children and pregnant women
True☐ False☐

8. It is better to take at least half the treatment dose for malaria than none at all
True☐ False☐

9. Residual spraying prevents malaria by killing all mosquitoes
True☐ False☐

10. Pregnant women and children are more at risk from malaria in _______ than other groups
True☐ False☐

11. What are the main malaria vectors in _________?

12. What is the recommended first line treatment for malaria in _________ and in what dosage?

13. The most effective method of malaria control is the use of Insecticide treated bed nets?
True☐ False☐

14. There are over 350 species of anopheles mosquitoes
True☐ False☐

15. Malaria is responsible for 1.5 – 2.7 million deaths world wide each year
True☐ False☐

---

[32] Taken from Oxfam Malaria Control Guidelines

16. In sub-saharan Africa there are approximately 270 - 480 million cases of malaria each year

True☐ False☐

17. What are the main species of malaria in ____________?

18. Malaria is easy to diagnose and can be done in all clinics and health centres

True☐ False☐

19. A malaria vaccine will soon be available

True☐ False☐

20. Most adults from Sub Saharan Africa have developed life long immunity to malaria

True☐ False☐

21. Why can treatment for malaria fail? (give as many reasons as possible)

22. ___________ is an area of stable malaria transmission

True☐ False☐

23. What methods can you use to protect yourself from malaria? (give as many methods as possible)

24. Severe, life threatening malaria is usually caused by one particular type of malaria

True☐ False☐

25. Insecticide treated bed nets need to be re-impregnated every three months

True☐ False☐

26. How do ITN's/LLIN's protect people from malaria?

27. Which groups should be targeted for the distribution of insecticide treated bed nets?

28. Why might bed nets fail to protect people from malaria? (give as many reasons as possible)

# Malaria Focus Group Discussion Framework

- What are the most common diseases at present and which are the most serious?
- Who gets these diseases? Men, Women, Young children or older children?
- What do you do when someone has Malaria/Fever/Fits? (find out if people classify these separately)
- Who do you go to?
- When do you go?
- What do they do?
- What do you do if this treatment doesn't work?
- Do you give any home treatments? What are they – who do you get them from?
- Is this what happens to all members of the family?
- Is this what everybody does?
- Who gets malaria?
- What causes malaria? – (probe for other answers)
- How can it be prevented?
- At what time do mosquitoes bite most?
- Do people use bed nets here?
- How much did they cost – how much do they cost now / are they available?
- Do they dip them in anything?
- Who uses them (how many in a family)- why do they use them – who do they use them for? Are there people or family members who don't use them – if not do they take any other precaution?
- How long do they last – what happens when they get torn?
- How often do you wash them?
- Where and how do people sleep?
- What time do young children go to sleep?
- What time do adults go to sleep and get up?

# HYGIENE PROMOTION IN EMERGENCIES

## A BRIEFING PAPER

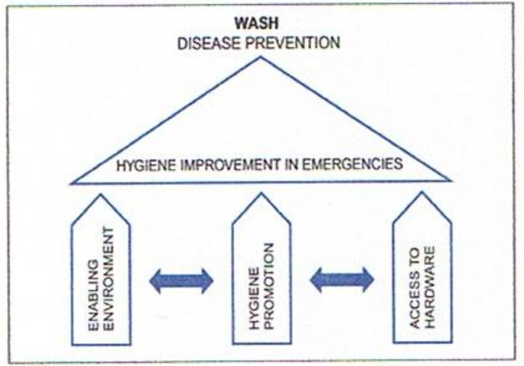
This briefing paper is aimed at all those involved in facilitating hygiene improvement in an acute emergency context, especially WASH co-ordinators and programme managers. It aims to provide an overview of the focus and content of Hygiene Promotion interventions and why they must be integrated with hardware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

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

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

## What is Hygiene Promotion?

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

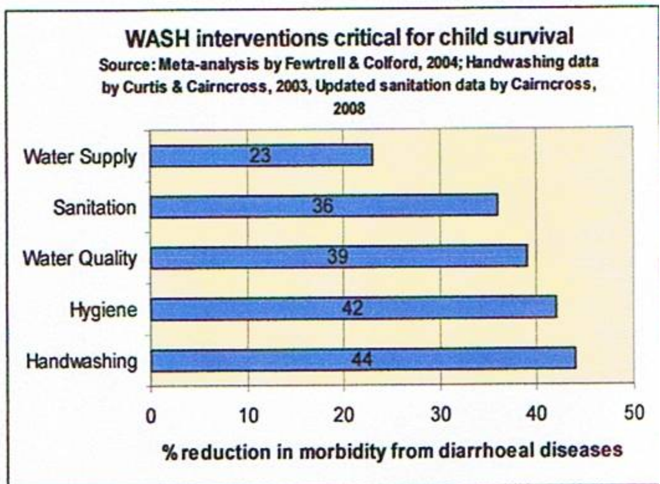



Hygiene Promotion also involves ensuring that **optimal use** is made **of the water, sanitation and hygiene enabling facilities that are provided**. Previous experience has shown **that facilities are frequently not used in an effective and sustainable manner** unless Hygiene Promotion is carried out.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

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

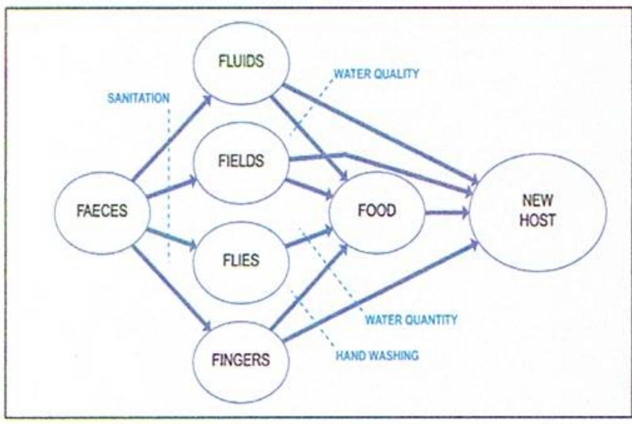
- **Safe disposal of excreta**
- **Effective handwashing.**
- **Reducing the contamination of household drinking water**[2]

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




[1] See Sphere Standards

[2] Example indicators for these objectives can be found in the List of Indicators




The 'F' diagram (left) illustrates the transmission routes of most diarrhoeal diseases and how the transmission routes can be interrupted. Although the main focus of Hygiene Promotion should be the prevention or reduction of diarrhoea, the methods employed may also be used to address other public health issues such as malaria or other water and sanitation related diseases.

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

## Components of Hygiene Promotion

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



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

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

**Selection and distribution of hygiene items e.g.:**
- Decide on content and acceptability of items for hygiene kits
- Ensure the optimal use of hygiene items (including insecticide-treated bed nets where used)

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

**Communication with WASH stakeholders e.g.:**
- Collaborate with and/or orientate government workers
- Train women's groups/co-operatives and national NGOs

Best practice materials produced through the WASH Cluster HP project 2007, amended 2008 c/- UNICEF

**Monitoring:**

**Collect, analyse and use data on:**

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

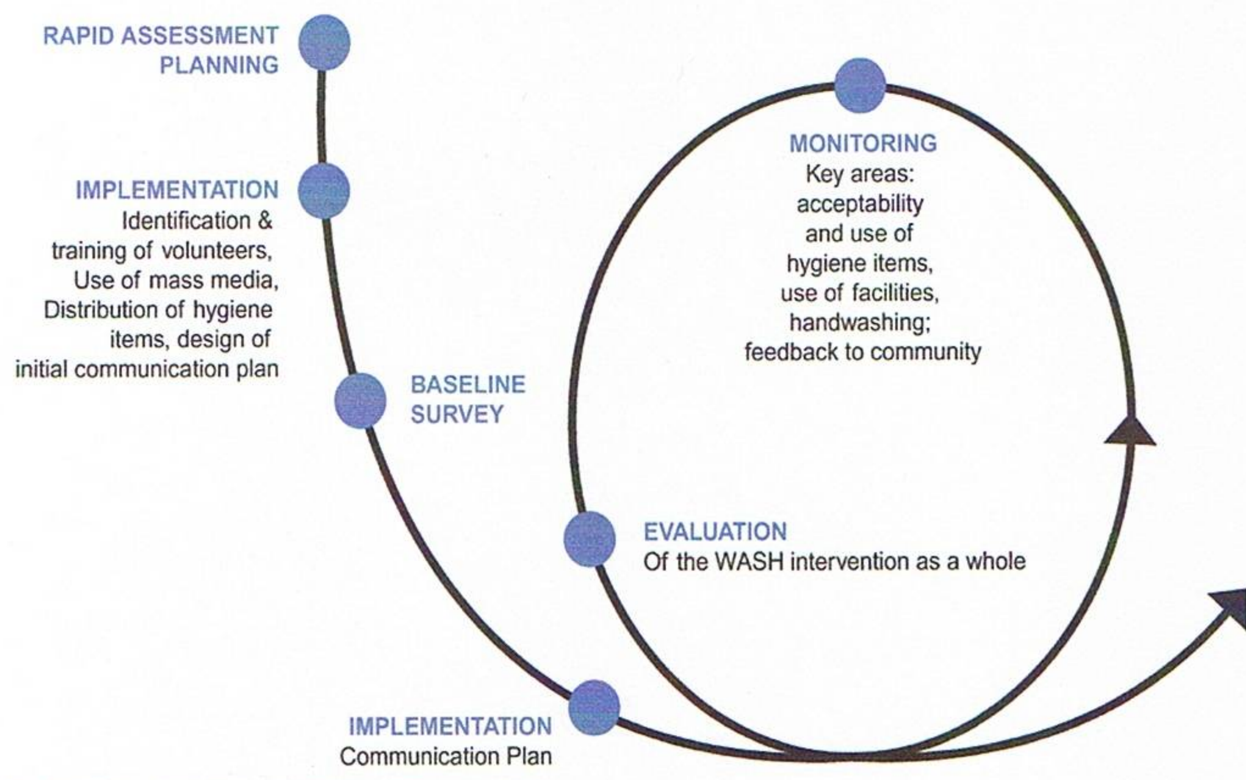
**Action & Information**

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

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

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

**A simplified model of the Project Cycle**




In any emergency intervention, be it chronic or acute, the hygiene promotion aspect of the programme should follow the project cycle and include assessment, planning, implementation and monitoring as shown in the diagram above.

However, in a situation where the public health risks are acute, the stages or steps in the project cycle may be condensed or may take place in parallel with each other.

Best practice materials produced through the WASH Cluster HP project 2007, amended 2008 c/- UNICEF

# Hygiene Promotion in different phases and contexts of an emergency

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

### Team Integration

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

## Hygiene Promotion steps

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

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

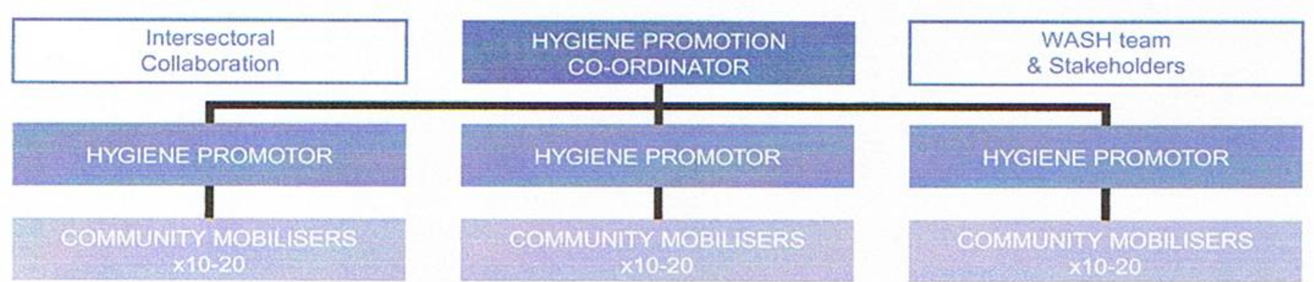
*** Adapted from Guidance Manual on Water Supply and Sanitation: LSHTM/WEDC 1998**

## Hygiene Promotion approaches and methods

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

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

**Cascade Outreach System**




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

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

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

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

[3] The ratio of 1:500 people is suggested as the minimum level of intervention by Sphere

# Appendix 1: Supporting materials

## Introduction to Hygiene Promotion: Tools and Approaches

- **A rapid staff orientation package** focusing on how to engage women, men, and children in WASH interventions, with materials for individual or group inductions and an outline for the content of a half-day workshop for managers, health promoters, and engineers. These materials aim to create awareness and commitment to WASH interventions. This includes an outline, handouts, facilitator's resources and a powerpoint.

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

- **Annotated Bibliography** A list of hygiene promotion tools and resources, (books, manuals, training modules, audio visual materials) as reference materials for WASH coordinators and others.

- **List of Essential Hygiene Promotion Equipment for Communication** to inform WASH coordinators and guide field implementing agencies.

- **Hygiene related Non-Food Items Briefing Paper** A briefing paper that aims to ensure that the distribution of hygiene related non-food items (NFIs) achieves maximum impact.

- **Generic job descriptions and overview** for field hygiene promoters and community level mobilisers that aim to inform and guide WASH coordinators and implementing agencies to encourage consistency and minimum standards.

## Appendix 2: Example Hygiene Improvement Framework for emergencies

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

**ENABLING ENVIRONMENT**

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

**HYGIENE PROMOTION**

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

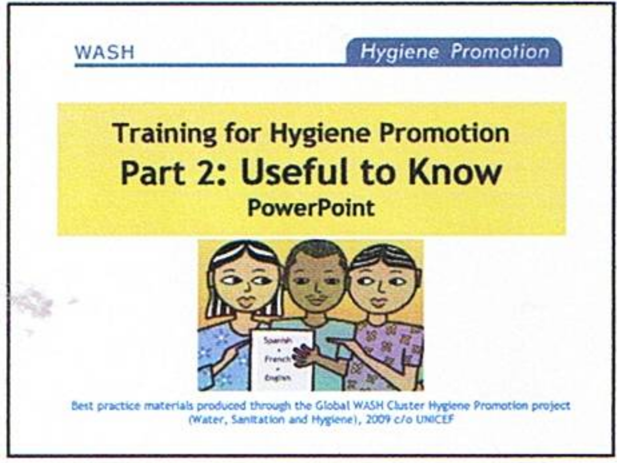
**ACCESS TO HARDWARE**

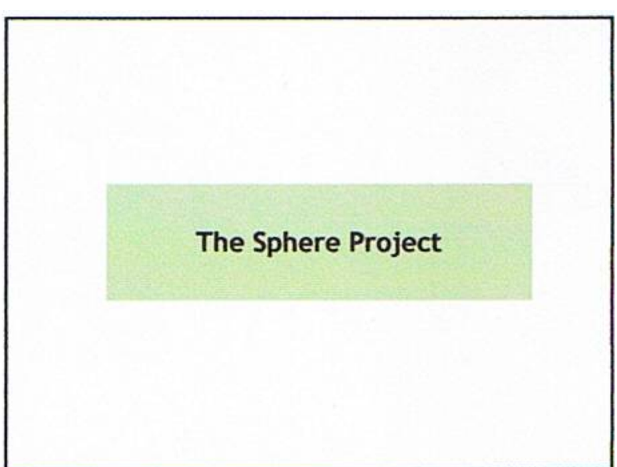
- Water systems: water quality and quantity
- Toilets
- Drainage
- Rubbish disposal facilities
- Household level technologies e.g. water containers, water filters, soap, (contents of hygiene kits)
- Handwashing facilities
- ORS
- ITNs

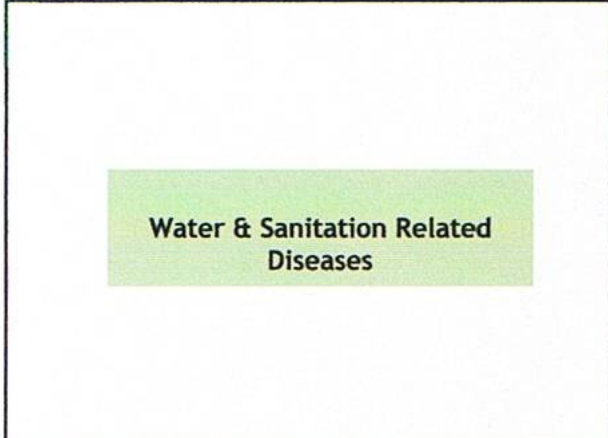
*NB In some agencies, different sectors will take primary responsibility for the provision of Oral Rehydration Sachets (ORS) and Insecticide-treated Nets (ITNs).

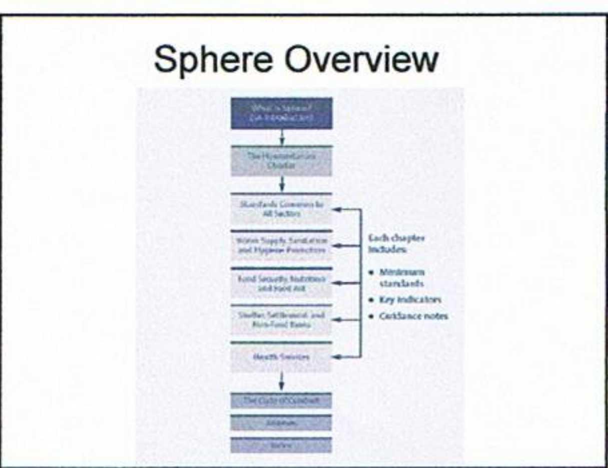
December 2008 (amended graph)

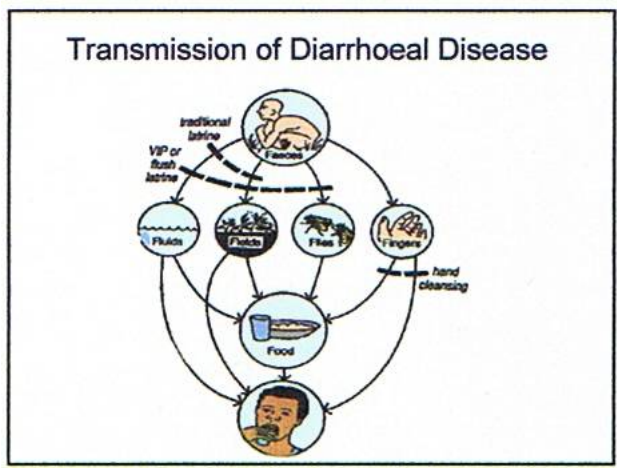
# PowerPoint






Sphere Standards

Example Standards for Hygiene Promotion

## Hygiene Promotion Standard 1: Programme Design and Implementation

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

## Introduction to Gender

## Water supply standard 3 Water use facilities and goods

People have adequate facilities and supplies to collect, store and use sufficient quantities of water for drinking, cooking and personal hygiene, and to ensure that drinking water remains safe until it is consumed.

Indicators:-

- Each household has at least two drinking water containers of 10-20 litres, plus enough clean water storage containers to ensure there is always water in the household
- Water collection and storage containers have narrow necks and/or covers, or other safe means of storage, drawing and handling and are demonstrably used
- There is at least 250g of soap available for personal hygiene per person per month

## What is Gender?

The socially defined roles and responsibilities attached to being a man or a woman. These change according to time and place

## Excreta disposal standard 1: Access to, and number of, toilets

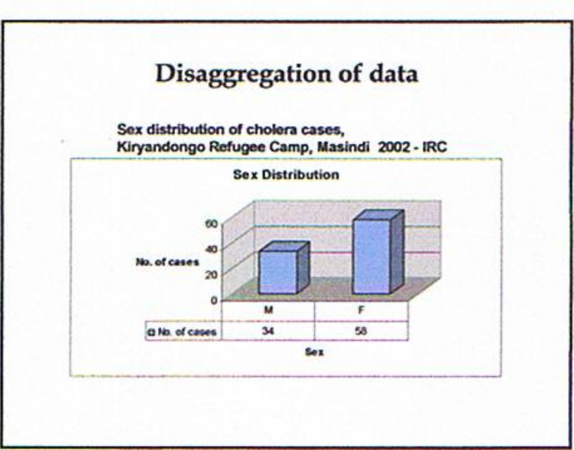
People have adequate numbers of toilets sufficiently close to their dwellings to allow them rapid, safe and acceptable access at all times of day and night.

Indicators:-

- A maximum of 20 people use each toilet
- Use of toilets arranged by household(s) and/or segregated by sex
- Separate toilets for women and men are available in public places (markets, distribution centres, health centres)
- Shared or public toilets are cleaned and maintained in such a way that they are used by all intended users
- Toilets are no more than 50 metres from dwellings
- Toilets are used in the most hygienic way and children's faeces are disposed of immediately and hygienically

## Disaggregation of data

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



## Practical gender recommendations

- Identify gender-disaggregated needs of the target population. Plan your activities based on those needs.
- Ensure privacy, safety and dignity of sanitation facilities (latrines, bathing areas and laundry facilities).
- Ensure proportional provision of facilities
- Ensure facilities and appropriate NFI's to address menstrual needs.
- In societies that practice *purdah* or gender segregation, identify women field workers as well as men.
- Ensure gender-balanced teams. Women sometimes find it easier to express their views to other women and vice versa.
- Involve men in hygiene promotion activities (hygiene can not be seen as an issue related only to women's sphere).

## Common Standard 1: Participation

The disaster affected population actively participates in the assessment, design, implementation, monitoring and evaluation of the assistance programme.

**Indicators**

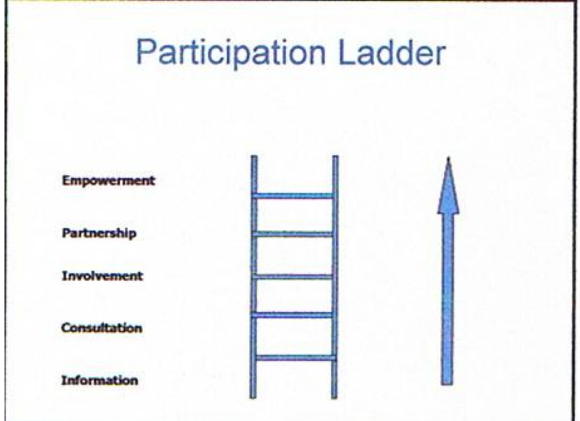
- Women and men of all ages from the disaster affected and wider local populations, including vulnerable groups, receive information about the assistance programme and are given the opportunity to comment to the assistance agency during all stages of the project cycle
- Written assistance programme objectives and plans should reflect the needs, concerns and values of disaster-affected people, particularly those belonging to vulnerable groups, and contribute to their protection
- Programming is designed to maximise the use of local skills and capacities

## Community Participation

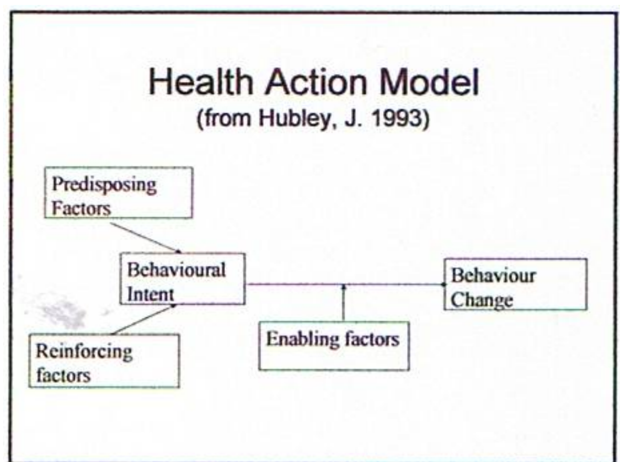
## Activities to promote participation

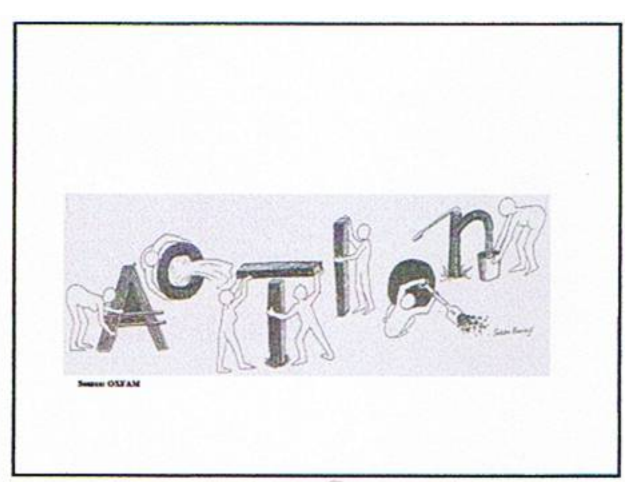
- Listen to men and women separately and analyse their different perspectives and needs
- Identify those who might be vulnerable (e.g. women, young children, elderly, those with disabilities, minority or excluded groups) and ensure access to facilities, information and education
- Feed back information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

## Participation Ladder




## Behaviour Change

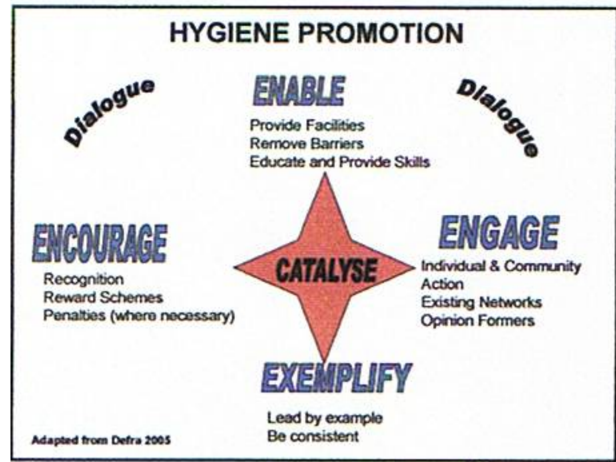


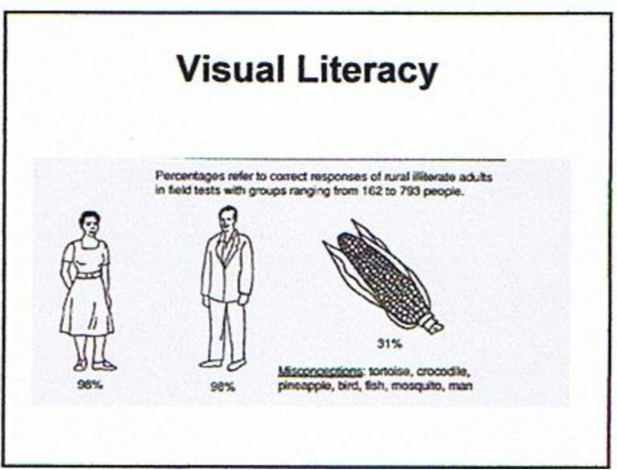



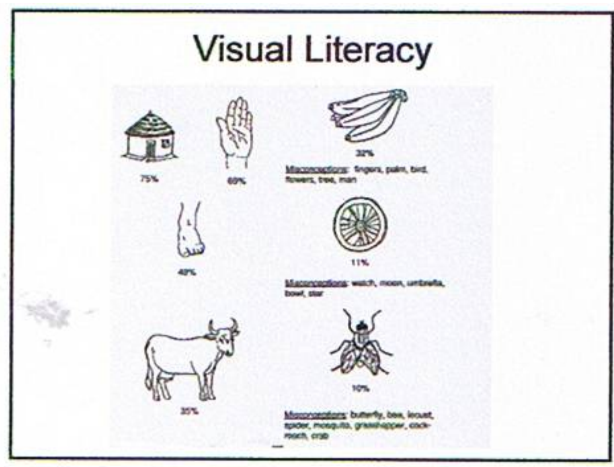

# Positive Deviance

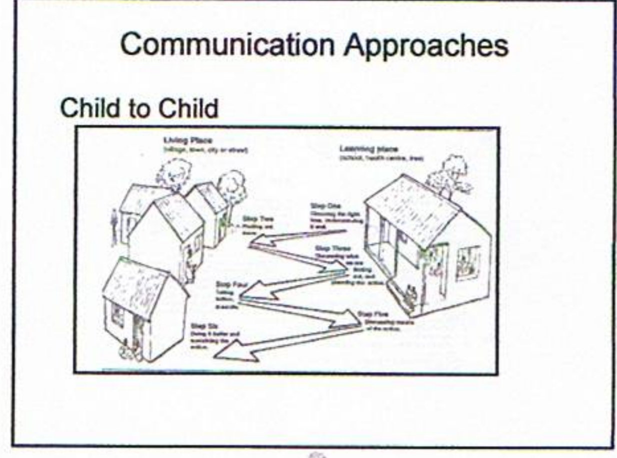
- Why do some people manage to pursue positive health actions despite difficult conditions?
- Examine the reasons for this
- Use this to inform health promotion initiative
- www.positivedeviance.org

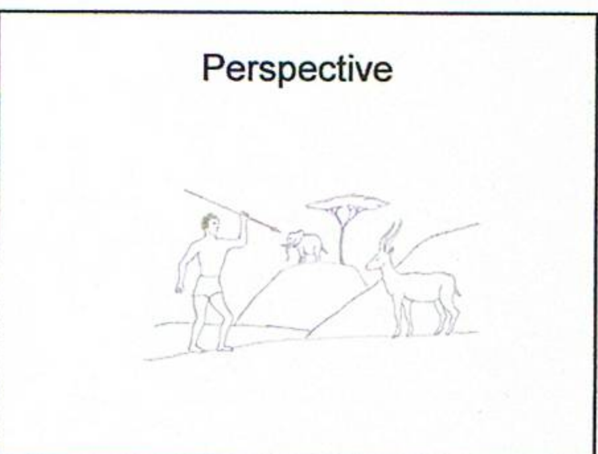
# Using Visual Aids





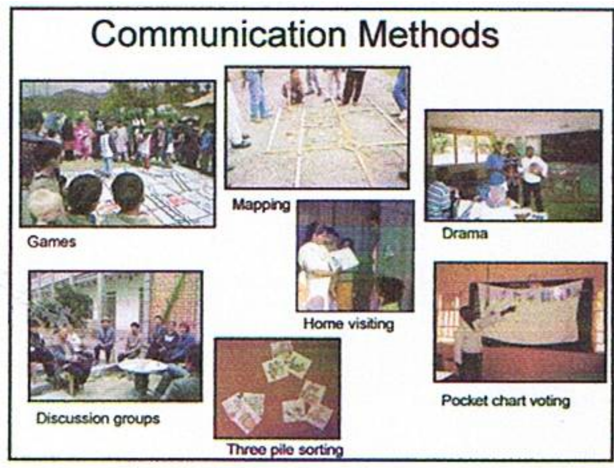

## Communication Approaches

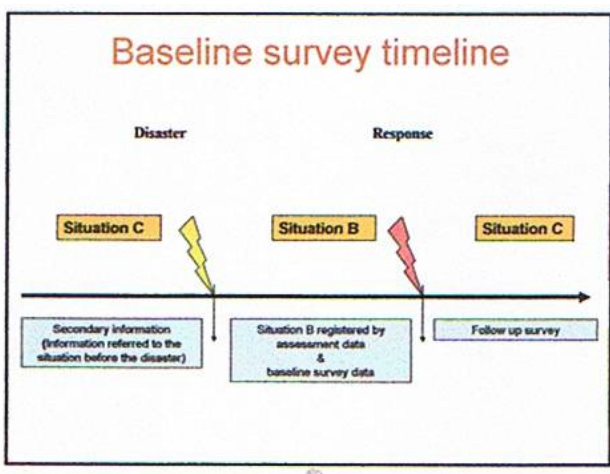
- PHAST?
- Faster PHAST
- CHAST

## Other Promotional Approaches and Methods

## Communication Approaches

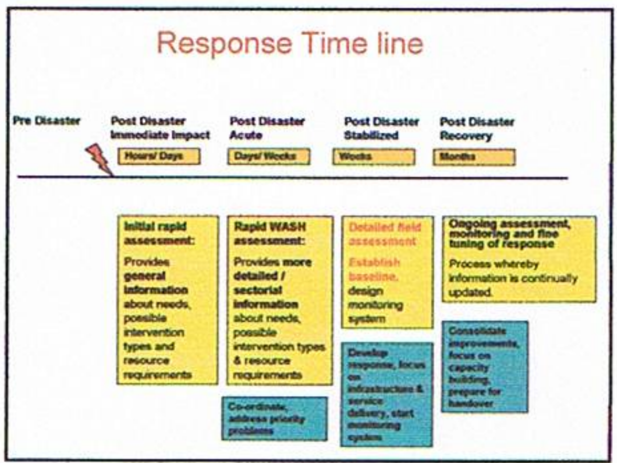
- Social Marketing?
- Campaigns
- Peer Education




## Communication Methods

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




## Introduction to Baseline Survey

## Sampling

**Purposive sampling**

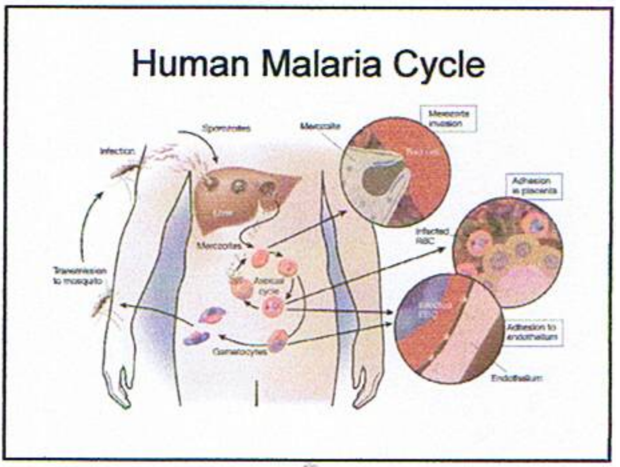
- Used to explore particular issue in depth with particular group
- Used for FGDs etc.
- Sample to redundancy

**Random Sampling**

- Allows us to use the 'few' to describe the 'whole'
- If done well, results can be as reliable as a census
- Used for questionnaire or KAP survey

## Simple Random Sample

- Use sample size of approximately 100 units
- Represents a 'good enough' approach for a social survey in an emergency




## Malaria Control