

Supplementary materials for the Hygiene Promotion Orientation Package

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

Facilitator's resources:

1. PHAST (Participatory Hygiene and Sanitation Transformation)¹ overview
2. Social marketing overview
3. Child-to-Child overview
4. Communication for Social Change and Hygiene Promotion
5. SPHERE
6. Hygiene Promotion and Avian and Pandemic Influenza
7. Hygiene Promotion and HIV and AIDS
8. Humanitarian accountability

Supporting materials

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

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

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

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

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

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

¹ Adapted from IRC information sheets

PHAST Overview **(Participatory Hygiene and Sanitation Transformation)²**

GENERAL DESCRIPTION

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

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

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

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

KEY CONSIDERATIONS

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

² Adapted from IRC information sheets

- 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; visualising a future scenario; analysing constraints to change; planning for change; and finally, implementing change.
- The participatory approach helps people to feel more confident about themselves and their ability to take action and make improvements in their communities. Feelings of empowerment and personal growth are as important as the physical changes, such as cleaning up the environment or building latrines.
- Each step of PHAST contains between one and four easy-to-follow activities and also instructions on how to facilitate each activity.

DISADVANTAGES

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

LIKELY SCENARIOS

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

PHAST IN EMERGENCIES

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

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

Step 1: Problem identification

Step 2: Problem analysis

Step 3: Selecting options for solutions

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

EVIDENCE BASE

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

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

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

KEY TECHNICAL REFERENCES

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

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Social marketing³

What is social marketing?

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

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

The key components of social marketing are:

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

What are the basic characteristics of social marketing?

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

The four Ps of social marketing		Examples:
Product Decide on the product, its form, format, and presentation in terms of packaging and characteristics.	The marketed product can be: <ul style="list-style-type: none"> • a physical item e.g. VIP latrines, SanPlats; or • a practice or behaviour e.g. washing hands after using latrines; or • an idea e.g. clean environment, good sanitation for health 	
Price Decide on what the consumer would be willing	The price can be : <ul style="list-style-type: none"> • monetary or direct costs – cost of products (with or without subsidies), social cost 	

³ Adapted from: LSHTM/WEDC (1998). [Guidance Manual on Water Supply and Sanitation Programmes](#). Published by WEDC for DFID.

to pay, both in terms of direct and indirect costs and perceptions of benefits: make the product worth getting.	<ul style="list-style-type: none"> • opportunity/indirect costs – time lost from other activities, missed opportunities, transport, loss in production or income • psychological or physical costs – stress in changing behaviour, effort involved in maintaining latrine or obtaining additional water required
Place Where will the product be available to consumers? Include where it is displayed or demonstrated.	The place is every location where the product will be available, e.g. in tea shops, religious buildings, clinics, pharmacies, clubs, and/or local businesses
Promotion How will the consumers know the product exists, its benefits, costs, and where and how to get it?	Promotion relates to the ways of delivery of the information about the product. For example, this can be done through television, radio, newspapers, posters, billboards, banners, folk singers or dramatists, public rallies, or interpersonal contact and counselling. Because of its visibility, this element is often mistakenly thought of as comprising the whole of social marketing.

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

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

Evidence base

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

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

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

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

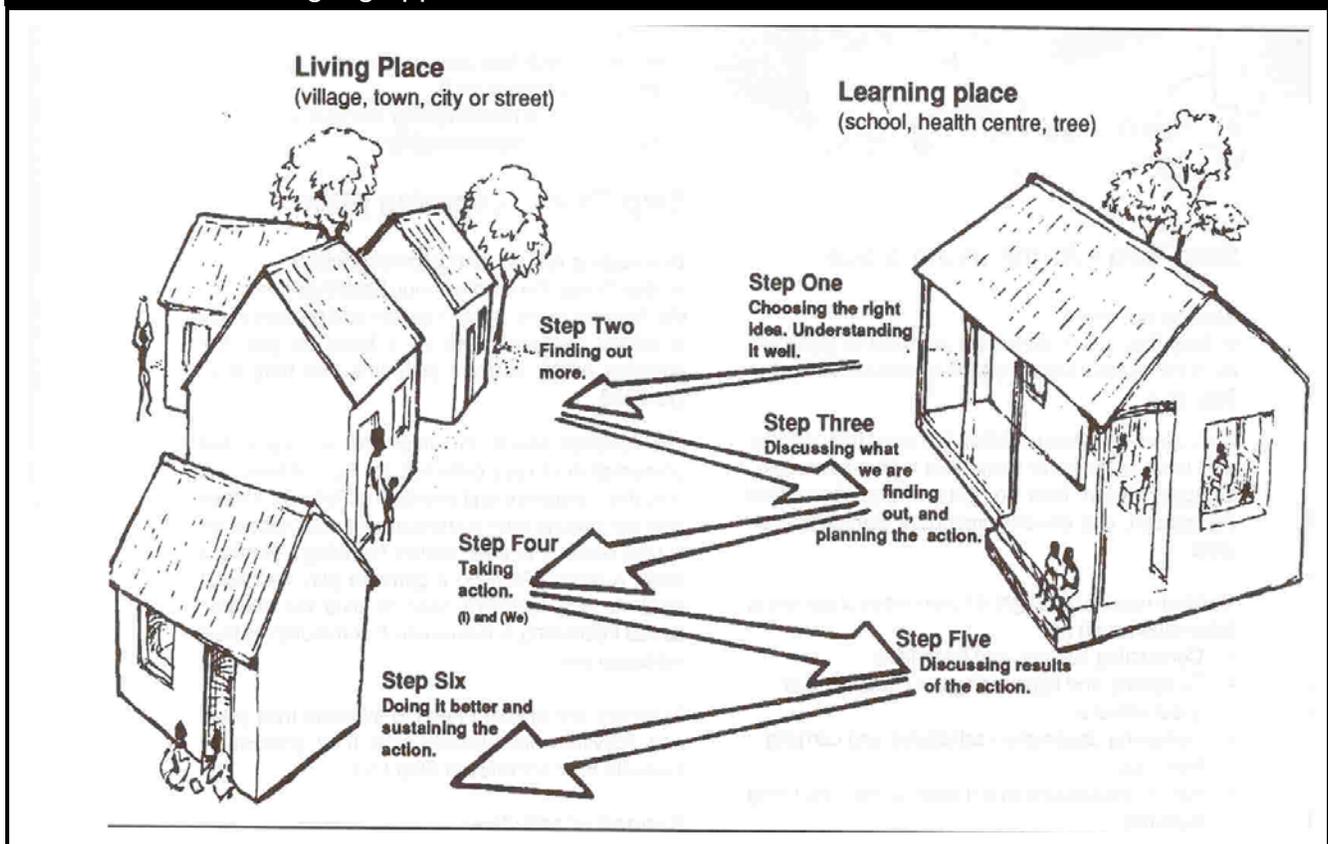
Where there are cyclical emergencies, e.g. cholera outbreaks, social marketing has been used to good effect following the necessary formative research.

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Child-to-Child overview*

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

The Child-to-Child zigzag approach



*UNICEF/WES

Starting the project

- Gathering the children

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

- Choosing activities

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

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

- Getting going

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

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

For example caring for children with diarrhoea:

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

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

Step 2 Getting the children to find out more.

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

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

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

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

For example: what can I do to prevent diarrhoea
what can we do if another child is affected
what can we do to teach others about the dangers

Step 4 Taking action.

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

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

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

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

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

Step 6 Doing the activities better next time!

Some examples:

1. Clean, safe water**Step 1 The Idea**

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

Have three pictures of:

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

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

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

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

Step 2 *Finding out more*

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

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

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

Step 3 *Discussing and planning to take action*

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

Step 4 *Taking action*

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

Step 5 *Discussing the results*

Ask the children how well they thought their activities were carried out. Did they encounter any unexpected problems? If so, discuss these and look for alternative solutions. Ask the children what effect their play and/or poster had on the knowledge and practice of other

children, families, and the population [suggest 'community'] as a whole. How will they know in the longer term?

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

Step 6 *Doing it better next time*

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

2. Working with Schools

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: UNICEF/WES

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Communication for Social Change⁴

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

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

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

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

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

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

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

In the CFSC model, information is shared or exchanged between two or more individuals rather than transmitted from one to the other. All participants act on the same information;

⁴Adapted 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.

none are passive receivers of information. The information can be created by the action of any participant, or it may originate from a third source such as television or radio, or a person or institution not directly participating, such as a church, school, non-governmental agency and so on. The second feature of the model is that it stresses the important role of the perception and interpretation of participants, and understanding is seen in terms of a dialogue or ongoing cultural conversation.

The 10 steps of community dialogue are:

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

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

What relevance does CFSC have for Hygiene Promotion in emergencies?

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

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

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

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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

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Hygiene Promotion and Avian and Pandemic Influenza

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

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

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

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

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

http://www.who.int/csr/disease/avian_influenza/guidelinetopics/en/index.html

Other potentially useful websites:

1. UN Consolidated Action Plan on avian flu Nov 2006

http://un-influenza.org/files/review_nov06_dec07.pdf

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

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

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

http://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_05_8-EN.pdf

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

http://www.who.int/csr/disease/avian_influenza/avian_faqs/en/

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Hygiene Promotion and HIV and AIDS

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

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

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

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

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

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

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

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

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

For further information see:

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

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

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

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

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

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

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

http://www.irc.nl/content/download/4199/48511/file/TOP2HIV_AIDS05.pdf

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Humanitarian accountability

A current working definition of accountability to those affected by crisis is the following: People and communities with whom we work systematically inform programme choices and implementation, throughout the lifetime of the project, and are the most important judges of programme impact.

At a minimum, humanitarian project staff should:

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

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

This seminal report published in 1996 included the following recommendations:

i. Systems for improving accountability need to be strengthened..... The Red Cross/NGO Code of Conduct commits signatories to "hold ourselves accountable to both those we seek to assist and those from whom we accept resources". Full implementation of this commitment

would entail establishment of NGO mechanisms for consultation with people affected by humanitarian emergencies.....

ii. Establish a unit in UN/DHA that would serve as ombudsman to which any party can express a concern related to the provision of assistance or security

Identify a respected, independent organisation or network of organisations to act on behalf of beneficiaries of humanitarian assistance

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

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