CHAPTER- 4

HYGIENE PROMOTION

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WHY PROMOTE HYGIENE IN EMERGENCIES?

Hygiene is the practice of keeping oneself and one's surroundings clean, especially in order to prevent illness or the spread of disease. Emergencies create an environment in which germs flourish: over crowding, traumatised immune systems, poor (or no) access to facilities, latrines, safe water and exposure to disease pathogens - all of which endanger people's health and survival.

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PAKISTAN: A mother washes her daughter's hands with soap and water near their temporary shelter.

Common myths in hygiene promotion that you can avoid.

1. People are empty vessels into which new ideas can simply be poured.
2. People will listen to me because I'm medically trained.
3. People can learn germ theory in a few sessions at the health centre.
4. Health education can reach large populations.
5. Knowing means doing.

Source: Curtis, V.[5]

Research shows that hygienic practices can have an equal or greater impact on disease prevention than water supply and sanitation facilities. Modern thinking suggests that the two must go hand-in-hand to effectively combat disease and to boost healthy, sustainable hygienic behaviours.

What is hygiene promotion?

Hygiene promotion empowers people to prevent disease. It is the process of influencing people's knowledge, attitudes and practices, and an agency's knowledge

and resources which together enable family members to avoid risky behaviours related to water use, waste and excreta disposal and cleaning habits.[1]

The key ingredients to effective hygiene promotion are:
- A mutual sharing of information and knowledge.
- Mobilising communities for concerted action.
- Providing essential supplies and facilities.

We can group hygiene promotion into three categories:[2]
- Reducing high-risk hygienic practices.
- Promoting appropriate use and maintenance of facilities.
- Promoting participation in programmes.

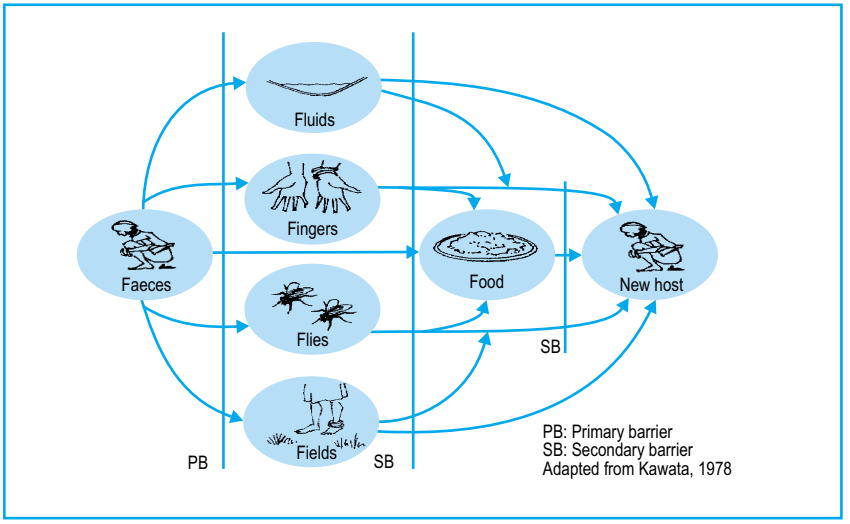
Such a multi-pronged approach should enable the affected community to practice hygienic behaviours and stay healthy.

The role of hygiene promotion in emergencies

Preventing diarrhoeal infection by promoting hygienic practices should be your communication priority Number One in an emergency situation. In camp situations, diarrhoeal diseases can account from 25 to 40 percent of deaths in the acute phase of an emergency. More than 80 percent of the deaths usually occur in children under 2 years.

The F-diagram below illustrates the different routes diarrhoea microbes take from faeces to a person. Interrupting the transmission chain, thus, should be your first priority.

F-diagram: How do people catch diarrhoea?[4]



NEPAL: Teaching proper hand washing techniques in Pumdi Bhumdi, 2004.

PRINCIPLES OF HYGIENE PROMOTION

In emergency situations, you have to coordinate closely with all agencies involved in relief work on a small number of hygiene messages of proven public health importance. Coordination of programme communication activities avoids duplication of efforts and wasting of time and resources - both of the programmes and of the affected community. Apply the following essential principles to hygiene promotion:

1. Focus on a small number of risk practices

To control diarrhoeal disease, your messages should highlight the priority hygiene practices: hand wash with water and soap, or when not available use ash after contact with faeces; and safe disposal of adults' and children's faeces to prevent infection and contamination – i.e. clear scattered faeces, control open defaecation and shallow trench latrines, repair toilet facilities and/or build temporary family or communal latrines.[6]

2. Involve specific participant groups

Involve fathers, mothers, children, older siblings, opinion leaders and other influential persons and groups in the affected community. Public health promoters need to identify primary child caregivers and those who influence and make decisions for them. Involve these influencers in the different stages of a health promotion initiative.

3. Identify the motives for adopting positive behaviours

By working with the various participant groups from affected communities you can discover individual views of the benefits of safer hygiene practices. This insight can provide the basis for a motivational strategy.

4. Keep hygiene messages positive

People learn best when they laugh and pay attention longer if they are entertained. Programmes that attempt to frighten the audiences will tend to alienate them. Therefore, avoid the mention of death in hygiene promotion programmes.

A special word on female hygiene

Provisions for female hygiene have often been neglected in hygiene promotion programmes. Recent lessons from emergency responses in South Asia clearly show that many girls and women find it difficult to practice female hygienic behaviours because of one or more of the following constraints:

- Unavailability of underwear and sanitary napkins.
- Inaccessibility to sanitary napkins; and/or the manner in which sanitary napkins are distributed in the camps and affected areas.
- Lack of clean water and soap for washing and laundering.
- Lack of privacy to change and wash, launder underwear and menstrual rags (in the absence of disposable sanitary napkins).
- Inappropriate positioning of female latrines.
- Social taboos attached to menstruation.
- Lack of knowledge or sensitivity among camp managers and relief workers to hygiene and sanitation-related needs and requests.

These issues make a strong case for the need of a gender-sensitive emergency response team in the camps/affected areas. These also call for sensitivity training for male camp managers, government officials and health workers to ensure that the needs of women and girls are provided for.

A case in point

In the 1998 Bangladesh floods, adolescent girls reported perineal rashes and urinary tract infections because they could not properly wash themselves, and launder and dry menstrual rags in private. They also lacked access to clean water. The girls said they wore the still damp clothes because they did not have a place to dry them.

Women and girls of reproductive age must have access to appropriate materials for absorption and disposal of menstrual blood. Hygiene promoters should advocate for providing private facilities for girls and women to wash themselves, wash and dry underwear and sanitary clothes, and properly dispose of women's sanitary napkins.[7]

DOING THE GROUNDWORK

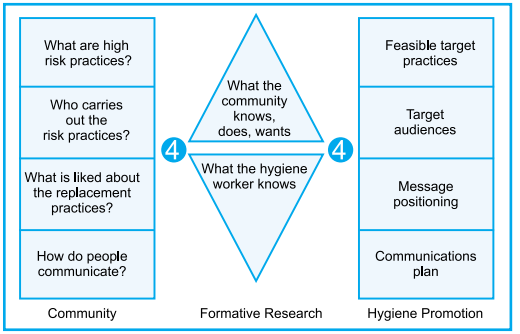
Doing the groundwork for your hygiene emergency response depends on how well you were prepared in the first place, what data and capacities exist, and which partnerships and networks you work with - whom you can quickly tap. When you do your ground work (rapid communication assessment), keep in mind to build on what people already know rather than importing ideas from people the community regards as "outsiders". This should be the basis for any hygiene promotion programme.

The following diagram shows how your planning team should work together with representatives of the affected community in the rapid communication assessment, which is also a formative research process. Your aim is to answer four main questions: Which specific practices are placing the people's health at risk? What messages are most crucial? What or who could (serve as effective channels) motivate them to adopt new practices? Who should be targeted by the hygiene promotion initiative? And how can we communicate with these groups effectively?

Assessment stages

In an emergency situation one of the first steps to doing the groundwork is the rapid assessment. There are different stages involved in the doing the assessment. These stages help you to plan, monitor and adjust your hygiene promotion programme according to behavioural results and feedback from affected community groups, health and relief workers, camp managers and other stakeholders.

RAPID COMMUNICATION ASSESSMENT FOR HYGIENE PROMOTION [8]



Stage I: You can do an initial rapid assessment using tools such as exploratory or transect walks and interviews with key informants from the camps or affected areas, as the case may be, in order to identify priority issues. You need to do this in the first few days after a disaster, working with the emergency rapid assessment team.

Stage II: Use the initial data from Stage I in group discussions with camp managers and dwellers, as appropriate, with assessment tools such as mapping, network analysis, focus group discussions and household observation. This could be undertaken between weeks two and four after a disaster.

Stage III: Obtain a deeper understanding of what people know, do and think, by using tools such as matrix ranking, seasonal calendars, three pile sorting, pocket charts and gender analysis (see below), also as appropriate and feasible. You can choose to do this after you have collected the initial data.

Assessment tools

Please refer to **Part III of the toolkit** for further participatory assessment and planning tools. You can also use the two simple examples below to help you understand the hygiene practices and beliefs of the affected community.

Ranking exercise

In a ranking exercise, ask participants to rank their health needs and priorities on a numerical scale that you would have prepared earlier. A facilitator then guides a discussion with the participants on the relevance and appropriateness of their choices. Ranking provides a quick way to assess the affected community's hygiene and sanitation practices and gets them involved in the initial stages of a hygiene promotion programme. **Please see Tool 7 in Part III of the toolkit.**

PAKISTAN: Women and children who were displaced by the South Asia earthquake in October 2005 fetch water from a water tank provided by UNICEF.

Focus group discussions

You can do focus group discussions (FGDs) in an emergency situation even among a few participants, say three to five. FGDs help you determine what motivates people in the affected community to adopt safe practices and barriers for doing so. It is more productive to group the older women, young women, adolescent girls, men, etc., separately. By so doing, you can elicit uninhibited responses. The qualities of the facilitator and the democratic manner in which the discussions are conducted are critical to your effectiveness in eliciting reliable information. Consider that most hygiene-related information is personal in South Asian cultures and affected groups may share this information only with trusted and/or respected persons, among peer groups or in private.

Note on focus groups:

You can make arrangements for an FGD at any stage of an initiative. You can also use it to share new information with affected community members, while learning about their practices and beliefs. **Please See Tool 8 in Part III of the toolkit.**

Developing behavioural objectives

Once you have completed the initial rapid assessments, you can then develop SMART behavioural objectives for your hygiene promotion programme. The behavioural objectives depend on many factors including the severity of an emergency, pre-existing knowledge and practices, access to and availability of water and sanitation facilities. **Please see Tool 1 in Part III of the toolkit.**

GETTING THE MESSAGE RIGHT

NEPAL: A young girl fetches water from deep well.

Be mindful that in emergencies, having too many messages can create confusion. The only way to make a sensible choice is to know the main risk factor for disease and death - diarrhoeal infection - and to know what practices are common among the affected families and communities. Messages also need to reach the emergency and camp managers and health workers to ensure that the required supplies, facilities and services are available to the affected community groups.

While there are many factors that can help prevent diarrhoeal infection, evidence suggests that the two main factors are:

1. Hand washing with soap or ash after contact with faeces.
2. Safe disposal of adults' and children's excreta.

These are the two most important practices that you need to promote to prevent diarrhoeal infection in the initial emergency response.

What is the correct way to wash hands?

Use at least 0.5 litres (8 ounces) of water, and soap or ash, and rub your hands in at least three different directions.

Note: Use locally understood measursements!

Source: *The sustainability of hygiene behaviour and the effectiveness of change interventions.*[9]

The key-hygiene related messages for all family members, including children are:

- Wash your hands thoroughly with water and soap, or, if soap is not available, water and ash, after contact with faeces and before touching food or before feeding children.
- Dispose of all faeces safely. The best way is to use a toilet or (pit or trench) latrine, or other appropriately safe alternatives.

When diarrhoeal infection is not the most important risk factor anymore, address the range of other risk factors through good hygiene practices like drinking safe water, clean food preparations and safe disposal of household refuse.

Key messages can include:

Building a local lexicon

Discovering local names for diseases helps the affected community link illnesses with causes, preventions and cures; and it allows programmers to tailor the messages.

In Zaire, people use 6 names to describe illnesses that are accompanied with loose stools. A survey found that more than 50 percent of the respondents used ORS to treat kuhara, but less than one-sixth of the respondents used ORS to treat lukungga and kilonde ntumbo - all diseases with diarrhoea symptoms. Programmers adjusted the messages to promote ORS use for each of the six diseases separately rather than using a general term such as diarrhoea.

Source: Strategic Communication for Development Projects[10]

Keeping water clean and safe

- Use only water that comes from a safe source or is purified.
- Boil water until the bubbles appear.
- Drink only safe water.
- Use clean containers with lid/cap to store water.
- Use a clean cup for drawing water from the container, making sure your hands are clean too.

Handling food safely

- Wash hands with soap or ash before preparing food.
- Always cover cooked food.
- Keep kitchen and cooking utensils and water containers clean.
- Keep rubbish bin away from food and cooking.

Safe household refuse disposal

- Put rubbish in bin with lid.
- Empty your rubbish in a collective pit.
- When full, cover rubbish in collective pit with soil.

- If you have a problem with your rubbish, contact:
  1. Camp management.
  2. Municipal council.
  3. Urban council.

Developing and choosing the right and appropriate local variations of these basic messages depends on (1) your knowledge of the main risk factors for disease and death in the emergency situation, and (2) your knowledge of which practices are common among the affected families and communities.

PAKISTAN: Children wait for their turn to use the latrine in one of the camps for people displaced by the South Asia earthquake.

COMMUNICATION ACTIONS FOR HYGIENE PROMOTION

UNICEF's response to emergencies is guided by the Core Commitments for Children in Emergencies (CCC), which provide the overarching organisational framework in a humanitarian response (see Chapter 3). The table below outlines UNICEF's Core Commitments for Children in Emergencies in the areas of Water, Sanitation and Hygiene. We included suggested BCC and social mobilisation activities that have shown evidence to improve hygiene situations in an emergency. Remember to plan your risk communication and social mobilisation actions with the participation of the affected community, the children, youth and your partners, and to carefully monitor and evaluate the programme.

When you choose the mix of communication actions remember that a key aspect to hygiene promotion is to target a small number of risk practices only. For this reason, it is important for you to plan the activities in stages rather than trying to tackle all risky behaviours at once.[11] Your mix of hygiene promotion actions depends on the impact of the disaster; identified priorities; cultural and socio-economic contexts of the affected community; availability of facilities; and existing partnerships and capacity – both human and financial.

TABLE: UNICEF's CCC in the areas of Water, Sanitation and Hygiene and corresponding BCC and social mobilisation support

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
1. Ensuring the availability of a minimum safe drinking water supply taking into account the privacy, dignity and security of women and girls.	■ Make sure that those who are providing water supplies are in dialogue with women and girl representatives to determine the best modes, times, locations and/or distribution points for water supplies.
2. Providing bleach, chlorine or water purification tablets, including detailed user and safety instructions in the local language.	■ Make sure the affected community and service providers receive information on the importance of and how to use bleach, chlorine or water purification tablets – i.e. through loudspeaker announcements, printed materials, and IPC. ■ Train motivated and interested people who live in or near the camp to provide group demonstrations on how to use bleach, chlorine and water purification tablets. ■ Enable service providers through communication skills and counselling training to communicate with and motivate affected individuals and families to use bleach, purify water with chlorine or water purification tablets. ■ Mobilise and engage community volunteers to monitor changes.
3. Providing jerrycans, or an appropriate alternative, including user instructions and messages in the local language on handling of water and disposal of excreta and solid waste.	■ Assess the level of knowledge on hygiene aspects in the different populations of the affected community (since it can vary widely) remembering that this is an area where most related activities are carried out by women and girls.

TABLE: UNICEF's CCC in the areas of Water, Sanitation and Hygiene and corresponding BCC and social mobilisation support Contd..

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	■ Ensure affected community receives information on importance of and how to handle safe water, dispose of excreta and solid waste – i.e. using a combination of loudspeakers, IEC materials, community radio, and/or peer educators. ■ Enable hygiene promoters, facilitators, peer educators, animators to provide one-to-one or small group participatory hygiene education. Ensure they can handle questions and clarify doubts. ■ Enable service providers to communicate with and motivate affected individuals and families to wash hands, handle safe water, and dispose of excreta and solid waste. ■ Engage motivated school-aged children or other interested groups to observe and share information on the handling of safe water, disposable of excreta and solid waste.
4. Providing soap and disseminating key hygiene messages on the dangers of cholera and other water- and excreta-related diseases.	■ Establish and train a team that is familiar with local practices and social structures. ■ Use local languages or pictograms if possible. ■ Work through existing social structures to: ensure affected communities receive soap and information on benefits of hand washing, cholera prevention and the prevention of other excreta-related diseases. ■ Ensure that affected communities, especially primary caregivers, know how to wash hands with soap, and how to prepare ORS to prevent dehydration, by giving demonstrations on hand washing and how to make ORS/ORT. ■ Train female communication agents, including community health workers, volunteers and Girl Guides to ensure women's and girls' access to basic health and hygiene information.

TABLE: UNICEF's CCC in the areas of Water, Sanitation and Hygiene and corresponding BCC and social mobilisation support Contd..

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	■ Train motivated school-aged children or other groups to demonstrate proper hand washing techniques, and for them to observe community practices as part of monitoring.
5. Facilitating the safe disposal of excreta and solid waste by providing shovels or funds for contracting local service companies; spreading messages on the importance of keeping excreta (including infant faeces) buried and away from habitations and public areas; disseminating messages on disposal of human and animal corpses; and giving instructions on, and support for, construction of trench and pit latrines	■ Make certain that affected community receives information on importance of and how to keep human (including infant) faeces from public and living areas, the importance of using latrines – i.e. using IEC materials (including flip charts), demonstrations on how to dispose of infant faeces/diapers. ■ Engage positive deviants or people who bury infant faeces and dispose solid waste properly, as positive role models. ■ Enable service providers to communicate with and motivate affected individuals and families to safely dispose of excreta and solid waste, safely dispose of human and animal corpses, and the use of trench/pit latrines. ■ Train motivated young people to be "link leaders" between camp residents and government officials – i.e. to report on broken and unsanitary facilities, observe facility maintenance and use; and help with monitoring.

In the initial response of an emergency, many activities are likely to be led by programme staff, relief workers and government officials with the assistance of a rapidly mobilised task team of community volunteers. It is essential that you only implement the basic immediate actions this way. Be sure to plan, implement and monitor all long-term aspects of the programme in partnership with affected community groups and other relevant stakeholders.[12]

BEYOND INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
1. Making approaches and technologies used consistent with national standards, thus reinforcing long-term sustainability.	
2. Defining UNICEF's continuing involvement beyond the initial response by:	
■ Establishing, improving and expanding safe water systems for source development, distribution, purification, storage and drainage, taking into account evolving needs, changing health risks and greater demand.	■ Make sure the affected community has the knowledge of how excreta contaminates water and contributes to the spread of diarrhoeal disease, and the relation between unsafe water and cholera – i.e. through group discussions, children volunteers, loudspeakers, community radio, community theatre and IEC materials. ■ Mobilise the community to keep water safe – i.e. train camp residents as water source attendants who encourage people not to defecate near water sources; train support workers to chlorinate all wells and test for residual chlorine levels.[13] ■ Train health workers and other service providers on specific cholera, diarrhoea prevention methods. Enable them to motivate affected community to handle safe water, purify water through boiling, chlorination or water purification tablets.

BEYOND INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
■ Providing a safe water supply and sanitation and hand washing facilities at schools and health posts.	■ Strengthen community knowledge of handling safe water and importance of and how to wash hands with soap, using latrines – i.e. through IPC like animators, IEC materials, etc. ■ Train educators, health workers, school-age children and camp/community residents to demonstrate proper hand washing techniques. ■ Empower service providers with tools and information to motivate school-age children and community to use latrines and to wash hands with soap or ash after defecation. ■ Observe pump and latrine maintenance and promote hand washing practices at schools and health posts as part of monitoring.
■ Supplying and upgrading sanitation facilities to include semi-permanent structures and household solutions, and providing basic family sanitation kits.	■ Involve the community in the design, implementation, and maintenance of sanitation facilities so that the facilities are culturally appropriate, private, child-friendly, accessible by the disabled – and in line with the Sphere Standards, which can be reviewed at http://www.sphereproject.org. ■ Enable service providers to motivate the affected community to use sanitation facilities and basic family sanitation kits. ■ Specifically enable female service providers or community health volunteers to communicate with girls and women about female hygiene. ■ Ensure that girls and women have access to appropriate materials for absorption and disposal of menstrual blood, that facilities allow the disposal of women's sanitary napkins or provide the necessary privacy for washing themselves and for drying sanitary clothes.

BEYOND INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	■ Train motivated school-age children and interested groups to attend and monitor latrines – i.e. report on broken or unsanitary latrines and water pumps, observe facility/latrine use for monitoring purposes, and put up motivational IEC materials with hygiene messages, e.g. posters.
■ Establishing regular hygiene promotion activities.	■ Identify main risk practices to adjust your hygiene promotion initiative in affected areas. ■ Ensure that affected individuals and communities understand good hygiene practices – i.e. by using a mix channels like street plays, traditional folk media, video showings, and other appropriate art forms that draw out local talents. ■ Provide supportive supervision to ensure that hygiene promoters are discussing ways to prevent diarrhoea, cholera and other excreta-related diseases with affected communities – i.e. by advocating hand washing with soap or ash and the use of latrines and by organising training sessions for community and opinion leaders on ways to reduce risk of diarrhoea, malaria or cholera cases/outbreaks. [14] ■ Mobilise community to monitor any changes – i.e. hold community meetings to discuss and share monitoring findings. Jointly decide on how the initiative can be improved.
■ Planning for long-term solid waste disposal.	■ Facilitate water-related discussions on making safe water available. Clearly identify the relationship between safe water, waste disposal and disease and relate those factors to action – both in the preparedness and emergency phases. ■ Engage affected communities in planning safe ways to dispose of solid waste – i.e. by involving them in identifying solutions and developing monitoring plans.

MONITORING MILESTONES

One of the main aims of a hygiene promotion initiative in an emergency situation is to ensure that all populations of the affected community know and adopt the priority hygiene practices to protect their health. The following section presents the key indicators to measure hygiene practices related to excreta disposal.[15] **Tool 13 in Part III lists possible sources of information to help you measure the indicators.**

Key indicators for good hygiene practice

- People use the toilets available and children's faeces are disposed of immediately and hygienically.
- People use toilets in the most hygienic way, both for their own health and for the health of others.
- Household toilets are cleaned and maintained in such a way that they are used by all intended users and are hygienic and safe to use.
- Parents (mothers and fathers, or other primary caregivers) demonstrate knowledge of the need to dispose of children's faeces safely.
- Families and individuals participate in a family latrine programme by registering with the agency, digging pits or collecting materials.
- People wash their hands after defecation and handling children's faeces and before cooking and eating.
- People demonstrate correct hand washing and know when to engage in this behaviour.

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PAKISTAN: A woman cleans a latrine in one of the temporary camps for people who were displaced by the South Asia earthquake.

Key indicators for the design and implementation of your hygiene promotion programme

Ideally, you should base your hygiene promotion activities on the specific vulnerabilities, needs and preferences of all populations in the affected

PAKISTAN: Adolescent girls cooking outside their family tent in one of the camps for earthquake affected families.

communities. These are often influenced by factors like displacement, age, gender, ethnicity, disability and socio-economic status. Take note of the following key indicators for measuring the design and implementation of your hygiene promotion programme:[16]

- Key hygiene risks of public health importance are identified.
- Programmes include an effective mechanism for representative and participatory input from all users at all phases, including the initial design and location of facilities – making sure that latrines accommodate the disabled; are well-lit and designed to protect women from sexual molestation; and provide girls and women the privacy to cleanse themselves, wash underclothes and sanitary rags.
- All groups within the affected community have equitable access to the resources or facilities needed to practice or continue the proper hygiene practices.
- Hygiene promotion messages and activities address key behaviours and misconceptions and reach all participant groups. Representatives from these groups participate in planning, training, implementation, monitoring and evaluation.
- Participants take responsibility for the management and maintenance of facilities as appropriate, and all populations of the affected community contribute equitably.

Note: Plan the behavioural monitoring and set indicators from the start and encourage follow-up action. In other words, encourage your staff, partners and affected communities *to do something* with the results of monitoring. In planning the monitoring and evaluation indicators, you need to be concerned about *information for action* rather than "information to be more informed".[17]

PRACTICAL EXPERIENCES

INDIA: (Second from left) UNICEF Programme Officer Geeta Athreya briefs a team of UNICEF animators before they visit relief centres for tsunami-affected displaced people, in the Union Territory of Pondicherry. The teams are promoting the use of ORS and good hygiene practices to prevent and treat diarrhoea and other water-related diseases. Team members are wearing T-shirts bearing the UNICEF logo.

College students trained to promote hygiene in tsunami relief camps, India

As UNICEF worked to provide and install water storage tanks in Nagapattinam and other tsunami-affected districts in India, one of the priority goals was to prevent an outbreak of diarrhoea. With thousands of homeless huddling in 200-odd camps, the threats from diarrhoea, dysentery and dehydration loomed.

Just one week after the tsunami hit, UNICEF in partnership with a social marketing agency, trained 140 college students and cadets to deliver ORS demonstrations. A team consisted of three student animators, supervisors and UNICEF staff. They travelled by van, from camp to camp to the worst-hit areas.

One such team stopped at the Shakuntaladevi Ramaswami Kalyana Mandapam – a reception hall for marriages cum temporary home – to some 300 people. The animators, supervised by UNICEF's Geeta Athreya, talked about how diarrhoea breaks out in crowded, unsanitary conditions; the importance of washing hands with soap and water after defaecation, before handling food and feeding children. They organised hand washing demonstrations; trained community volunteers to show others how to prevent diarrhoea and recognise the symptoms of dehydration. They instructed the affected individuals on how to prepare ORS.

This experience shows that even in the initial response, group communication approaches can be used to influence participants to adopt healthy practices. In this case live demonstrations occurred simultaneously with flyer and pamphlet distribution. Posters displaying messages about diarrhoea prevention and ORS were also tacked in public areas. By engaging a mix of communication channels, the hygiene promotion team was able to increase the possibilities of hygiene messages being heard, remembered and applied.

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Web sites

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2. Health Communication Partnership
   http://www.hcpartnership.org/mmc/

3. HealtheCommunication
   http://www.comminit.com/healthecomm/index.php

4. HORIZON Communications
   http://www.solutions-site.org/artman/publish/

5. IRC International Water and Sanitation Centre
   http://www.irc.watsan.net

6. PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoea
   http://www.who.int/water_sanitation_health/hygiene/envsan/phastep/en/

7. United Nations Children's Fund
   http://www.unicef.org/wes/index.html

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Footnotes

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