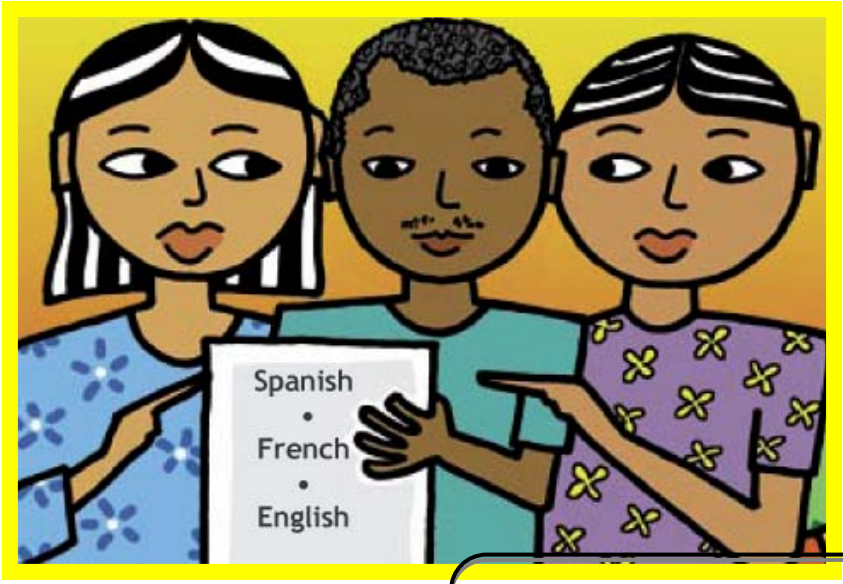
WASH

Training for Hygiene Promoters and HP Coordinators

Part 1 of 3
Essential To Know Training for Hygiene Promoters



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.

This Project has been led by Oxfam GB on behalf of the Global WASH Cluster, with the support of the following Steering Group agencies: IFRC, ACF France, IRC, UNICEF.

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

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

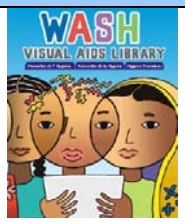
- Session Plans
- Handouts
- PowerPoint

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

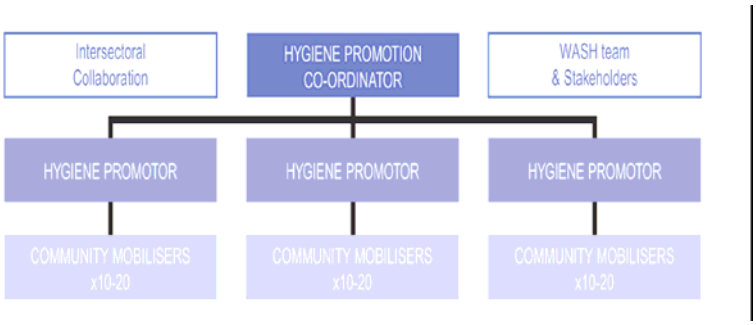
ON:	Where to find
Accountability	Orientation Pack in Introduction CD Part 1 Participation & accountability Part 3 Managing accountability
Assessment	Part 1 Assessment and baseline Part 1 Focus group discussions Part 1 Participatory methods Part 1 Introduction to baseline Part 1 Questionnaire survey Part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

Table of contents

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 2 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 Training for Hygiene Promoters	Part 2: Useful To Know Training for Hygiene Promoters	Part 3: Additional Training for 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. Covers basics of HP in emergencies	Additional sessions that can be run as time allows and as required. Optional sessions on: Baseline and questionnaire survey Malaria Cholera 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 Of interest may be: Behaviour change versus social change Other promotional methods 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: WASH Cluster and coordination Public health in emergencies Hygiene promotion in emergencies Assessment and baseline Hygiene kits: selection and distribution Monitoring	Optional Of interest may be: Behaviour change versus social change Other promotional methods Community management of facilities	HP human resource issues Promoting Integration Co-ordination responsibilities Designing and managing an assessment Data collection & analysis Monitoring 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: WASH Cluster and coordination Public health in emergencies Hygiene promotion in emergencies Assessment and baseline Hygiene kits: selection and distribution Monitoring	Optional Of interest may be: Behaviour change versus social change Other promotional methods Community management of facilities	Overview and project cycle HP human resource issues Promoting Integration Co-ordination responsibilities Designing and managing an assessment Data collection & analysis Monitoring 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 Development versus emergency HP human resource issues Co-ordination responsibilities Designing and managing an assessment Data collection & analysis Monitoring 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: Hygiene kits Selection and support of community mobilisers	Of interest may be: Behaviour change versus social change Other promotion methods	Overview and project cycle HP human resource issues II Promoting Integration Messages versus dialogue

Essential 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 Focus Group discussions Participatory Methods	Introduction to baseline survey Questionnaire Survey	Designing & Managing an Assessment Data Analysis & Reporting
Public Health & Hygiene Promotion	Public health in Emergencies Hygiene Promotion in Emergencies Key water and sanitation priorities Key actions to prevent diarrhoea	Water & Sanitation Related Diseases Behaviour change and Social Change Introduction to HIV/AIDS Use of Oral Rehydration Therapy Cholera Control Issues Malaria Control Issues	Evidence Base Overview of HP Intervention HP Communication Strategy
HP communication methods and approaches	Participatory Methods Communication Skills I and II Working with children Carrying out a campaign	Behaviour change & Social Change Other promotional methods Using Visual Aids Understanding different perspectives	Overview of HP Intervention HP Communication Strategy
Human resource issues/staffing requirements	Job description Selection and Support of Community Mobilisers Adult Learning Planning training & training practice		Job description Recruitment & Managing Others
Key indicators, monitoring and evaluation	Hygiene Kits: Selection and Distribution Monitoring		Impact & Evaluation Logical Framework Monitoring for Managers
Coordination, collaboration and integration	WASH Cluster & Coordination		Development versus Emergency Promoting Integration Developing Partnerships Coordination Responsibilities Managing Meetings
Hygiene kits	Hygiene Kits: Selection and Distribution		Logistics and Financial Systems
Participation and accountability	Participation and Accountability Participatory Methods Community Involvement in Design of Facilities Communication Skills I and II	Introduction to Sphere Introduction to Gender Community Participation Understanding different perspectives Introduction to Protection	Managing Accountability Monitoring for Managers Advocacy
Community management	Community Involvement in Design of Facilities	Community Participation 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 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 **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* *Slides 2-4*	Focus group discussion	*Focus Group Discussion* *Focus group discussion sample questions* *Analysing qualitative data and reporting*
Public health in emergencies	*Public Health Model Slide 5-8*	Job Description	*Hygiene Promoter job description* *PowerPoint Slide 42-43*
Hygiene promotion in emergencies	*Terminology and Definitions* *Hygiene promotion briefing paper* *Hygiene Promotion Slides 9-20*	Assessment and baseline	*Qualitative and Quantitative Assessment* *Leading Questions* *Assessment Methods Overview of Data Collection for Hygiene Promotion* *Example rapid assessment checklist* *Example observation guide for an exploratory walk* *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* *Hygiene Kit Monitoring Form*
Key actions to prevent diarrhoea	*F diagram (also slides 23 -35)* *Instructions for management of diarrhoea*	Selection and support of Community Mobilisers	*Information on community mobilisers and example job description* *Community mobiliser attributes*
Participation and Accountability	*Humanitarian accountability and hygiene promotion* *PowerPoint slide 34-45*	Community Involvement Design of facilities	*PowerPoint Slides 49-51*
Communication skills	*Listening Techniques* *Observation and Listening –slide 36-39*	Introduction to Working with Children	*Child protection good practice guide* *Child Protection Scenarios* *Child to Child Activity Sheets* *Example activities for children* *Children and Learning* *PowerPoint slides 53-56*
Communication skills II	*Communication Worksheet* *Training and communication skills*	Training Practice	*HP 2 Training for Community Mobilisers*
Participatory methods	*Facilitation skills for participatory methods* *Instructions for activities*	Monitoring	*Example of a WASH logical framework matrix* *Indicators for monitoring hygiene promotion in emergencies* *Example hygiene promotion monitoring form* *Examples of PHAST*

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

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

Example Timetable for Essential Training

Session	Day 1	Day 2	Day 3	Day 4
1	Welcome and Introductions **45 minutes**	Review & evaluation of previous day **30 minutes**	Review & evaluation of previous day **30 minutes**	Review & evaluation of previous day **30 minutes**
2	WASH cluster and co-ordination **45 minutes**	Communication skills II **60 minutes**	Job description **60 minutes**	Carrying out a campaign **90 minutes**
Break				
3	Public health in emergencies **45 minutes**	Selection of community mobilisers **60 minutes**	Assessment and baseline **60 minutes**	Working with children **60 minutes**
4	Hygiene promotion in emergencies **90 minutes**	Adult learning **60 minutes**	Hygiene Kits **60 minutes**	Monitoring **90 minutes**
Lunch Break				
5	Key water and sanitation priorities **60 minutes**	Participatory methods **3 hours**	Community involvement in design of facilities **60 minutes**	Planning training and training practice **3 hours**
6	Key actions to prevent diarrhoea **60 minutes**		Focus Group discussion & fieldwork practice **2-3 hours**	
7	Participation & Accountability **60 minutes**			

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

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

pairs, show their paper to each other, and try to guess which of the 'facts' is a lie.

- 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.

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Session Plans

Context

WASH Cluster and Co-ordination

Aims:

This session is designed to:
Ensure that participants understand the rationale of the WASH cluster and the importance of co-ordination

Outcomes:

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

- Describe the WASH cluster rationale and approach
- Describe what they can do to promote co-ordination

45 Minutes

Resources/Handouts:

Flip chart paper
WASH overview PowerPoint slides 6, 7 & 8
Cluster Overview

Session Plan:

Briefly introduce the aims and objectives of the session

Using either the PowerPoint slides or the handout, present an overview of the WASH cluster approach. Encourage the group to ask questions and to identify issues in the current context.
Refer to the different sectors that are covered in Sphere: Hygiene, Water & Sanitation, Food Security, Nutrition & Food Aid, Shelter, Settlement and Non Food Items and Health Services.
Ask the group if there are examples of duplication or lack of co-ordination in the current situation.

15 minutes

In small groups ask participants to draw a Venn diagram of the different actors in the current emergency and consider how best these groups can co-ordinate.
20 minutes

Ask participants to consider the role they have to play in co-ordination. For example:

- Hygiene Promoters will need to liaise with the affected community, government officials, other WASH agencies, other hygiene promoters and others members of their WASH team and they will need to be consistent and

informed when talking to these different groups.

- They will need to be clear about the aims and approaches of the agency they work for and should be working in line with agreed principles and practice common to all the WASH agencies.
- They also have a role to play in actually co-ordinating the work of the community mobilisers that they will supervise and feeding back information from and to the community they are working in.

10 minutes

Facilitators Notes/Key Learning Points:

- Emphasise the importance of the different sectors working together in an emergency in order to achieve an impact on health
- Stress the importance of co-ordination within and between sectors

Where can I find out more?

Sphere Manual (sector specific chapters)
Humanitarian Reform website: www.humanitarianreform.org

Public Health in Emergencies

Aims:

This session is designed to:
Ensure that participants understand the broader health context in which they will be working

Outcomes:

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

- Describe the factors influencing Public Health in an emergency situation
- List the priority areas of intervention
- Explain why it is important for the different sectors to co-ordinate their interventions

45 Minutes

Resources/Handouts:

Large picture of Sick Baby (see Visual Aids Library)
Handout of Public Health Model or PowerPoint Slides 3 and 4

Session Plan:

Briefly introduce aims and objectives

Show the group a picture of a sick baby or child and ask them 'WHY is this baby sick?' For each answer continue to ask the question WHY until the group begins to identify the immediate, underlying and fundamental causes of ill health.
For example:

WHY is this baby sick?
Because she has diarrhoea
WHY does she have diarrhoea?
Because she drinks dirty water or her mother does not breastfeed her or her mother does not know how to make up ORS etc.
WHY does she drink dirty water? Or WHY does her mother not breastfeed her?
Because there is no hand pump or because her mother has not been to school
WHY?
Because she is poor, there are no schools, the government does not prioritise education/health etc. etc.
10 minutes

Show the PowerPoint slide/flipchart of the simple public health model and explain the different levels of causes of ill health i.e. Immediate, Underlying and Structural.
10 minutes

In small groups ask participants to think of examples for each area from the current situation and discuss in plenary

25 minutes

Facilitators Notes/Key Learning Points:

- Emphasise the interrelationship of health and the different sectors working in an emergency
- It is not necessary to explain in detail what public health is (as time is limited) only to explain how the health of the public/population is influenced by many different factors
- Emphasise the link between malnutrition and diarrhoea
- Stress the importance of co-ordination between sectors to achieve impact on health especially on the incidence of diarrhoea and other water and sanitation related diseases

Where can I find out more?

Sphere Manual (sector specific chapters)
MSF (1997) Refugee Health: An approach to emergency situations

Hygiene Promotion in Emergencies

Aims:

This session is designed to:
Ensure that participants have an overview of Hygiene Promotion as part of the WASH response

Outcomes:

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

- Describe the aims and objectives of their WASH intervention project
- Explain the different components of the WASH response
- Explain the different components of Hygiene Promotion
- List some examples of how teams can work effectively together

90 Minutes

Resources/Handouts:

PowerPoint slides 10 -20 (or used as handouts / copied onto flipchart paper)
Terminology and Definitions Paper
Hygiene Promotion Briefing Paper

Session Plan:

Introduction to session with aims and outcomes

In plenary ask participants to call out the aims and objectives of a Water and Sanitation Programme

On flipchart or PowerPoint list the key aims and objectives for your WASH project and show the Hygiene Improvement Framework diagram explaining that access to hardware, an enabling environment and hygiene promotion are necessary if we want to improve health.
10 minutes

Ask participants how the WASH team can work effectively together. Possible answers might include:

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

10 minutes

Ask participants for a definition of Hygiene Promotion and show PowerPoint/flip chart with definition. Discuss the importance of enabling people to take action and that hygiene promotion is not just about changing individual's behaviour.
Show the diagram illustrating the components of hygiene promotion.

In small groups ask the participants to provide examples of each component. Feedback to larger group and discuss the choices made
Total 25 minutes

Show PowerPoint/flip chart on 'why do we need hygiene promotion' to ensure that participants are aware of the three key elements:

- To ensure the best use of facilities
- To facilitate participation and accountability
- To mitigate public health risks/monitor impact on health

5 minutes

Show the project cycle and explain the limitations of the model (i.e. in an emergency activities often have to happen in parallel, monitoring must start as soon as project activities start etc.)
5 minutes

Provide participants with a copy of the Hygiene Promotion Briefing Paper and allow 5-10 minutes for them to read through this and ask questions.
Refer to the Hygiene Promotion Steps on the last page 4 and ask them to read through this and consider how the steps apply to the current situation and what needs to be done and how it will be done. Allow ten minutes to discuss this in groups.
20 minutes

Go through the steps and identify the activities that the hygiene promoters will be involved in.
15 minutes

Facilitators Notes/Key Learning Points:

- Aim of WASH intervention to promote improved hygiene in order to prevent water and sanitation related diseases
- Emphasise the optimal use of facilities and key hygiene practices
- Emphasise the importance of enabling improved hygiene and ensure that participants are aware that hygiene promotion isn't just about message dissemination.
- **ACTION and DIALOGUE** are also key elements of Hygiene Promotion even in an emergency
- Engineers and hygiene promoters must work together to ensure that the maximum benefit from the intervention is achieved.
- Hygiene promoters must inform engineers of community feedback and engineers must be prepared to clarify and use this feedback to inform the design and siting of facilities etc.
- Joint community discussions can be arranged and training of water and sanitation committees should involve the engineers. Even when training mobilisers, it is helpful if engineers attend some of the sessions to meet and familiarise themselves with the field workers.

Where can I find out more?

Hygiene Promotion Guidelines (agency defined)
WASH Hygiene Promotion annotated bibliography

Key Water & Sanitation Priorities

Aims:

This session is designed to:
Ensure that participants are familiar with the different aspects of a water and sanitation programme and understand the priority interventions for the specific context in which they are working

Outcomes:

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

- List the key components of a water and sanitation programme
- Describe the priority hygiene issues that will have the biggest impact on public health and the reasons for this
- Explain how they can work in conjunction with engineers to ensure that these issues are addressed
- List the key areas of hygiene promotion focus for the particular context in which they are working
- Describe the hardware and software elements of the programme on which they are now working and how they work together to achieve an impact on health

60 Minutes

Resources/Handouts:

Four pieces of A4 labelled as described below
PowerPoint slide 22

Session Plan:

Label the four corners of the room with: 1. *Clean Water, 2. Large Quantity of Water, 3. Good Hygiene, 4. Disposal of Faeces.*

Ask participants to go to a corner of the room depending on what they think is the most important priority in a WASH programme and in groups discuss why they have chosen their particular 'corner'

Interview each group and ask them to give two reasons for their choice.
15 minutes

Show the Fewtrell et al PowerPoint/flip chart on relative impact of different WASH interventions and the research on hand washing. Ask how does this relate to the current situation?

Display the key priorities for the specific context and phase of the current intervention in bold letters and discuss how these priorities are to be addressed.
15 minutes

Divide participants into small groups and give each group a specific area to focus on e.g.

excreta disposal, children's excreta disposal, hand washing, clean drinking water. Ask each group to think about what activities and inputs are required for each area of intervention and how the 'hardware' and 'software' need to work together.

Ask each group to present a summary of their discussions and clarify any misconceptions or points of contention.

Draw out key learning points.
30 minutes

Facilitators Notes/Key Learning Points:

- It is important not to try to promote change in too many areas at the same time but to focus on areas that will have the biggest impact: in many cases this will be hand washing (if not currently practiced), effective excreta disposal and ensuring that people drink uncontaminated water.
- In some places, people may be used to washing hands but this may become difficult when living in a camp situation and when water and soap are not easily available. Whatever the hygiene promotion focus, sensitivity is required when dealing with people's hygiene habits.
- However, some issues such as rubbish disposal or the disposal of dead animal carcasses may not pose an immediate public health risk compared to the above issues (although it will encourage fly breeding and will need to be addressed at some point) but can affect people's psychological wellbeing. Additional resources may need to be found to address these issues earlier in the programme – depending on the situation.
- Software and hardware need to work together to achieve impact – one without the other will not succeed in an emergency context

Where can I find out more?

Sphere (Water, Sanitation and Hygiene Chapter)
Hygiene Promotion Guidelines (agency defined)

Key actions to prevent diarrhoea

Aims:

This session is designed to:
Deepen participants' understanding of the chain of contamination of diarrhoeal diseases

Outcomes:

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

- Describe the 'f' diagram and the transmission of diarrhoea
- Describe the correct hand washing technique and why hand washing is important
- Describe how diarrhoea can be prevented

60 Minutes

Resources/Handouts:

Flip Chart Paper
PowerPoint slides 24 - 33
F diagram
Instructions for management of diarrhoea
Pictures/examples of possible hand washing facilities

Session Plan:

Briefly introduce the aims and objectives of the session

In plenary brainstorm the ways in which water can become contaminated (ask participants to think about their own situation unless they all have piped water at home!)

Ask participants to think about how they keep drinking water clean in their own home and discuss with their neighbour. Ask for examples from the group.
10 minutes

In small groups ask participants to consider what people can do in the present situation to prevent the contamination of water:

1. at the source
2. during transportation
3. at home

Each group should list the points on flip chart paper. Then groups should rotate to review each others' points. When reviewing ask them to consider how feasible these suggestions are and what can be done to make these suggestions happen.

Ask each group to feedback on one important method of contamination and suggestions for addressing this until the most important methods have been covered.
30 minutes

Show F Diagram and explain the other modes of transmission of diarrhoea. Explain how the transmission routes can be blocked especially by hand washing and safe excreta disposal. Explain or show the evidence from the Curtis and Cairncross study (see PowerPoint slide)

Show PowerPoint/pictures/demonstration of possible hand washing facilities and hand washing technique. Also give an example of a hand washing song e.g. hand washing rap.

Provide each group with pictures from 'F' diagram and asked them to construct this and place the barriers to interrupt transmission
20 minutes

Facilitators Notes/Key Learning Points:

- Once again software and hardware should be working together: hardware could include the distribution of household water filters, chlorine solution or clean water collection and storage containers; software is ensuring that these are used appropriately. In this instance the hygiene promoters may be responsible for some of the hardware interventions
- Poor water, sanitation and hygiene practices can cause diarrhoea, which is spread by the faeco-oral route.
- It is useful to again highlight the important link between malnutrition and diarrhoea.
- When discussing safe water, the focus should be on drinking water rather than water for all purposes – people may collect/store water from a variety of sources for different purposes
- Hand washing with soap or an abrasive substance is required rather than just water.
- Participants should consider how they can enable people to prevent water contamination e.g. hand washing containers by the latrine, group discussions with households to motivate them etc.

Hygiene Promotion & Accountability

Aims:

This session is designed to:
Ensure that participants understand the terms accountability and participation and how they can help to make their work more accountable to those affected

Outcomes:

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

- Explain what accountability is and why it is important
- List some practical ways that they can facilitate participation of and accountability to those affected by the emergency
- Describe how hygiene promotion can enhance the accountability of WASH interventions

60 Minutes

Resources/Handouts:

PowerPoint slide 35 (Activities to promote participation & accountability)
Humanitarian Accountability and Hygiene Promotion
Cards or post its (2 for each participant)

Session Plan:

Briefly introduce aims and objectives
Ask participants to define what is meant by accountability and why it is important.
For example the HAP definition is:

Accountability is the means by which power is used responsibly.

Ask the group to think of examples of how power is misused and what can be done to guard against this.
15 minutes

Ask participants to write down different stakeholders in a WASH project on cards or post its. Place a card with 'Me' written on it in the centre of a board and ask participants to come and place their 'stakeholder' cards above or below the 'Me' card depending on whether the stakeholder is more or less powerful.

Ask the group where to place arrows showing lines of accountability between the different stakeholders and ask what individual participants can do to improve their accountability to those affected by disasters.
20 minutes

Ask the group for a definition of Participation in this context (see later session on Community Participation in Part 2, for more information) and explain how different levels of participation may be required at different stages of the emergency.

Ask how they can enable different groups to have greater influence in the project and show the PowerPoint slide with some examples.
15 minutes

Explain that hygiene promoters are in a good position to listen to community views and to feed these back to their own and other agencies. They need to make this a key responsibility of their work and use a participatory rather than directive approach when working with those affected. They also need to ensure that they are able to answer community questions about their organisation or the project and be ready to listen to feedback and complaints from people.

Clarify the key learning points and distribute the handout on accountability. Ensure that any questions are clarified.
10 minutes

Facilitators Notes/Key Learning Points:

- Another definition of accountability is:
  *The people and communities with whom the WASH cluster work, systematically inform decisions and implementation, throughout the lifetime of the response, and are important judges of programme impact***.**
- Hygiene Promotion can help to ensure that WASH agencies are accountable to the emergency affected population by making sure that, women, men and children participate in planning, implementing and judging the agencies' wash initiatives.
- Providing information about your agency and what you can offer and how you intend to work with those affected, helps people to understand what assistance they can expect.
- Drawing up agreements and MoUs can also help to clarify the responsibilities of both your agency and the people you are working with
- It is also possible to provide affected communities with information about what finances and other resources are available for a specific project and give them the opportunity to input into key decisions about how these resources are used.
- Talking and listening to those affected (ensuring separate groups of women, men and children) is the basis for ensuring participation and an adequate gender perspective
- Activities should be adapted in response to community feedback and those affected should be provided with some form of complaints and feedback mechanism.
- Examples of exploitation of beneficiaries have been well documented and ALL field workers must guard against the misuse of their power and take responsibility for their actions.
- Disaggregation of data is necessary if you are to know about different segments of the population e.g. men and women, those with disabilities, the elderly, children under five years.
- If there is time it is useful to organise a role-play showing community members asking questions to fieldworkers and giving feedback on the project. Fieldworkers need to know the best way to answer questions and how to manage feedback or complaints.

Where can I find out more?

The Emergency Capacity Building Project (2007) The Good Enough Guide: Impact measurement and accountability in emergencies: Oxfam Publications, Oxford
www.globalpolicy.org/ngos/aid/2007/0209**goodenough**.pdf

Humanitarian Accountability Partnership (HAP) www.hapinternational.org

Hygiene Promotion Skills

Communication Skills I

Aims:

This session is designed to:
Familiarise participants with some of the key principles of communication

Outcomes:

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

- Describe some of the factors that are necessary for effective communication
- Apply principles of effective communication to their work as hygiene promoters

60 Minutes

Resources/Handouts:

Listening Techniques
Johari's Window pictures (see Visual Aids Library)
PowerPoint slides 37 -39 = Johari's window pictures

Session Plan:

Aims

Post up four pictures (Johari's Window pictures) on the board and place four labels (Open, Blind, Hidden and Unknown) in random order to one side of board.

Briefly explain what the labels refer to but do not link the explanation to the pictures i.e. fieldworker assumes that the community member knows nothing (BLIND), the community member deliberately keeps things HIDDEN from the fieldworker even when the fieldworker wants to communicate openly, neither party knows or understands the other (UNKNOWN), OPEN communication exists between the two – both parties are willing to communicate freely.

Ask people to consider how these labels might apply to communication between community members and fieldworkers and to give examples from their own experience. They may also have alternative suggestions for the ways that people communicate such as combinations of the above.

Ask for volunteers to attach the labels to each picture (Johari's windows, see above) and explain what communication issues they need to think about when working with the affected population.

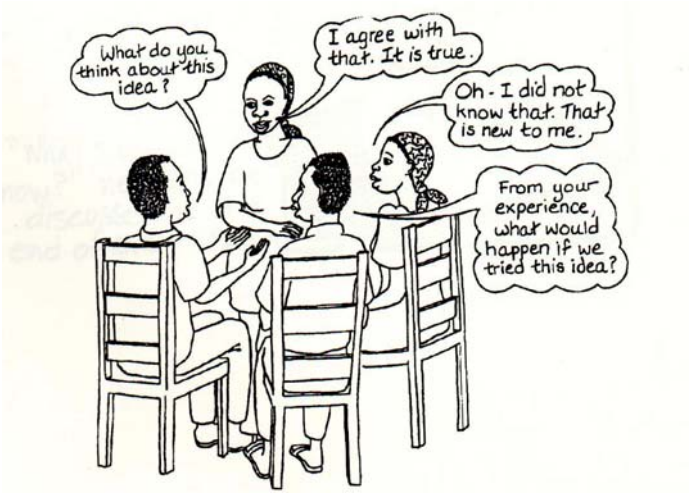
Show the last two pictures and explain that these represent ways to enable better communication i.e. active listening and using pictures or visual aids to stimulate discussion.

15 minutes

Divide participants into 4 groups and ask 2 groups to develop a short role play depicting good communication skills and 2 groups to depict poor communication skills (ask them to make this as realistic as possible without exaggerating too much!)

Ask 2 groups to present their role-play (one positive communication and one negative communication) and discuss in plenary.

Make sure participants are aware of



ways to help convey that they are listening well e.g. nodding, maintaining eye contact where appropriate, saying 'mm' etc. Show the picture of the person with large ears and eyes and impress on participants the importance of learning to listen.
30 minutes

Ask the group to consider how they would communicate with someone who was grieving because of the loss of loved ones or their homes and possessions.
10 minutes

Review the Key Learning Points by asking the group to reiterate the key things they need to remember about communication.
5 minutes

Communication Skills II

This session is designed to:
Further participants understanding and practice of effective communication

Outcomes:

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

- Explain how communication can be enhanced when working with groups
- Identify at least one way they can improve their own communication skills

60 Minutes (minimum)

Methods:

- Discussion
- Group work

Resources/Handouts:

Communication Worksheet
Training and Communication Skills
Several pieces of square scrap paper
Blindfolds (optional)

Session Plan:

Briefly introduce the aims and objectives of the session and ask for examples of good and bad communication that the Hygiene Promoters have come across so far in their work.
10 minutes

Divide the group into small groups of three and follow the instructions for the exercise below:

Listening Exercise
This exercise serves to demonstrate how difficult it is to listen well and what can be done to help improve listening.

- Ask one person to be the speaker, one the listener and one the observer
- Ask the speaker to recount a story/event/problem that has happened to them recently. This should last for about three to five minutes.
- Ask the observer to observe the non-verbal communication of the listener and listen carefully to the 'story'
- Ask the listener to use their body language to make the speaker feel he/she is being listened to.
- Once the speaker has finished, ask the listener to recount the 'story'
- The observer and the speaker should then fill in any missing details and discuss how the listener could improve their listening skills

In plenary share specific examples of the problems encountered and how listening could

be improved

Using the same groups give each group the communication worksheet and ask them to think about the scenarios and what is wrong with the styles of communication and how they might handle this differently. Ask them to think of times when they might have communicated badly - especially when working with the community. Ask them how they would do this differently.
40 minutes

Recap on the outcomes of the session and ask them to try and make a record of examples of good and bad communication to bring to the next meeting or training session.
10 minutes

Alternative Activities for learning about communication

1. Whispers Game
This exercise can be used to show how information loses its original meaning as it passes through different channels. By the end of the session participants should be able to describe the requirements for clear verbal communication.

- Ask participants to form a line or circle.
- Whisper a sentence to the first person in the line and ask them to whisper exactly the same words to the person on their left. Pass the message around in this way from person to person until the last person, who should then tell everyone what he/she has heard.
- (The last person often says something considerably different to the original statement, especially if this was long or complicated.)
- Ask everyone to consider how we get feedback in real situations. How can we increase the likelihood that verbal messages are understood?

15 minutes

2. Illustration of miscommunication
Tell participants the story of the aid worker below:

Kerry came from the city but had trained to be a social worker. She wanted to help her people and went to work in a rural village near to a large lake, deep in the interior of the country. She had always been fond of swimming and was excited that in her free time she would be able to go swimming in the lake. One day on her return from swimming she was told by an old man that she passed that she should not go into the lake because there were evil spirits there. Kerry had studied at university and she didn't believe in witches and evil spirits but knew that people in the rural areas were very superstitious. In part she felt that this superstition was a severe handicap to their development. She told the old man that she didn't believe in evil spirits and so she would be OK to carry on swimming there. Several months later and following many enjoyable swimming sessions on the weekends she was talking to one of the teachers at the local school and the issue of evil spirits and superstition came up. She told the teacher about what the old man had said. 'Ah' – said the teacher – 'sometimes those evil spirits are also known as crocodiles!'

Ask for participants' reactions and discuss how we can often make assumptions without fully understanding the situation. Hygiene Promoters need to try and get into the 'shoes' of the individuals and groups they are talking to and see the world through their eyes.
15 minutes

3. Folding paper Game
This activity serves to demonstrate how even simple instructions can be misinterpreted and why it is better to hear, see and do (rather than just hear or see) in order to understand something well.

- Select four volunteers and ask them to stand in front of the group facing them
- Give each person a sheet of paper and either blindfold them or tell them to shut their eyes
- Tell the four people that they have to listen to instructions and to carry them out without looking or asking questions
- Instruct them to fold the paper in half and then tear off the bottom right hand corner, then fold the paper in half again and tear off the upper right hand corner. Fold the paper in half again and tear off the lower left hand corner
- Ask the participants to open their eyes and display the unfolded paper to the rest of the group

None of the papers will look the same. Discuss why this is and what can be learnt from the exercise.
20 minutes

4. Role-play – the disrupter[3]
The purpose of this exercise is to show how communication in groups can be disrupted and to help participants to think about how they might handle different group situations. At the end of the session the participants should be able to discuss the ways in which the behaviour of individuals can influence groups, suggest how they might manage disruptive or distracting behaviour and describe ways of maximizing the participation of less forthcoming individuals.

- One person will be the speaker, another, the listener and a third will play the role of the disrupter.
- The speaker is asked to talk to the listener about some aspect of their life, while the disrupter has to try to interrupt the session (without using violence!)
- The disrupters can move around the different groups. After a couple of minutes everyone should change roles until each person has had an opportunity to try each role.

Discuss with the group afterwards. Ask everyone how they felt about being interrupted and what other experience they have had of this in the past? Discuss ways of dealing with difficult people in groups, e.g. ignoring them, confronting them, distracting or diverting them, politely interrupting them. Ask them what other types of individual can help or hinder a group discussion?
40 minutes

Facilitators Notes/Key Learning Points:

[3] Adapted from Pretty et al., 1995

- Many people in the affected population may be grieving and may not want to engage with assessment or other activities. Hygiene Promoters must show sensitivity and empathy when communicating with the population.
- Spending time listening to people will often be time well spent – even if hygiene is not being discussed – as people may be more willing to collaborate in the future and are more likely to trust the hygiene promoters
- There will, however, be many people who are focussed on adapting and improving the situation and who are in a better position to engage with mobilisation activities
- It should be remembered that even HPs who are from a particular community may make assumptions about what other people think and believe – the important point is trying to understand another person's perspective and using that as a starting point for communication
- When carrying out a role-play, make sure you debrief the participants and allow them to disengage from their role characters. This can be done by asking participants in turn to introduce themselves. If this is not done, uncomfortable feelings brought out by the roles and between the actors may cause problems later.
- Further role-plays could develop from this session. The group could act out how they might help a shy person to participate in the discussion, or ensure that particular people, e.g. women, or people with disabilities are not marginalized.
- Listening is a key communication skill and hygiene promoters must always be thinking how they can 'listen' better
- If possible try to identify communication scenarios that have actually taken place recently to illustrate the communication worksheet
- Too much information or information that is ambiguous may confuse people
- Developing good communication skills is an ongoing process and this issue should be addressed in subsequent meetings and trainings

Participatory Methods

Aims:

This session is designed to:
To introduce the participants to participatory methods and how to use them

Outcomes:

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

- Describe why participatory methods can be appropriate for hygiene promotion.
- Facilitate a variety of participatory methods including 3 pile sorting, chain of contamination, Take 2 children, a pocket chart exercise and community mapping
- Explain when and how they might use these methods in the current context

3 hours

Resources/Handouts:

- Picture sets for each activity (see Visual Aids Library)
- Instructions for each activity
- Community Mobilisers session plans for each activity (see CM training)
- Facilitation Skills for Participatory Methods
- Pocket chart/containers
- Pictures of hygiene practices
- Voting slips
- Large stick and resources for making map

Session Plan:

Introduction to session aims and outcomes.

Ask the group why participatory methods are useful. Possible answers might include:

- Allows for more interaction and discussion
- More fun than learning facts or being lectured at
- Group more likely to keep to task
- Less likely to get bored
- Can make the discussion specific to situation
- Use of pictures helps people to visualise the problem and analyse it better

Explain that these methods can be used for assessment, implementation and monitoring of the WASH intervention. However, not all of the methods will be appropriate early on in the emergency and their main use will initially be in training mobilisers.
10 minutes

Briefly describe how to undertake 3 pile sorting, chain of contamination and the take 2 children exercise and explain that the best way to understand these exercises is to try them out.
5 minutes

Divide participants into 3 groups and give each group a copy of the session plans in the community mobiliser training for the different activities. Each group should go through the session plan and try out each activity.

Discuss in plenary how the activities went and any problems that the groups encountered.

Explain that these methods can be used to motivate people to take action but also as a means of ensuring that they understand the community's viewpoint and obtain a more in depth assessment of the situation.

Explain how to facilitate further action once the activity is finished, by asking those taking part to think about what they will do next.

Explain the importance of making notes and collating and using the information if the activity is used as an assessment exercise.
45 minutes

Ask each group to then demonstrate how they would introduce one activity to an imaginary group of community mobilisers. Give them 10 minutes to prepare this and five minutes to do the introduction.
25 minutes

Short break and/or energiser

Describe how to use the pocket chart and ask for 4- 5 volunteers to try the voting (explain that normally this is done in private so no one else knows what has been chosen). Once the votes have been cast, it is then important to tally them and discuss the results.
Ask for questions and clarifications.
20 minutes

(The pocket chart can be used in various ways. For example the pictures of hygiene practices can be placed along the top of the chart and the three symbols depicting 'sometimes', 'always' and 'never' along the side. Participants are then invited to 'cast' their vote for each hygiene practice according to what they currently do e.g. do they wash their hands after using the latrine sometimes, always or never? Alternatively water use and water sources could be used or men, women and children and different areas for defaecation or different latrine designs).

Describe how to do a Mapping exercise and show the example of a community map with key landmarks and water and sanitation problems highlighted. Ask for questions and clarifications.
10 minutes

Divide participants into two groups and ask them to either experiment with doing a Community Map or using the Pocket Chart. Ask one person to facilitate each session. The others should imagine they are community members and observe the facilitation skills used whilst they are trying out the exercise.
40 minutes

Ask each group to feedback on how the exercise went including facilitation. Suggest that they focus on the good aspects of facilitation first and then make constructive suggestions for doing it differently. Ask the facilitator to explain how easy it was to facilitate the others in the group and how they would do it differently next time.
15 minutes

Discuss in plenary the benefits and constraints of using participatory methods, including the trade off between reaching a larger number of people and effectiveness. Also the limitations of message dissemination.
5 minutes

Ask the group how and when they might use these methods in the current context.
5 minutes

Facilitators Notes/Key Learning Points:

- The main aim of this session is to introduce participants to the methods and allow them to have a go. They will then need to practice them with community groups – preferably with supervision but they should also be asked to review their own progress at facilitation.
- It will not be appropriate to use all of these methods with affected in the early stages of an emergency but they can be used for training mobilisers etc.
- The philosophy behind the use of participatory methodologies is that people learn better in by sharing experiences that are relevant to them.
- The use of participatory methods can help people to develop a creative approach to problem solving
- Participatory methodologies are very useful at all stages of the hygiene promotion project cycle, in particular for mobilising individuals and communities and for obtaining an in depth assessment of the situation.
- They are particularly useful for communities where literacy is low but even in areas of high literacy people can gain much from the use of pictures and diagrams to help to visualise a problem.
- It is important to use a broad range of methods for promoting hygiene promotion to maintain interest and provide broader experiences.
- Issues to consider when conducting a participatory exercise include:
  - Selecting appropriate participatory tools and knowing the resources to use.
  - Ensuring that people understand the aim of the exercise.
  - Encouraging participants to take as much control as possible without allowing them to dominate.
  - Probing deeper if the outcome is unclear
  - Recording on paper the outcome of the exercises including what happened and when.
- When using the pocket chart with community members who have limited literacy/schooling, it is wise to just vote on one variable at a time
- When using the pocket chart, the main discussion is initiated when the votes are counted and this should be done with the group as a whole.

Where can I find out more?

- Hygiene Promotion. A Practical Manual for Relief & Development pp 14-15 &

Appendix 1 Assessment Tools

- PHAST Manual
- Pretty et al (1995) Participatory Learning and Action: A trainer's guide
- Tools for Community Participation: A Manual for Training Trainers in Participatory Techniques, Srinivasan, L. (1990) PROWESS/UNDP

Adult Learning

Aims:

This session is designed to:
Ensure that participants know how to organise effective training sessions

Outcomes:

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

- Describe the key principles of adult learning
- Plan and execute training courses for community volunteers that are informed by adult learning principles

60 minutes

Resources/Handouts:

How adults learn
PowerPoint slide 41

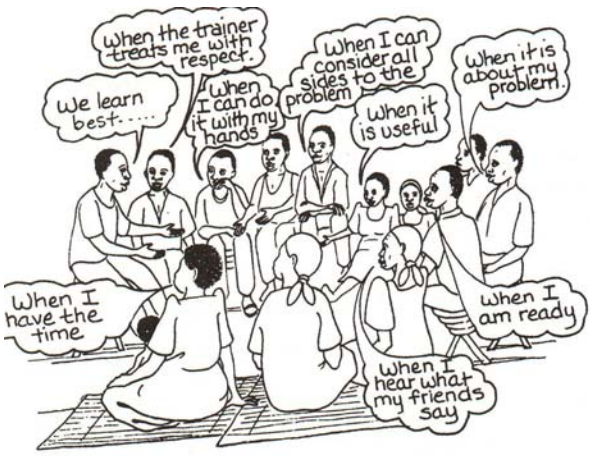
Session Plan:

Briefly introduce the session

Participants are asked to close their eyes and think back to when they were at school or to training events that they have attended.
In groups of three they should list the positive and negative factors about their trainers or teachers

The positive list may have included the following:

- The teacher made everyone feel at ease
- The sessions were well organised
- There was lots of discussion and activities
- The sessions made you think for yourself
- You felt that you had learnt something useful



The negative list may have included the following:

- The teacher lectured the group for too long
- You were made to feel embarrassed in front of others
- It was difficult to know how to use the information subsequently
- The trainer didn't ask what the participants already knew
- There were too many tests

Participants need to think about these factors when they are planning training sessions for others. Explain that it is important that they do not simply try to fill people up with knowledge. Show PowerPoint slide/picture to illustrate this.
15 minutes

Ask participants to imagine they are training in front of a large group and how they would look to the group (see pictures below). What image is the best one for training? What other attributes are useful for training and why?
For example:

- Expressions
- Body language
- Voice
- Heart
- Brain

5 minutes

Divide the participants into 3 groups and ask each group to make up a role play of a good and bad teacher.
Ask one group to perform their role play and ask other participants to make a mental note of the key qualities necessary for a good teacher or trainer.
30 minutes

Ask the group to brainstorm the most important qualities in a trainer and highlight the lessons and examples from the role plays they have just performed

The list may include the following:

- Confidence and knowledge about subject
- Plans session and is prepared
- Able to listen well to what participants have to say
- Uses and builds on the existing knowledge of the group
- Able to clarify points of contention
- Does not embarrass participants or make them feel small
- Puts participants at their ease
- Makes learning fun

Explain that later on they will have a chance to practice some training and facilitation skills and that they should try to keep these issues in mind.
10 minutes

Facilitators Notes/Key Learning Points:

- Participants need to develop their skills of facilitation and training in order to effectively carry out training with mobilisers, community groups or other stakeholders
- An understanding of some of the key principles of adult learning will give them the skills necessary for training others and these are also skills needed for carrying out effective hygiene promotion with groups

Where can I find out more?

Pretty et al (1995) Participatory Learning and Action: A trainer's guide

Focus Group Discussion

Aims:

This session is designed to:
Provide participants with an introduction to running a focus group discussion

Outcomes:

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

- Identify participants for a focus group discussion
- Involve all members of the group in discussing water, sanitation and hygiene issues
- Manage a FGD so that one or two members do not dominate the discussion
- Use probing questions to explore issues in more depth

2-3 hours (including fieldwork)

Resources/Handouts:

Focus Group Discussion Handout
Focus Group Discussion – sample questions (aide memoire)
Recording and Analysing Qualitative Data

Session Plan:

Provide a brief overview of how to run a focus group (see handout) explaining how to put people at ease, ensure that one person does not dominate and the use of probing questions especially.

Refer back to the importance of using listening skills and explain that the idea is to get the participants in the focus group to do most of the talking.
10 minutes

Think up an appropriate topic that all participants are interested in, for example, 'arranged marriages' or 'are computer games bad for you'? Prepare three or four 'roles' beforehand and write the details on separate pieces of paper (see below).
Ask for four volunteers: two people to observe, one to lead the session and the other to take notes. The remainder of the group will be participants (if a large group divide into male and female groups). Give out the four 'roles' to different participants.

Allow fifteen minutes for the group to discuss the topic and then discuss in plenary. Ensure that the participants consider the following factors: putting people at ease, explaining the task, asking open ended questions, listening, probing, summing up. Who participated? How did the facilitator deal with trouble-makers? What could have made the session better?
25 minutes

Example roles: 1. You want to be first to answer every question and have a point of view on everything. You disagree with what most other people have to say…2. You are

very unsure of yourself and feel intimidated by even a small group but if asked you will give your point of view…3. You are the leader of a women's group and keep trying to turn the discussion round to the issues that concern you…4. You are a politician and just say things that you think will make you popular….

End the session by explaining how the fieldwork will be carried out.
Provide participants with a list of questions for water and sanitation to use in the fieldwork practice but explain that this is only meant to help to jog their memory and should not be used as a question and answer session. Divide the group into pairs and ask them to practise using the questions on each other.
10 minutes

Facilitators Notes/Key Learning Points:

- FGD's can easily become question and answer sessions and Hygiene Promoters will need to practice running groups to ensure an effective and interactive discussion
- Ensure that the note taker takes as detailed notes as possible and records key quotes from the FGD participants
- Question and answer sessions may be unavoidable in the first few weeks and useful information can still be obtained from these
- The fieldwork will need to be prepared at least a day before. It may not always be possible to organise a proper focus group and a mixed community group may have to suffice but ideally groups should be homogenous.
- Ideally pairs of participants should work with a 'coach' to conduct the fieldwork practice. However, there will rarely be enough trained people available to do this. Try to pair Hygiene Promoters with someone who has previous experience where possible.

Role of the Hygiene Promoter

Job Description

Aims:

This session is designed to:
Ensure that participants are clear about their role in the project

Outcomes:

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

- Explain the role of the hygiene promoter
- List the key tasks that are expected of them

60 Minutes

Resources/Handouts:

Hygiene Promotion Job Description
Paper slips with one HP task per slip of paper and/or pictures of HP tasks (see visual aids library 'role of the mobiliser' picture set).
PowerPoint slide 43

Session Plan:

Introduction to session with aims and outcomes

In plenary ask participants if they can remember the aims and objectives of their project

Provide a list of the key aims and objectives

Ask participants if they can remember the definition of Hygiene Promotion and show PowerPoint/flip chart to remind them
10 minutes

Divide participants into pairs and provide each pair with a set of tasks or pictures from their job description. Ask them to rank the HP Tasks in order of importance and to justify their choice

Feedback to larger group and discuss choices made ensuring that you clarify the specific tasks they will be expected to do as soon as the training has finished.
30 minutes

In plenary brainstorm the key qualities that are needed to perform the tasks described previously.
Once completed circle the qualities that emphasise communication, listening, observation and facilitation skills

10 minutes

Show PowerPoint or flipchart to remind participants of key components of hygiene promotion. Provide handout of job descriptions for participants to review and ask specific questions about their role.

10 minutes

Facilitators Notes/Key Learning Points:

- The first part of this session is a review of the earlier session examining what hygiene promotion is but this looks more specifically at what the hygiene promoters will do.
- The aim of a WASH intervention is to promote improved hygiene in order to prevent water and sanitation related diseases. Remind participants about ensuring the optimal use of facilities and promotion of key hygiene practices and their role in enabling improved hygiene
- The key skills of the hygiene promoter are the ability to communicate and facilitate learning
- Ensure that participants are aware of their role in enabling the participation of those affected and in making the response accountable[4] to them

[4] See one pager on Accountability and HP briefing paper for more information on this.

Assessment & Baseline

Aims:

This session is designed to:
Provide participants with an overview of the assessment process and their role in ensuring a comprehensive assessment

Outcomes:

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

- Explain their role in carrying out ongoing assessment activities
- Explain the importance of collecting both qualitative and quantitative information

60 Minutes

Resources/Handouts:

Qualitative and Quantitative Assessment
Leading Questions Exercise
Assessment Methods
Overview of Data Collection for Hygiene Promotion
Example Rapid Assessment Checklist
Example Observation Guide for an Exploratory Walk
PowerPoint Slides 45 -48

Session Plan:

Briefly introduce the aim of the session.

Provide a brief overview of the process of assessment explaining that it is a continuous process, especially in an emergency where initial decisions may have to be made on limited information. Explain that the baseline study starts with the rapid assessment and that this then feeds into the more detailed baseline assessment (see Part 2).

Ask the group what are the key qualities needed when carrying out an assessment. Show the PowerPoint/flip chart on listening and observing.

Ask the group why we need to assess and what we will be looking for when we assess.
10 minutes

Ask the group what is the difference between qualitative and quantitative assessment and what methods might be used for both. Distribute the handout on qualitative and quantitative data and clarify any questions.
10 minutes

In pairs hand out the 'Leading Questions' exercise and give them time to discuss the questions and then ask for feedback.

Explain the difference between different types of questions e.g. 'open' and 'closed'

questions and when you might them. (See PowerPoint slides: That's a good question!)
20 minutes

Ask the group what assessment methods they are familiar with and ask for a brief explanation of each method suggested. Provide handout on assessment methods and exploratory walk. Briefly explain the process of an exploratory walk and ensure that participants have a chance to try this under supervision – either in the fieldwork session or once the training is finished.

Ask the group what they will do with the assessment data? Answers should include:

- Record it
- Share it
- Use it to inform intervention and change or adapt style of working

Provide an example of the assessment format that will be used in the current situation and ensure that the group has practice filling this in.
20 minutes

Facilitators Notes/Key Learning Points:

- This session is only an introduction to the assessment process and more time will be needed to broaden and consolidate knowledge on this important aspect of their work. The best way to do this is to initially provide some practice in the field. The fieldwork session aims to do this but supervised field visits should be a part of each hygiene promoter's personal development plan and these can be arranged at any time after the training. Plan this session, the skills session on focus group discussions and the fieldwork session to work together.
- Ongoing assessment is an important aspect of the HP's everyday work
- Observation and Listening Skills are key to good assessment
- Recording and capturing information in a systematic way is necessary – even when informally assessing the situation
- There is an overlap between assessment and monitoring. Monitoring forms and reports provide a useful means to systematically continue assessing but it is vital that data is analysed and used.
- The initial rapid assessment provides an initial 'baseline' against which progress can be monitored (see Part 2)
- A more detailed baseline assessment is usually necessary and should be gathered within 3 months of the start of the intervention.

Where can I find out more?

Sphere Manual (Water, Sanitation and Hygiene section)
WASH Information Management Project

Selection and Distribution of Hygiene Kits and Hygiene items

Aims:

This session is designed to:
Ensure that participants understand their role in the selection, distribution and follow up of hygiene items

Outcomes:

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

- Describe how to identify the need for specific hygiene items
- Explain how the distribution of hygiene items will be carried out
- Describe the activities that are necessary to ensure effective use of hygiene items

60 Minutes

Resources/Handouts:

Hygiene related NFI Briefing Paper
Hygiene Kit monitoring form

Session Plan:

Briefly introduce the aims and objectives for the session

Ask participants to list the non-food items that have already been distributed in the current situation. Ask them if they have heard of any feedback on these items or on the way the distribution was carried out and discuss this. Are there any mechanisms in place for people to register complaints or to ensure their rights are being upheld?
10 minutes

In small groups ask them to list the items that might be necessary to enable better hygiene in the current situation. Once they have completed their list, provide each group with a few examples of actual hygiene materials that might be or have been distributed and ask them to assess their suitability and the quality of the product.

In plenary compile a list of items. Explain that funding restrictions might mean that not everything can be distributed and ask them to rank the most important items and why they are important.
30 minutes

In pairs ask the participants to think of how they would monitor the distribution of hygiene kits and invite suggestions. Provide an example of a Hygiene Kit monitoring form and ask participants to try this out on each other. Discuss in plenary and provide the briefing paper on WASH related NFIs.
20 minutes

Facilitators Notes/Key Learning Points:

- This session will need to be planned according to the specific demands of

each situation.

- It is important to discuss with affected men and women to determine most appropriate items
- It cannot just be assumed that people will use the distributed items for their intended purpose and people must – at the very least –be provided with information on optimal use
- It is important to monitor use and satisfaction with items

Selection and Support of Community Mobilisers

Aims:

This session is designed to:
Ensure that hygiene promoters know how to select the most appropriate community mobilisers for the hygiene promotion programme.

Outcomes:

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

- List the important criteria to take into consideration when selecting community mobilisers for the programme
- Describe how they will enable the selection of community mobilisers in the current situation
- Describe how they will support community mobilisers

60 Minutes

Resources/Handouts:

Information on Community Mobilisers and Example Job Description
Community Mobiliser Attributes

Session Plan:

Introduction to session aims and outcomes.

Ask participants to brainstorm some possible criteria for selection of mobilisers and why they have chosen those qualities or attributes.
Divide participants into small groups and provide handout with list of possible attributes. Ask each group to prioritise the ones that they think are essential in this context and add any of their own choosing. Discuss in plenary.
20 minutes

In small groups ask participants to list the key activities of community mobilisers.
Provide the handout of the specific Task or Job Description used in your organisation for community mobilisers and discuss in plenary.
Ensure that you clarify the hours of work that are expected and the remuneration provided (see handout)
20 minutes

Discuss the practical process of selection of mobilisers and ensure that the hygiene promoters are confident to carry this out – consider how they arrange meetings with key members of the community and the election process etc. Initially they may need to do this under supervision and it may help to work in teams or pairs so that they can support each other.

Ask each group to think of how they will provide support to the mobilisers once identified. Answers should include:

- Training on approaches and methods for the job
- Provision of tools to do the job (e.g. visual aids)
- Regular group meetings to discuss progress and address problems
- Individual meetings to discuss performance and training needs
- Incentives where agreed
- Field visits to other programmes to learn new ideas etc.

20 minutes

Facilitators Notes/Key Learning Points:

- It is not possible to provide specific details on this process as each situation will be different but the introduction to the example WASH HP Job descriptions has some useful information on the issues that need to be considered
- It is important to take into consideration whether a separate cadre of community facilitators will be selected for this emergency programme, or existing local health or extension workers will be used, promoting a more integrated approach.
- It is useful to consider in selection of volunteers including: gender, age, literacy and numeracy, whether they are community members, able to communicate in the local language, able to communicate well, respected figures in the community and anticipated remuneration.
- It is important to calculate the total number of community mobilisers that need to be selected in the affected area (at least two mobilisers for every 1,000 people but this will depend on the geographical area covered, level of public health risk etc.)

Where can I find out more?

- Hygiene Promotion. A Practical Manual for Relief & Development (Implementation chapter pp 54 - 59)
- WASH Hygiene Promotion Job Descriptions

Community Involvement in the Design of Facilities

Aims:

This session is designed to:
Ensure that participants are aware of their role in supporting the design, siting and modification of facilities for water and sanitation

Outcomes:

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

- Describe how they can involve men, women and children in assessing the acceptability of facilities
- Explain why facilities might not be acceptable and how this can influence the impact of the programme

60 Minutes

Resources/Handouts:

Photographs of different latrine/water point/laundry/hand washing facilities etc.(see example PowerPoint slides 50 and 51)

Session Plan:

Show three or four pictures of water and sanitation facilities and point out some of the feedback received from users e.g. latrine too narrow, hole too big for children to use, shower next to latrine, stairs too steep etc. The following feedback for the designs in the accompanying PowerPoint was received from users:

Picture 1 – Two toilets are adjacent to two bathrooms and a washing slab. People complained that when washing clothes the dirty water from the bathing cubicles drained out onto the washing slab. Similarly the dirty water from first bathing cubicles drained into second. People in the bathing cubicles were bothered by the sound of people going to the toilet and people in the toilet were embarrassed by the fact that there were people having showers next to them.

Picture 2 – The metal sheeting used for these latrines meant that they were very hot in Summer (40 degrees outside and hotter in!). The pump was meant to be for anal cleansing only but sometimes children used it for drinking water. These toilets were meant for men and women but people wanted separate toilets.

20 minutes

Ask participants to think about the design of the water and sanitation facilities that they currently use. In pairs ask them to discuss the pros and cons of the current design and what they would like to see improved.

If they are not part of the affected population, ask them to step inside the shoes of the men, women and children affected by the emergency and think of some of the problems they might have with the current facilities (or lack of them) and what needs to be considered when providing new facilities.

Discuss in plenary. Explain that it can also be very enlightening for hygiene promoters and empowering for community members to ask them how they would suggest improving the facilities.
10 minutes

Divide participants into small groups and ask each group to think of what modifications in the design of water and sanitation facilities might be possible/necessary for the following groups:

- Men and women with physical disabilities
- Children
- Elderly men and women
- People with HIV or AIDS

Each group should feedback their suggestions in plenary. Discuss what is possible in this specific context and clarify the responsibilities of the hygiene promoters in ensuring community participation/consultation in the design of facilities.
30 minutes

Facilitators Notes/Key Learning Points:

- It may be useful to design this session in conjunction with those responsible for the hardware provision and ensure that they are also present to discuss issues and possible solutions.
- Some issues in design may be pre-empted but there is always a need to consult with the users to find the most acceptable design.
- Even where the initial facilities are pre-designed, it is important to get an idea of how well they are working and how they can be modified
- Feedback on community satisfaction with facilities should be a part of the monitoring process.
- The needs of different groups e.g. those with disabilities or the elderly will also need to be considered. Bedpans, urinals, commodes or potties may be useful where mobility is particularly poor or for use at night.

Introduction to Working with Children

Aims:

This session is designed to:
Ensure that participants are able to plan and safely carry out HP activities with children

Outcomes:

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

- Explain the key differences between child and adult learning
- Describe some of the HP methods that can be used with children
- Explain the responsibilities of hygiene promoters to ensure that children are protected from harm

60 Minutes

Resources/Handouts:

Child Protection Good Practice Guide
Child Protection Scenarios
Child to Child Activity Sheets
Example activities for working with children
Children and Learning
PowerPoint slides 53-56
(Other ideas for games with children are also available on the Visual Aids Library)

Session Plan:

Briefly introduce the session
Discuss with participants what they understand by child rights, protection and abuse. Ask how children could be vulnerable to abuse in the current situation.

Show the PowerPoint slide/flip chart with the WHO definition of abuse and discuss
10 minutes

Divide participants into small groups and give each a scenario on child rights/abuse. Ask them to identify and discuss the key issues in the scenario and what should be done to prevent and address these issues.
20 minutes

In pairs ask participants to think of how adult and children are different in the way that they learn.

The list might include the following:

- Children are more flexible and open to new ideas
- Children are very inquisitive
- Young Children learn through play

Ask participants what is the best way to motivate children and if they have any examples of learning through play.

Use PowerPoint slides/printed handouts to provide an overview of the child-to-child and CHAST approaches. Provide handouts of child-to-child activity sheets explaining that they may not be exactly pertinent to the situation but that they can provide ideas of activities that can be carried out with children.

Discuss how the hygiene promoters might include work with children in the current context e.g. work through schools/teachers/youth groups, train children's facilitators. Explain that they will have more training and practice on this issue at a later date. Participants could be given the task of finding out more about what is available – who might make a good facilitator, if members of a youth group are present in the affected population etc.
30 minutes

Facilitators Notes/Key Learning Points:

- A large percentage of the population affected in emergencies are often children (under 18)
- In many countries, children are often caretakers of other children and can be influential in promoting hygiene
- The under fives are most vulnerable to disease and death. They may be scared to use latrines and some latrines may not be appropriate for under fives
- Specific sanitation solutions for children at home, in the community and in schools may be required e.g. adapted latrines, potties and nappies etc.
- Youth groups may already exist and may provide a useful entry point for activities with older children
- Any intervention with children must not put them at risk of abuse – those working with children need to adhere to the Child Protection Good Practice Guide

Where can I find out more?

Child-to-Child, A Resource Book (Second edition, 2007) Editors: Hugh Hawes, Donna Bailey and Grazyna Bonati
Hygiene Promotion. A Practical Manual for Relief & Development pp 47-54

Carrying out a Hygiene Promotion Campaign

Aims:

This session is designed to:
Inform participants about how to carry out a hygiene campaign in an emergency.

Outcomes:

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

- Describe the key elements of a hygiene education campaign
- Describe communication methods which can be used

90 Minutes

Resources/Handouts:

Flipchart and pens

Session Plan:

Introduction to session aims and outcomes.

Ask the participants if they have experience of a campaign – give examples of what this might be – e.g. encouraging people to buy treated bed nets, give up smoking, wash hands, take their children for immunisation etc. Ask them to explain what methods were used and what makes a campaign different from everyday health promotion or health education.

Explain that a campaign is a short and intensive effort to address the problem and in an emergency is often used when there is an outbreak of disease or when the public health risks are high.

A campaign should normally not last longer than two weeks as it will lose it's novelty quite quickly. Campaigns often rely heavily on delivering messages/information to as many people as possible using a variety of methods but predominantly the mass media e.g. radio, television, loudspeakers.
These methods may be effective in providing information but are not always effective in changing people's behaviours or practices and that is why interactive methods should also be used as much as possible.

Interactive methods are more time consuming and it is often difficult to reach as many people in the same space of time but such methods can often be more effective in getting people to take action or change the way they do things.
10 minutes

Ask participants if a campaign is appropriate in the current situation and if so what the focus of the campaign should be and what methods could be used to communicate with the population – bearing in mind that the aim is to reach as many people as possible.

Divide participants into three groups and give each group a particular campaign focus appropriate for the context e.g. the use of a specific water treatment agent or getting children to use the latrines. Ask each group to:

- Identify the methods that they will use to reach as many people as possible
- Identify the key messages or ideas they want to convey
- List the resources they will need to carry out the campaign
- Explain how they will show if the campaign has been effective or not

30 minutes

Each group should present their approach in plenary and comments and discussion should be invited from the other groups. Ensure that the approaches and methods suggested are practical in the current context.
30 minutes

Guided by the facilitator participants should discuss how they will implement their chosen campaign plan (if this is appropriate for the current context). Further meetings will be necessary to take this forward.
20 minutes

Facilitators Notes/Key Learning Points:

- A campaign is often appropriate in the early weeks of an emergency or as a response to outbreaks of a specific disease. Campaigns may also be initiated by other sectors to encourage immunisation or to inform people about a particular issue
- The main steps in implementing a hygiene promotion campaign include selecting key hygiene promotion messages, selecting appropriate communication methods, preparing communication materials, promoting the messages.
- Remember it is possible to plan and implement an information campaign focussed on a specific health topic over a short time span targeted at a large number of people or specific groups of people.
- It is important to know how to select the most effective method or mixture of methods for the campaign including announcements with loudspeakers, posters (including cloth or on walls), street theatre (drama, puppets), slides, films & videos, games, community radio broadcasts, household visits (face-to-face communication), large and small group discussions, child to child methodologies.
- It is important to recognise the importance having a few important messages rather than too many messages e.g. excreta disposal, hand washing with soap and keeping water clean.

Where can I find out more?

- Hygiene Promotion. A Practical Manual for Relief & Development pp73-82

Training Practice

Aims:

This session is designed to:
Ensure that participants are equipped to provide well organised and interactive training sessions for community members

Outcomes:

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

- List the requirements for carrying out a training course for community mobilisers
- Explain how to formulate learning outcomes
- Describe how to facilitate training
- Present a training session to community mobilisers on managing diarrhoea

3 hours

Resources/Handouts:

WASH Training Package for Community Mobilisers

Session Plan:

Explain to participants that a major part of their work will be training others and they will need to feel comfortable organising training courses and sessions.

Divide participants into small groups and brainstorm the requirements for carrying out a training course. Ask them to imagine that they will need to do this in the next few days.

Ask one group to feedback and others to supplement their suggestions once they have finished.

Suggestions might include:

- Training venue
- Training plans
- Equipment (ask them for examples – flipchart/board and pens, plain paper, certificates etc.)
- Demonstration materials
- Flip charts/visual aids
- Handouts
- Evaluation sheets
- Refreshments

15 minutes

Explain to the group that it is important to be able to monitor the learning of the participants. In order to do this, objectives should be set for each session in the form of 'learning outcomes'. Give an example using this specific session's outcomes.

In pairs ask participants to come up with 2-3 'learning outcomes' for a training session on managing diarrhoea.

Ask for examples and write these on the board/flipchart. Clarify/simplify where necessary.
30 minutes

Provide each pair with the training material and ask them to familiarise themselves with one session of their choice. They should then prepare a 5-minute training slot from this session (they will have to decide what they can leave out of this practice session).
1 hour preparation

Ask the groups to present their session to the other participants – pretending that the other participants are community members

Ask for feedback from the group and provide constructive criticism where improvements can be made.
1 hour feedback

Review the key skills necessary for a good facilitator and encourage hygiene promoters to familiarise themselves with the training package for the community mobilisers as they will have to begin to carry this out as soon as mobilisers have been identified.
15 minutes

Facilitators Notes/Key Learning Points:

- The hygiene promoters will need to familiarise themselves with the whole training package for the community mobilisers in preparation for the subsequent training they will be doing. This session provides an opportunity to encourage the trainers to 'facilitate' rather than to simply provide information.
- The session also provides an assessment of the Hygiene Promoters Knowledge and understanding of previous sessions

Monitoring

Aims:

This session is designed to:
Ensure that hygiene promoters understand the importance of monitoring and how to undertake monitoring.

Outcomes:

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

- Describe why monitoring and evaluation are necessary.
- List the essential hygiene practices to monitor including safe excreta disposal, hand washing with soap and safe water practices.
- Explain how to use a simple monitoring framework.
- Be familiar with monitoring forms for use by community mobilisers

90 Minutes

Resources/Handouts:

- Example of a WASH logical framework matrix
- Indicators for Monitoring Hygiene Promotion in Emergencies
- Example Hygiene Promotion Monitoring Form
- Examples of PHAST monitoring forms
- Monitoring Exercise
- Example SMART and Not so SMART Indicators

Session Plan:

Introduction to session aims and outcomes.

Ask participants why monitoring and evaluation are important and the difference between the two. Explain that monitoring is an ongoing process of checking whether the project is going to plan and evaluation is usually a one off activity that tries to take an overview of the total changes that have taken place as a result of the project activities.

Explain that everyone on the project has a specific responsibility for monitoring and ensure that the hygiene promoters have an overview of what they will be monitoring and how often.
10 minutes

SMART Indicators
Explain the concept of SMART (Specific, Measurable, Attainable, Realistic and Time bound) to the participants and explain that the objectives and indicators together should be SMART.
Prepare Objective and Indicator Cards in advance (use example logical framework and handout on SMART and Not so SMART indicators). Divide participants into groups and ask each group to place appropriate indicators next to example objectives. Ask the group

to decide if the indicator is good or bad and if necessary suggest how to improve the indicator to make it 'smarter'.
Each group should feedback in plenary and clarification should be provided where necessary.
30 minutes

Using Monitoring forms
Divide participants into pairs and provide examples of project monitoring forms. Ask each pair to try out one monitoring form and discuss between themselves how they would use it. Invite questions and comments. Be sure to ask about the process of collecting the data as well as about the actual data collected.
Ask the participants what should happen to the data and how it will be used?

Divide the participants into small groups and give each group a scenario from the Monitoring exercise (or from the current situation). Ask the group to think what they will do.
40 minutes

Review when, where and how often the hygiene promoters will carry out monitoring activities.
10 minutes

Facilitators Notes/Key Learning Points:

- It is important to undertake monitoring and evaluation and recognise its contribution to feedback into future planning to adjust project objectives, and help identify strengths and weaknesses.
- Monitoring is the systematic and continuous process of collecting and using information throughout the programme cycle.
- It is useful to understand that the logical framework is an active tool to guide monitoring.
- The process of monitoring is greatly enhanced if a systematic baseline survey has been undertaken (see Part 2) but monitoring should still continue even in the absence of a systematic baseline.
- There is a difference between impact and outcome indicators (to measure if project aim and purpose has been achieved) and process indicators (to measure how the project is being developed).
- The 3 essential indicators for monitoring in emergencies are:
    - Safe excreta disposal
    - Hand washing with soap at key times (after contact with faecal matter and before handling food)
    - Use of safe water for drinking
- To be aware of other important indicators for emergencies including:-
    - Community participation and representation
- Community mobilisers can monitor the impact of hygiene practices and how the project is progressing (number of community sessions, attendance of these sessions).

Where can I find out more?

- WASH Information Management Project

Fieldwork and Feedback Session

Aims:

This session is designed to:
Provide an opportunity for hygiene promoters to apply the knowledge they have gained from other training sessions

Outcomes:

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

- Organise and facilitate a community group e.g. focus group discussion, three pile sorting, exploratory walk or mapping exercise etc.
- Collect and analyse qualitative data gathered in focus group discussions

2 – 3 Hours

Session Plan

Fieldwork and Feedback
It is useful to have a practice session in the classroom first to recap on the methods to be used. The actual time spent carrying out the exercise should be kept relatively short (about 30 minutes) but it may take a while to obtain permission, identify participants, get people comfortable and explain the purpose of the meeting.

Participants should work in groups of 2-3 people and the responsibilities of each person must be clarified prior to going out into the field.
1-2 hours

Ensure that each facilitation group feeds back on both the process and the content of the session afterwards. It is also useful to try to get them to define how they will do it differently next time.

Briefly explain how to analyse qualitative data and what will be expected from Hygiene Promoters in terms of reporting. Provide the handout on analysing and reporting data.
1 hour

Facilitators Notes/Key Learning Points:

- The example timetable only includes fieldwork on using a focus group discussion but time should be made to also include an exploratory walk (this was introduced in the session 'assessment overview') and the use of other participatory methods.
- As with the other exercises it is useful if participants can be supervised when carrying out the exploratory walk and that they have a chance to discuss how the exercise went in terms of the process and their findings.
- The feedback session is very important to allow participants the opportunity to discuss any problems and to share good and bad practice
- Where resources allow, a video could be used to capture the activities of one group and then used as a means of highlighting good practice and explaining how to avoid the common pitfalls

Review & Evaluation

Example review session

Aims:

This session is designed to:
Consolidate learning on Hygiene Promotion and evaluate the training

Outcomes:

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

- Explain key points from the day's learning
- Describe how they will use the knowledge and skills gained

30 Minutes

Resources/Handouts:

Example quiz sheets
Flip chart paper and pens
Visual aids

Session Plan:

For these sessions the following ideas might be helpful:

Quiz
Divide participants into small teams (2-3 people) and either:

- provide written quiz for teams to fill out and then swap the papers so that another group marks them
- call out quiz questions and each group records these on paper
- call out quiz questions to each group in turn

Role Play
Divide participants into groups of 3-4 people and ask them to compile a mini role play or drama that highlights one important learning point from the day. It is hoped that the different presentations will then cover several key learning points which the facilitator should clarify and/or reiterate.

Teaching Others
In groups of 2 ask participants to prepare and present a 5-10 minute teaching session on a key point of learning using interactive facilitation skills. Ensure that you provide time for preparation.

Preparing and Presenting Overview
In groups of 2 ask the participants to prepare an overview of the days learning that they

will then present to the large group. Only one to two groups per day will be chosen but all must prepare. Ask for questions and feedback from the rest of the group.

Facilitators Notes/Key Learning Points:

- Continual review and clarification is useful in all training courses as participants will often forget things very quickly
- As an alternative to one long session, it is possible to have mini review sessions at key points during the day

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.

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 hardware and software aspects of the WASH response are integrated and work together to achieve a common goal.
- 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 toolkits 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, 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. the elderly, children, the disabled.

Person specification:

1. Knowledge of one or more of the following: public health, health or hygiene promotion, community development, education, community water supply and sanitation. Academic or professional qualifications are desirable but not essential.

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.

December 2007

Terminology and Definitions[5]

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[6](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 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

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

[6] 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.

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.[7]

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.

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

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

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, women's or men'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 wellbeing, 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

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

Available Handouts

Part 1: Essential To Know Training for Hygiene Promoters

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

1. Uno Winblad, Pataholm 5503,384 92 ALEM, Sweden
2. The MOST Project (2005) Draft Diarrhoea Treatment Guidelines for Clinic-Based Healthcare Workers
3. Hope, A. and Timmel, S. (2007) Training for Transformation Book 2, ITDG Publishing
4. UNICEF Pakistan (2005) PHAST in emergencies Participatory approach in fighting against diseases with faecal-oral transmission 2005 (ed: Dr Maigul Turatbekova)
5. Wateraid Mozambique. Harvey, E (2002) Participatory Methodology and Facilitation Guide
6. Ferron, S. Morgan, J. and O'Reilly, M. (2007) Hygiene Promotion: A Practical Manual for Relief and Development, ITDG Publishing
7. Almedom (1997) – Source: Oxfam Guidelines for Public Health Promotion in Emergencies
8. Srinivasan L. (1993) Tools for Community Participation PROWESS/UNDP
9. Tearfund (2008) Child Health Club Training Manual: (internal document – publication planned)
10. Action Contre La Faim, Sri Lanka: Leonie Barnes, An Integrated WatSan/Hygiene Promotion Manual in the Post-Tsunami context

Context

Public Health in Emergencies

- (see PowerPoint slide 4)

WASH Cluster and Co-ordination

- Cluster Overview

Hygiene Promotion in Emergencies

- Terminology and Definitions Paper (see appendices above)

Key actions to prevent diarrhoea

- F diagram
- Instructions for the management of diarrhoea

Participation and Accountability

- Humanitarian Accountability & Hygiene Promotion

WASH Cluster & Co-ordination

The concept of global clusters was adopted by the Inter Agency Standing Committee (IASC) in September 2005 in recognition of the capacity gaps which often undermine the effectiveness of humanitarian assistance delivered to communities affected by emergencies. Cluster leads were identified for nine areas of activity with UNICEF the designated global lead for the Water, Sanitation and Hygiene Promotion (WASH) sector.

The aim of the global clusters is to 'improve the predictability, timeliness and effectiveness of a comprehensive response to humanitarian crises' through strengthening partnerships between NGOs, international organizations, the International Red Cross and Red Crescent Movement and UN agencies. At country level it is anticipated that enhanced inter agency collaboration will improve the quality of response by encouraging better prioritisation of available resources and greater clarity in defining the division of labour and the roles and responsibilities of humanitarian actors.

The development of the Water Sanitation and Hygiene (WASH) Cluster provides an open formal platform for all emergency WASH actors. Formal recognition of UNICEF's role as global cluster lead has also allowed the organisation to ensure that dedicated resources are made available to ensure standards, systems and capacity for rapid response. Critical in ensuring participation in the WASH cluster in emergencies, is ensuring that all key WASH sector actors are fully involved at the global level.

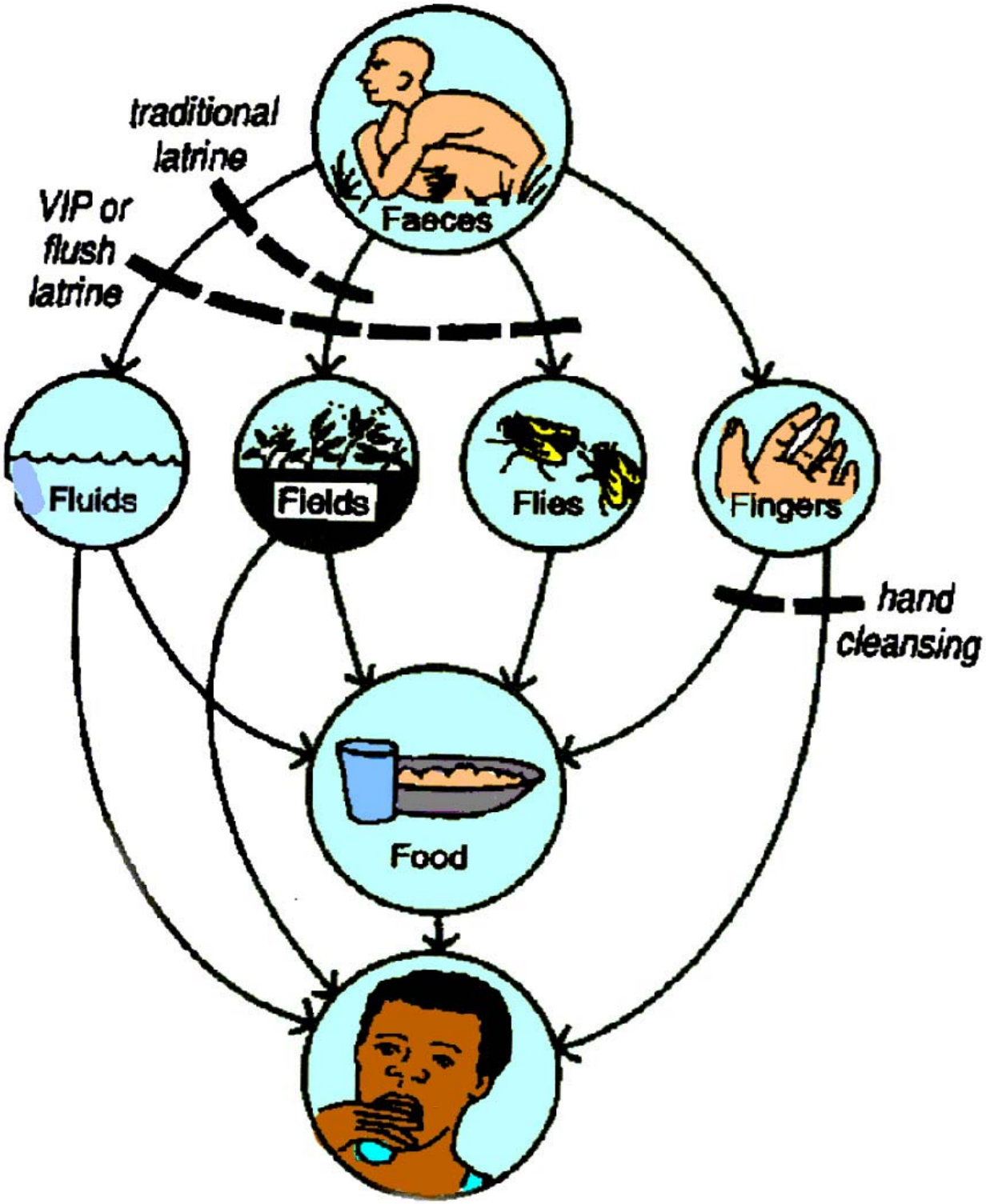
Whilst informal networking certainly has made a contribution to the sector's response, prior to the humanitarian reform, there had never been a formal analysis of the key issues that were bottlenecks in improving the sector's response in an emergency.

The Hygiene Promotion project relates to a larger WASH cluster project: building capacity for humanitarian response. Currently, the way in which hygiene promotion is implemented varies widely within agencies and it is frequently given scant attention during sector co-ordination meetings. It has been suggested that there is a lack of clarity within the WASH sector in relation to the purpose of hygiene promotion and its expected outcomes and that it suffers from a lack of common understanding of methods and approaches in its implementation. The aim of the Hygiene Promotion project is to improve capacity and coordination of hygiene promotion interventions in emergencies and to produce best practice materials drawing on information from key organisations working in emergencies.
For more information see www.humanitarianreform.org

July 2008

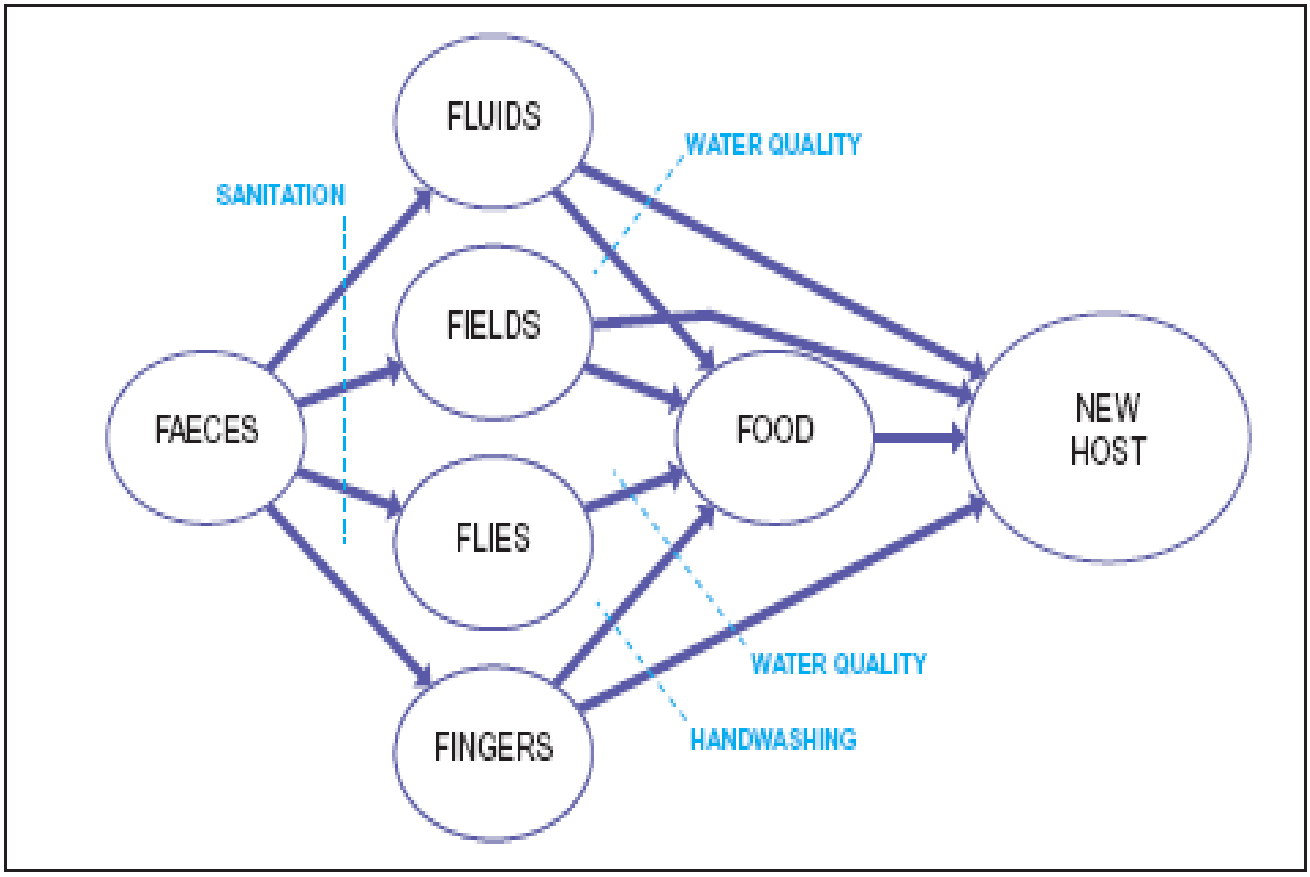
The F Diagram[8]

Transmission Routes for Diarrhoea



[8] Taken From Uno Winblad, Pataholm 5503,384 92 ALEM, Sweden.

The F Diagram II
Transmission Routes for Diarrhoea



Example Instructions for Management of Diarrhoea using ORS[9]

The information below could be adapted for use in a leaflet to support the promotion of ORS in the management of diarrhoea. Before embarking on this it is vital that you seek advice from the Ministry of Health and the Health Cluster.

- Diarrhoea usually cures itself in a few days. The real danger is the loss of water from the child's body, which can cause dehydration
- A child with diarrhoea loses weight and can quickly become malnourished. Food can help stop the diarrhoea and help the child recover more quickly
- A child with diarrhoea should never be given any tablets, antibiotics or other medicines unless these have been prescribed by a trained health worker
- The best treatment for diarrhoea is to drink lots of liquids and oral rehydration salts (ORS) properly mixed with clean water
- Measles frequently causes severe diarrhoea. Immunizing children against measles prevents this cause of diarrhoea

A special drink for diarrhoea: ORS

What is ORS? ORS (oral rehydration salts) is a special combination of dry salts that, when properly mixed with safe water, can help rehydrate the body when a lot of fluid has been lost due to diarrhoea.

Where can I get ORS? In most countries, ORS packets are available from health centres, pharmacies, markets and shops.

To make the ORS drink:

1. Wash your hands with soap (or ash) and water before preparing the mixture
2. Put the contents of the ORS packet in a clean container. Add one litre of water and stir. Too little water could make the diarrhoea worse.
3. Add water only. Do not add ORS to milk, soup, fruit juice or soft drinks. Do not add sugar.
4. Stir well, and feed it to the child from a clean cup. Do not use a bottle.
5. You can use this mixture for up to 24 hours after you have made it. After this any unused mixture must be thrown away.

How much ORS drink to give?

- Encourage the child to drink as much as possible.
- A child under the age of two needs at least a quarter to a half of a large cup of the ORS drink after each watery stool.
- A child aged two or older needs at least a half to a whole large cup of the ORS drink after each watery stool.
- Diarrhoea usually stops in three or four days.
- If it does not stop after one week, consult a trained health worker.

Rules for home treatment of diarrhoea

Rule 1: Give the child more fluids than usual
For example:

GIVE	DO NOT GIVE
Breast Milk	Soft drinks
Rice Water	Sweetened tea
Coconut water	Sweetened fruit drinks
ORS	Coffee
Weak tea	Some local medicinal teas or infusions

[9] Adapted from The MOST Project (2005) Draft **Diarrhoea Treatment Guidelines for Clinic-Based Healthcare Workers**

How much?
Give children under 2-years-old, approximately 50-100ml (¼ large cup) of fluid after each loose stool. Give older children ½ to 1 large cup. Older children and adults should drink as much as they want. Even if the child vomits continue to give small sips of ORS.
ORS or recommended home-fluids should be given until the diarrhoea stops. This may last several days.

Rule 2: Continue to feed the child
For example:
Breast Milk
Local Porridge
Beans
Mixes of cereal, meat and fish
Fresh fruit juices and bananas are helpful because they contain potassium.

Avoid:
- High fibre or bulky foods, such as coarse fruits and vegetables, fruits and vegetable peels, and whole grain cereals. These are hard to digest.
- Very dilute soups. These are recommended as fluids, but are not sufficient as foods because they fill up the child without providing sufficient nutrients.
- Foods with a lot of sugar can worsen diarrhoea.

Encourage the child to eat as much as he/she wants. Offer food every 3 to 4 hours (six times each day) or more often to a young child. Small frequent feedings are best because they are more easily digested and preferred by the child.

Rule 3: When to return to the clinic
Bring the child to a health worker if the child shows any of the following:
- Passes many stools,
- Is very thirsty,
- Has sunken eyes,

(The above 3 signs suggest the child is dehydrated)
- Seems not to be getting better after 3 days,
- Has a fever,
- Does not eat or drink normally.

Home Made Salt Sugar Solution

1. Wash your hands with soap and water before preparing solution.
2. In a clean container mix:

   Half a level teaspoon of salt
   8 teaspoons sugar
   1 litre of clean (boiled) water (or 5 cupfuls – each cup should be 200mls)

3. Stir the salt and the sugar until they are dissolved in the water
4. Give the sick child as much of the solution as it needs, in small amounts frequently either using a cup or a spoon.
5. Give child alternately other fluids - such as breast milk and juices.
6. Continue to give solids if child is four months or older
7. If the child still needs ORS after 24 hours, make a fresh solution.
8. If child vomits, wait ten minutes and give it ORS again. Usually vomiting will stop.
9. Banana or other non-sweetened mashed fruit can help provide potassium.
10. If diarrhoea increases and /or vomiting persist, take child over to a health clinic.

Home made solution and ORS do not stop the diarrhoea. They prevent the body from drying up. The diarrhoea will stop by itself.

Humanitarian Accountability & Hygiene Promotion

Humanitarian accountability stresses the fact that people and communities with whom we work should inform programme choices and implementation, throughout the lifetime of the project, and are the most important judges of programme impact. The participation of all those affected is at the heart of accountability and hygiene promoters can play a key role key in ensuring the practical application of both if they work in an enabling and facilitative way rather than emphasising only the dissemination of messages.

At a minimum, all 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 mechanisms** 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. (For further information: http://www.hapinternational.org/)

What can you do as a Hygiene Promoter?

- Aim to provide as much information to people as possible about your agency and your project (use whatever means are available locally such as notice boards, meetings, newspapers, radio – these will often be the same methods you use for hygiene promotion)
- Ensure that people are aware of their entitlement to aid.
- Ensure that you identify those who might be vulnerable (women, children, the elderly, people with disabilities, HIV/AIDS or people who are part of a minority group) and that information and project assistance also reaches them
- Feed back information to those affected (e.g. from surveys or meetings) and feed back from community to WASH team
- When possible, allow people to set their own objectives for action and to determine the success of the intervention
- Monitor intervention – including satisfaction and acceptability of facilities and impact on health

Hygiene Promotion Skills

Communication Skills 1

- Listening Techniques

Communication II[10]

- Communication Worksheet
- Training and Communication Skills

Adult Learning

- How adults learn

Participatory Methods

- Instructions for each activity
- Facilitation Skills for Participatory Methods

Focus Group Discussion

- Focus Group Discussion Handout
- Focus Group Discussion – sample questions (aide memoire)
- Recording and Analysing Qualitative Data

[10] Ideally this session should be developed following observation of hygiene promoters in the field and of the weaknesses in communication

Listening Techniques[11]

Types of Listening	Purpose	Possible Responses
Clarifying	1. To get at additional facts 2. To help the person explore all sides of a problem	'Can you clarify this?' 'Do you mean this?' 'Is this the problem as you see it now?'
Restatement	1. To check out meaning and interpretation with the other 2. To show you are listening and have understood what the other has said	'As I understand it your plan is…' 'Is this what you have decided to do….and the reasons are…'
Neutral	1. To convey that you are listening and interested 2. To encourage the person to continue talking	' I see' 'I understand' 'That is a god point'
Reflective	1. To show that you understand how the other feels about what s(h)e is saying 2. To help the other person to evaluate and temper his or her own feelings as expressed by someone else	'You feel that….' 'It was shocking as you saw it' 'You felt that you didn't get a fair hearing'
Summarising	1. To bring all the discussion into focus in terms of a summary 2. To serve as a springboard to discussion of new aspects of the problem	'These are the key ideas you have expressed…' 'If I understand how you feel about the situation…..'

Do's and Don'ts of Listening

Do	Don't
Show Interest	Argue
Be understanding	Interrupt
Express empathy	Pass judgement too quickly or in advance
Listen for causes of the problem	Give advice unless it is requested
Help the speaker associate the problem with the cause	Jump to conclusions
Encourage the speaker to develop competence and motivation to solve the problem	Let the speaker's emotions react too directly on your own
Cultivate the ability to be silent where necessary	Feel you always have to say something

[11] Taken from Training for Transformation Book 2 Hope, A. and Timmel, S. ITDG Publishing, reprinted 2007

Training And Communication Skills[12]

When working with individuals or groups, the hygiene promoter communicates verbally and non-verbally, with the audience. This contact is called interpersonal communication, - the exchange of information between two or more people.

To make the session fruitful, to keep the audience's attention and to lead the discussion, the trainer has to know:

a) Verbal communication is communication through words:

- The trainer has to be able to awake interest through discussion, express ideas and present the information so that all participants can understand the core of what the he is saying, using simple words and an appropriate tone of voice
- Avoid using unfamiliar words and idioms

b) Non-verbal communication – this is communication through movement, gestures, eye contact, posture etc.

In non-verbal communication it is important to:

- Pause frequently
- Use open gestures
- Do not express disapproval unless intended
- Be aware of the message your gestures and facial expressions may have on the participants
- Maintain eye contact with participants (see the whole audience, look at all participants)
- Be at the optimal distance for viewing the whole audience and so that people can hear the trainer well (distance is about 2-3.5 meters)
- Avoid talking in a monotone voice and try to make your voice express the meaning of what you are saying

c) Values and perception

- Everyone has his own individual idea on what is correct, desirable and useful. Therefore, in sessions it is preferable to allow every participant to speak and express their point of view on the topic discussed. The trainer has to keep in mind that every person perceives in a different way. Therefore, before presenting information the trainer has to try and imagine and familiarize him/herself with the perspective of the participants, i.e. their problems, interests, routines and desires.

d) Conducting a discussion

- In sessions the trainer should, through questions and discussion, provide participants with needed information and receive feedback, i.e. time to time the trainer should ask questions that revise what has been told. The trainer can thus define how far the participants have assimilated information.
- The trainer should form questions based on the goal of the session, so that the questions allow discussion on the basic idea of the topic.

These are the following types of questions:

- "Open" questions which suppose various answers. Open questions are used to identify participants' opinions. For example,

[12] Adapted from: PHAST in emergencies Participatory approach in fighting against diseases with faecal-oral transmission 2005 (ed: Dr Maigul Turatbekova) UNICEF Pakistan

- "What do you think of…?"
- "What is benefit of …?"
- "What will you do if …?"
- "What will you treat if …?"
- "What are the positive activities about health that you can see in the pictures?" etc.

- "Closed" questions which suppose a single meaning answer "yes" or "no" or "I do not know". As a rule it is impossible to develop discussion without "closed" questions. Therefore, in discussion, after asking a "closed" question you have to ask a relevant "open" question.

For example, "Would you like more privacy when you use the latrines?"- this is a "closed" question. "What could be done to improve privacy when using the latrines?"- this is an "open" question.

- "Testing" or "probing" questions which attempt to determine the cause or motive of an opinion or action. For example:

- "Why do you think that?"
- "Why have you decided this?"

If in discussion a conflict of opinion arises, then it can be solved with the help of words, which reflect the feelings and thoughts of the other person. For example:

- "I understand why you disagree… "
- "I feel you are about to propose something different…"
- "You say this because …?"

- Active hearing – this is showing you are listening to a person with the help of gestures and mimic (e.g. nodding, saying yes at appropriate intervals etc.

Methods of Communicating with different Age Groups

Different Learning Styles and Activities	**Children 6 - 10**	**Youth 11 -18**	**Men**	**Women**
Characteristics: These can act as weak points for receiving and understanding PH and Hygiene Promotion Or as Strong points for PH and Hygiene Promotion and will influence the method of teaching	• Curious • Adventurous • Instinctive nature • Limited concentration span • Follow elders example • Under parents supervision	• Affected by Peer pressure • Adventurous • Curious • Working and taking responsibilities at home • Under parents supervision • Strong minded	• Responsible for families income • Out of the house most of the day • Setting example for children and youth • Have life experience:	• Responsible for families life style and care • Often home based • Setting example for children and youth • Have life experience: • -Personal experiences
Methods of Communicating	• Visual aids • Poster, Photos… • Experiential: games, Drawings, Drama • Role plays • Stories	• Discussions • Visual aids: • Poster, Photos, maps • Experimental: games, drawings, • Drama, Role plays, Stories	• In-depth Discussions • Visual aids: • Poster, Photos, maps • Stories • Own experiences	• In-depth Discussions • Visual aids: • Poster, Photos, maps • Stories • Drama

Communication Worksheet

Ask the participants to look at the following scenarios and discuss what happened and why and what changes they would like to see.

- A hygiene promoter opened the door of a latrine in one compound, saw that it was dirty, and turned around immediately, slamming the door behind her. The lady of the house, an expectant mother whose hands were covered in soil as she had just returned from her shamba was visibly embarrassed by this reaction. The lady explained that she had only just returned from working in the gardens and that she had not had time to clean the latrine."

- A hygiene promoter arrived in the compound of a homestead owner where other members of the team were already engaged in a conversation with homestead owners. Instead of allowing the conversation to continue after greeting them, she immediately started asking her own questions, some of which had already been asked by the other team members."

- Two hygiene promoters are walking through the camp and observe that a young child is defaecating in the open. They immediately ask the other children where the child's mother is and when they point to a young mother nearby carrying a child on her back and trying to calm an infant who is crying, they go up to her and tell her quietly that she must make sure her children use the latrine provided.

- A hygiene promoter observes a man telling his wife off because the children are not clean. The woman starts crying and the HP goes over to her and tries to comfort her by saying, 'well, your husband has a good point – you must make sure you clean your children properly or they will get sick and die – now you don't want that do you?'

How Adults Learn

> "Tell me and I will forget. Show me and I will remember. Involve me and I will understand." Aristotle

The following are important when facilitating learning in adults:

- Respect
- Immediacy
- Experience

Respect:

Learners must feel listened to, honoured and respected as a person in order to learn something effectively. Learners automatically "turn off" when they feel humiliated or threatened.

Immediacy:

Learners must see how they can use their new knowledge, skills and attitudes immediately. Adults do not have time to waste. Immediacy makes for high motivation.

Relevance:

Adults will learn faster if the subject is important to them and to their present lives. The trainer's job is to connect the learning topic to the knowledge of the learners themselves.

20%, 40%, 80%:

Adults retain 20% of what they hear, 40% of what they both hear and see, and 80% of what they do or discover.

- Adults want to learn, they come to the class because they want to, not because they have to
- Adults have life experience; they have a great deal to contribute
- Adults are problem-oriented. They want to use their knowledge for problem solving; they want to be able to use the knowledge in their daily life.
- The knowledge they gain must be useful to them
- Adults do not want to be told things they already know, they want to build on that knowledge
- Adults have a different time perspective – they have limited time, it is less expendable
- Adults want to be treated as adults. Many of them have negative memories of school
- Adults all have different motives for learning, depending on their backgrounds – they cannot be treated as one group

Three-pile sorting

The purpose of this exercise is to encourage participants to discuss common hygiene practices and explore their attitudes to them. It will assist the facilitator's understanding of community hygiene practices and local knowledge about hygiene and can act as a catalyst for motivating people to take action.

By the end of the session participants should be able to identify good and bad hygiene practices and suggest ways in which some of the unhygienic practices could be improved.

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

- Divide the participants into small groups and provide each group with a set of picture cards describing a variety of hygiene practices. If there are people who are not used to looking at pictures, it is important that each group clarifies how the image is being interpreted (this usually comes out in the discussion but those who are not used to looking at pictures may struggle initially).

- Ask them to sort the pictures into three piles according to whether they think the activities depicted are good, bad or both good and bad in their impact on health.

- Encourage as much discussion as possible. The facilitator can help to clarify the relationship between local knowledge and practice. For example if people say that boiling water is good, it is important to explore how realistic this option is in terms of the availability of fuel.

- Ask each group to suggest one or two "bad" cards and to describe what would need to happen and who would be responsible for improving the situation. How can they be involved in making improvements?

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

- Take note of the discussion points using the local terms. The findings should be included in the project records and can be used as baseline data. Subsequently the same activity can be used for monitoring or evaluating progress.

Take Two Children

The purpose of this exercise is to encourage participants to examine some of the reasons for ill health and to identify practices that will protect or promote their children's health.

The causes of ill health are varied and include not only individual unhealthy practices but also underlying and structural factors such as conflict, gender relations, national and international policies. This activity can be carried out without reference to political factors but is enhanced if people are given the opportunity to explore this important issue more widely.

By the end of the session participants will be able to identify factors that are likely to cause disease and some methods for preventing disease. The activity can be carried out as part of the training of community mobilisers or with groups of mothers who have young children.

- Place two pictures in front of the participants - one is of a healthy baby/child and the other of a sick baby/child.

- Divide the participants into small groups. Then present each group with a set of randomly selected "unhealthy" and "healthy" pictures.

- Ask the groups to decide which practices lead to an unhealthy baby or child and which to a healthy one.

- In plenary ask for volunteers to describe a particular picture and to place the picture under the appropriate baby/child.

- Ask participants how common these practices are in their community and whether they can think of any others that could be added to the list.

- Ask the participants to reflect on whether they could do more to protect the health of their children and what changes they could make at home.

NB - Ideally the facilitator should have identified practices that are specific to the situation during the baseline survey and selected appropriate pictures prior to the session.

How to do a voting activity

Voting activities can be used to discuss preferences or practices within a community and explore options for taking action. Pocket charts (see below) can be used for voting activities. Alternatively you might like to use pots or jars on the ground. The voting should be done in secret so it's a good idea to use a screen or ask participants to wait outside the meeting place before coming in to vote.

- Prepare the voting tokens from paper or card or use bottle tops or small stones. It is a good idea to prepare different types of voting slips for different groups e.g. men and women or children or elderly if the group is mixed.

- Hang the pocket chart on a wall so that everyone can see it. Explain to the participants what the purpose of the activity is i.e. to find out about the frequency of various water and sanitation illnesses or of certain hygiene practices etc.

- The pictures along the top can denote hygiene practices, types of latrine, where people defecate, water sources or water and sanitation diseases. Down the side can be symbols representing 'sometimes', 'always' or 'never', pictures of men, women and children or pictures of water uses etc.

- Allow people to discuss the pictures first to ensure that everyone understands them in the same way. This discussion may also highlight other issues of concern. It is a good idea to try out a trial vote with two or three people to begin with.

- Hand out the voting tokens to each participant and explain that each person will vote in turn. If considering the most common diseases only one or two voting tokens need to be given out per person. If looking at hygiene practices hand out a token for each different practice. If several tokens are handed out it is a good idea to conduct each vote separately and count the votes before the next practice is considered.

- When each person has voted, count out the votes in front of the whole group. The voting chart could be placed on a table and the voting tokens lined up in front of each picture.

- The most important part of the exercise is the discussion about the findings and what will happen next.

Disease Transmission (Chain of Contamination)

The purpose of these exercises is to draw on the participants' existing knowledge and experience and assess their understanding of how diarrhoea, malaria or other water and sanitation diseases are transmitted. The activities can also be used to motivate people to take action by asking what can be done about the problems illustrated.
By the end of the session participants should be able to describe ways in which hygiene practices are related to the spread of water and sanitation related diseases and identify ways of preventing them.

Activity 1

- Divide participants into small groups and give each group a set of randomly ordered sequential pictures showing how a specific disease is transmitted

- Ask them to put the pictures into an ordered sequence. Some people in the group may have more knowledge than others and this activity usually generates a lot of discussion about how the disease is spread.

- Ask the groups to explain their 'story of transmission' to the rest of the group and clarify any misunderstandings

- Ask each group to draw pictures or symbols of barriers to transmission and to place these at key points in the story.

- What action could be taken in the current situation to prevent transmission? And by whom?

- Ask the participants to:
    1. Identify what they will do differently as a result of the activity
    2. Consider how they will mobilise others to take action to prevent this disease.
- Revise the main ways in which the disease is transmitted and the main prevention methods

Activity 2

- Ask the participants to think of the main ways in which diarrhoea is transmitted.

- Explain that the routes of transmission can be illustrated with the help of a diagram known as the 'F' diagram. Display a picture of the 'F' diagram and go over the different routes.

- Remove the diagram temporarily from view

- Divide participants into small groups and provide each group with picture cards depicting the different routes of transmission and ask them to compile the diagram from memory.

- Provide each group with a set of cards that depict how the chain of contamination can be broken and ask them to place these on the diagram in the appropriate places.

- In plenary ask the small groups to circulate around the different diagrams and to ask questions to clarify or correct misconceptions.

- Ask the group what they can do to prevent diarrhoea in their homes and community.

Facilitation Skills for Participatory Methods[13]

The single most critical factor for successful facilitation of participatory methodologies is *you.* Being a participatory facilitator is completely different from being a conventional field worker or trainer. This may mean that you will have to unlearn a whole range of habits and methods that you have become accustomed to. By doing so, you will not only begin to play a big role in achieving the benefits of participatory development, but you will be doing yourself a great favour. Participatory development work is extremely rewarding and is considered by many to be a lot less demanding than top-down development approaches, where you, as an external agent, do all the planning, design, implementation, monitoring and evaluation.

Let's look at an example:
A government environmental officer may be accustomed to:

- Performing health inspections within businesses, schools and households.
- In response to his/her findings, running formal group training sessions in a didactic manner (i.e. by lecturing to the group).
- Defining his or her solutions to the problems.

Experience shows us that this methodology is ineffective. Ask yourself this question, "If someone tells me that one of the reasons I may be getting diarrhoea is because I do not wash my hands after using the toilet, am I not going to feel patronised? Am I not going to say, but there is no clean water near my toilet?" The problem centres on the fact that this health worker has:

- Possibly undervalued my level of understanding of the issues.
- Possibly provided me with inappropriate solutions that I will be reluctant to implement because they were not my own ideas.
- Not gone the extra mile by assisting me to analyse the root cause of the diarrhoea problems and assisting me to plan the solutions.

It's that simple! As a facilitator, you must put yourself in the shoes of the individuals in the community in which you are working.

Facilitation is not the same as training. Training is the formal process of imparting skills. You will be both a facilitator and a trainer. Your role as a facilitator is to use participatory methods to enable participants to:

- Identify issues that are important to them.
- Express their problems.
- Analyse their problems.
- Identify their own possible solutions.
- Select their own appropriate actions.
- Develop a plan to implement the solutions they identify and agree on.
- Monitor the indicators and evaluate the outcomes of the plan.

The facilitator's role is to:

- Encourage participation.
- Create an enabling environment in which everyone feels comfortable to contribute.

The key principle here is communication. The core methods described below are essentially communication skills and tools. These are used as an integral part of

[13] Adapted from Harvey, E (2002) Participatory Methodology and Facilitation Guide, Wateraid Mozambique

everything that you do, whether you are facilitating a meeting, conducting an interview with a key informant or facilitating a tool with a focus group.

Listening versus talking
A good facilitator is therefore first and foremost someone who has learned the skill of listening. In order to achieve this you must develop a respect for the level of knowledge in the communities you are working with. Look at the group you are working with. They are people like yourself, and many of them may be older and wiser than you are. Those younger than you are probably vibrant and full of youth and enthusiasm. Respect this and begin to listen and learn from the group. This is their development process. Let them do the thinking and talking.

Creating an enabling participatory environment
To make participation happen when working with a group, you have the vital job of creating an environment in which the participants feel able to contribute freely without fear of:

- Embarrassment.
- Ridicule.
- Reprisal.
- Causing conflict.
- Revealing personal information.

Giving instructions
You will need to give clear instructions to a group when you are introducing a tool or activity. Your instructions must remain focused only on how the tool or activity should be used or performed. The following should be kept in mind:

- Have all the necessary materials ready for each activity. ; Make all the materials clearly visible to all the participants. Spread them out on the ground or table for all to see. Share the tool as you talk.
- If the activity is the first in a session, then do an'ice-breaker' activity first.
- While spreading out the materials for the activity, clearly explain in a step-by-step fashion what needs to be done. You can explain the purpose of the activity, the estimated amount of time and the process they need to follow. Keep your instructions short and to the point.
- Never imply what you think will be a logical outcome to the tool.

Relinquishing control and stepping back
Remember that the process you are facilitating is the community's process. Once you have introduced a tool or process you must step back and allow the group the freedom to take control. Your job now is to listen. If the group asks you a question, consider the following:

If they ask anything about the activity process:

- Answer them only in terms of the procedure for the activity.
- Do not limit their creativity. If they feel they need more materials, or more pictures, then let them use or create them.
- If they ask for extra information that they need in order to make informed decisions (e.g. technical expertise):
- First, ask the group as a whole if anyone knows anything about the subject in question.
- Only then should you add to or provide this information, but you must do so with full objectivity (i.e. do not express your preference for one option or the other but

provide full information on any option). If you do not know the answers than say so and discuss where such information can be found.

Watch the group dynamics. Only intervene if:

- You see particular individuals dominating (see below).
- Serious conflict ensues. In this case, you will have to use your conflict-resolution skills. It is a good idea to do this by asking the group to identify areas of common ground and then using any activities necessary to work through the issues in contention.
- The group has become stuck and appears to be unable to proceed. In this case:
    - Ask what the problem is.
    - Ask probing questions (see below).

Probing and stimulating

At times, it may be necessary to intervene in a way that helps the group to progress forward but that still does not provide any inferred direction from you.

In cases where you see the enthusiasm for an activity has been lost or where the group has reached a temporary dead-end, then you can:
Call a break, have tea or do a short, fun 'energising' exercise.
Throw in an open-ended question to stimulate discussion or to steer the group away from their sticking point.

Another use of probing is to help the group explore the issues being discussed in more detail. For example, the activity may have resulted in the group to identifying key problems, but has not resulted in the group thinking about the causes or implications of the problem. By asking a probing open-ended question you can steer the discussions to explore these issues further. An alternative is to use a different tool to do this. The choice is yours and it is dependent upon what you think will work best at that moment.

Focus group discussion

What is a focus group?

A focus group is a special type of group composed of not more than 10-12 participants who have been selected because they have certain characteristics in common that relate to the topic of the focus group. An example would be IDPs or refugees. The group is there to discuss and to present different views and opinions. The data collected from the group is always qualitative data.

How is the group run?

There is a facilitator who is there to do just that – facilitate.
There are one or sometimes two recorders
The group should be in a quiet place where no one can listen to them and they will not be disturbed
They should sit in a circle and be comfortable
Ground rules should be explained after introduction – everyone has a right to speak; no one has the right answer, no interrupting each other
If using a tape recorder ask permission to use it
The session should take about 1-$1^{1/2}$ hours
The facilitator makes sure everyone has a chance to speak and that the discussion does not go off onto another subject
The recorder takes notes and looks after the tape recorder if there is one
At the end of the session, the facilitator can give a brief summing up of what has been said in case someone has something to add
Refreshments can be served after the session

Why only 10-12 people?

In a larger group:
People's speaking time would be restricted and dominant people would speak more than others
The facilitator would have more of a controlling role
Some members of the group would become frustrated if they could not speak
Participants would start talking to each other
The group may deviate to another subject

It is best to have men and women separately as often women do not speak if men are present
It is best if all participants are roughly the same age as older people may do all the talking
A common language is important
It is best not to have leaders or people in authority in a group of ordinary people – interview them separately

Some common mistakes made in focus groups

There are too many people
Only a few people talk
No one takes notes
People start talking about something else
People start talking to each other or wander off if they are bored
The facilitator joins in the discussions, gives an opinion or starts teaching the group
Questions are closed questions that require one answer
There is little discussion, people just give information

Common mistakes with analysis of focus group data

Percentages are used and the data becomes quantitative
General statements are made without saying how many people actually talked
The facilitator makes assumptions about the group

What makes a good facilitator?

Being relaxed and at ease
Not wanting to be in control or to prove how clever or knowledgeable they are
A good listener
Shows interest in others
Able to draw out those who are not talking and to stop those who talk too much
Able to probe to get more information
Is able to interpret non-verbal communication – body language
Able to control their own body language
Someone who matches the group in age, gender and cultural background

Source: Walden, V, Oxfam

Focus Group Discussion Sample Questions

Water Use Look at these cards and tell me what sources of water you use for which activity? Why do you think people make these choices? Can you tell me about a typical day in collecting water (who, how, how long)? How do people traditionally store their water in the houses? Can you tell me what people are doing now in the camp? What do you think about the current water supply?	In your village, what did you use for washing clothes and your bodies? What about now? Can you tell me what people are using for washing now? Let us look at how much water you used before you came here – show me in these different piles Now lets look at how much water you use now – using the same piles

Latrine Use I see some of you have latrines here – can you tell me how you make the decision about building one? Can you describe to me the different roles of men and women in building, repairing and cleaning latrines? Can you tell me about using the latrines – for example, men, women and children? Other women tell me that using latrines at night is not safe – what do you think? Small children are often scared about falling through the hole – what do you think we can do to get them to use a latrine? How do you find the latrines? (Structure, cleanliness, privacy, smell etc.) From what age do children start to use the latrine?	What do people do in order to wash their hands after leaving the latrine? Is it possible to get small children to wash their hands after leaving the latrine? How can we do this? How can we persuade other people to build a latrine? What do people in this community believe is the cause of diarrhoea in small children?

Latrine Use What type of latrines do you have? What made you decide to have a latrine?	What happens to the stools of young babies? Does everybody do this? Who made the latrines?

How do you find the latrines? (structure, cleanliness, privacy, smell etc.) Are there times when you don't use a latrine? Do you use a latrine at night? If not - what do you do? Do young children use the latrines? From what age do children start to use the latrine?	Who cleans, repairs, empties the latrines? Do young children wash their hands after using the latrine? Do adults wash their hands after using the latrine? How can we persuade other people to build a latrine?

Malaria[14] What are the most common diseases at present and which are the most serious? Who gets these diseases? Men, Women, Young children 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?	What causes malaria? – (probe for other answers) How can it be prevented? At what time do mosquitoes bite most? Do people use bednets here? Do children under five sleep under a bednet? 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?

Source: Oxfam Guidelines for Public Health Promotion in Emergencies, 2001

[14] Some WASH agencies have separate teams responsible for malaria control

Recording and Analysing Qualitative Data[15]

Recording Qualitative Data

It is often useful to conduct the data collection sessions with at least two facilitators so that one person can concentrate on writing down the data. They should try to write down as much as possible of what is said and where possible quote people directly – especially where they seem to offer some key insights into the problem being discussed. This should be explained to participants and their permission for the data to be recorded should be obtained. If they refuse, the facilitators will have to try and record the data from memory after the session.

It is also possible to record the session with the permission of those taking part but the tapes then have to be transcribed and large amounts of data analysed and this may be difficult in an acute emergency. However, even if written notes are taken the data from the focus groups will still need to be collated and then analysed.

Where diagrams have been produced as in the case of mapping or seasonal calendars, these can be transcribed onto paper (where the ground has been used), copied or photographed – again with the permission of those who have taken part. They may also want to have a copy of the session left with them.

Photographs can also be taken of specific observations but care must be taken to obtain people's permission and to ensure that the photograph is not used to embarrass or shame someone in the future. (Where photographs are used for three pile sorting exercises, hygiene promoters or volunteers may be willing to pose for these).

Many people find it difficult to know what to do with the data collected from participatory methods. Below is a brief summary of how to analyse this type of data. However, remember that one of the main reasons why these methods are used is to try to enable the people that you are working with to analyse the information for themselves, in their own way and to come to some meaningful conclusions.

Qualitative data consists of the words that people say and once collected this will need to be analysed in a logical and systematic way if it is to be used formally in an assessment report. You will first need to state where the data came from e.g. who are the key informants, why did you choose them or who took part in the focus group discussions (without mentioning names) and why they are/are not representative of the wider population, who asked the questions or did the observations and how many groups you worked with.

There are four basic steps to analysing qualitative data:

- Organise data
- Shape or code the data
- Interpret and summarise the information
- Explain the information

On the following page is an example of how the hard data from an assessment might be shaped using a matrix:

[15] Taken from Ferron, S. Morgan, J. and O'Reilly, M. (2007) Hygiene Promotion: A Practical Manual for Relief and Development

Focus group discussion topic: Sanitation

Question	Response	Similar responses
What do young children do?	Go in the compound Use a plastic potty Use an old tin Taken to the toilet by sibling Scared of dark latrine Hole too big in latrine Cannot go to the bush as too far	𝍸 || || |||| ||| 𝍸 |||| |||| 𝍸 𝍸
What do older people in your family do?	Use bush Use latrine Have arthritis cannot bend legs – must stand up to go Use children's potty	𝍸 𝍸 |||| ||| 𝍸 𝍸 |||
What makes women use latrines?	Private do not expose self to strangers Convenient Stop compound smelling	𝍸 𝍸 𝍸 |||| 𝍸
What prevents people from using latrines?	No money to build Men too busy to dig pit - working or looking for money Men too hungry to dig pit Not in men's interest to dig – they don't use latrines	𝍸 ||| 𝍸 ||| 𝍸 || 𝍸
How could people be persuaded to build and use latrines	Force – laws Makes house better Good for family health Need help with cost	𝍸 || 𝍸 𝍸 |||

Remember that you cannot count up the tally marks and convert this into a percentage. However, you can say that there were a certain number of responses under a certain category and identify the categories that people mentioned most frequently or least frequently. However, you must then include a couple of quotes to back up your interpretation.

Once the data has been analysed, a report needs to be compiled. This can be a narrative report, illustrated with tables and diagrams where appropriate.

Below is an extract from an initial baseline data report – key areas for intervention have been highlighted:

Data has been gathered using exploratory walks, focus group discussions, mapping and voting charts. Discussions with key informants have also been held. Separate discussion groups and interviews were held with male and female groups in order to gain their different perspectives. It was also thought necessary to collect separate data from the Twa group – a group known to be marginalised and excluded from many aspects of day to day life - to try and understand if they had particular needs or preferences with regard to the provision of water and sanitation. The key areas of significant public health risk were explored rather than trying to obtain all the information possible on 'hygiene practices'. A total of 12 focus group discussions were held. Mapping was carried out in six communities and exploratory walks conducted in three of the mapping

[17] Source: Oxfam Guidelines for Public Health Promotion in Emergencies. 2001

communities and three additional communities. Voting charts on hygiene practices were used with a total of six groups – three men and three women.
Men and women do not use the same toilets and it is forbidden for a man to see his mother in law going to the toilet. Consequently many women wait until after dark before going to the toilet using a potty indoors if they want to pass urine. **Women are in need of cloth for sanitary protection**. **Men and women often go to the toilet by the river or in the bush** and only a few families have latrines – usually the better-educated and better off families. **There is a significant amount of children's excreta** observed throughout the villages and children were also observed defaecating in the compounds. Unless this is very close to the house **mothers do not clean this up and do not perceive it to be dangerous**. Even amongst the families who have a latrine, **young children under eight years old are not expected to use it**. The reasons usually given for having a latrine, although this is uncommon, were privacy and preventing sickness. The former was especially important for women who felt that it was shameful to be seen by other people when defaecating. One old woman claimed that the reason she had a latrine was that ' a home is not a home without a kitchen and a toilet'
Water is used for anal cleansing and people consider that hands washed with water following this procedure is sufficient to clean them of dirt. Those who have attended primary school seem to be more aware of the connection between germs/dirt and sickness but only about 20% of children attend primary school**. Handwashing is not common prior to eating** with less than a quarter of those taking part in the pocket chart voting claiming to always wash their hands at this time. Water and soap are never offered to guests before they eat but will be provided after eating.
Handwashing after cleaning the baby is also not practised as a rule. **Soap is no longer available** although people used to purchase locally produced 'black soap' made from coconut oil. People are not aware of ash as an alternative to soap.
Very few mothers are aware of how to make up ORS or home made salt and sugar solution and rarely take their children to the clinic for diarrhoea alone. Most men were also not aware of how to make up ORS. The clinic is at some distance and can take up to an hour and a half to walk there. There is no public transport. Mothers do not like to go to the clinic because they feel the staff are too bossy and always tell them off. They must also **seek permission from the child's father** before they can go to the clinic and payment will be provided by him if he feels the child's sickness warrants it**. A child with fever will be taken to the traditional healer first and then, if there is no improvement, to the clinic**. A child with diarrhoea will be given breastmilk or water but **food is withheld**. **A child with fever is often wrapped up** to provide protection from the spirits. It is a common belief amongst men and women that diarrhoea and fever are caused by malicious ancestors who call on the spirits to harm the family.
Only a few of those who have attended school seemed to be aware that mosquitoes caused malaria and even they seemed sceptical as it is a common belief amongst men and women that malaria is caused by eating over ripe watermelons as malaria is more serious following the end of the rains which coincides with the end of the watermelon season. People are aware that larvae turn into mosquitoes and complain of getting bitten severely late at night**. Pools of water and puddles were a common observation**. Sleeping patterns vary enormously but it is common for young children to sleep just after sunset. Adults will often sleep by 9pm but women usually rise before men to do their chores such as collecting water and firewood. Only the most wealthy people use bednets and these are not treated. Nets cost approximately 2,000 francs (equivalent of $10)in the market but are not available at present.
Water is collected by women and children and drinking water is usually collected from the handpump although many have presently fallen into disrepair. In some areas a charge was levied for the use of the handpump but this money was not thought to have been used for maintenance. If handpump water is not available then people usually use the water from unprotected wells providing it is not too salty. Only a few of these wells were observed to be covered. Many had mosquito larvae in them and the water was often quite turbid. People prefer not to drink this turbid water but if necessary they will allow the dirt to settle overnight and then strain the water through a muslin cloth. Drinking water is usually stored in a separate container but is not often covered. There is a shortage of water collecting and storage containers……etc.

Role of the Hygiene Promoter

Introduction to Assessment

- Qualitative and Quantitative Assessment
- Leading Questions Exercise
- Assessment Methods
- Overview of Data Collection for Hygiene Promotion
- Example Rapid Assessment Checklist
- Example Observation Guide for an Exploratory Walk

Selection and Distribution of Hygiene Kits and Hygiene items

- Hygiene related NFI Briefing Paper
- Hygiene Kit monitoring form

Selection & Support of Community Mobilisers

- Information on Community Mobilisers and Example Job Description
- Community Mobiliser Attributes

Introduction to Working with Children

- Child Protection Good Practice Guide
- Child Protection Scenarios
- Example activities for working with children
- Children and Learning

Monitoring

- Example of a WASH logical framework matrix
- Indicators for Monitoring Hygiene Promotion in Emergencies
- Example Hygiene Promotion Monitoring Form
- Examples of PHAST monitoring forms
- Example SMART and Not so SMART Indicators

Qualitative and Quantitative Data

Measures levels of occurrence	Provides depth of understanding
Asks “how many” and “how often”	Asks “why” and “how”
Studies action	Studies motivations
Is objective	Is subjective
Provides proof	Enables discovery
Is definitive	Is exploratory
Measures levels of action, trends and disease patterns	Allows insight into behaviour, trends, beliefs
Describes	Interprets
Can be participatory but will then not be scientific	Often participatory
Always measurable	Can be measurable but needs to be converted

Use of Different Assessment Methods

The table below is a summary of the use of different methodologies at the different stages of an emergency including rapid assessment, baseline data collection and monitoring. [18]

Stage I: Rapid Assessment	Stage II: Baseline Data Collection	Stage III: Ongoing Assessment & Monitoring
Exploratory Walk Use to collect initial data on what facilities are available at present and what main problems/risks are: provides rapid impression of situation	A checklist (see appendix) can be used to record information from different areas or zones to define indicators for monitoring. Information will be impressionistic and cannot be presented as 'survey' data	Using 'crude' indicators such as a rating of how much indiscriminate defecation observed, or evidence of hand washing facilities, change should become obvious by comparing checklists used for baseline data collection
Key Informant Interviews Use to collect initial data on main problems/risks and people's perception and understanding of risk	Record information and identify themes and trends to help define indicators. Do not present as percentages or statistical information but as narrative, qualitative information is cross checked by using other methods.	Repeat interviews and ask people to identify changes they perceive to have taken place using previously identified indicators. Previous and new key informants should be interviewed.
Mapping May be possible to do one or two maps at the same time as interviewing a group of key informants but may take time to do well	Structure mapping activities to include different areas and groups, ensure data is recorded both in form of map itself and accompanying commentary and observations. It may provide numbers of facilities or breeding sites.	Repeat mapping to use as visualisation of community perceived changes at three monthly intervals. It may be possible to obtain numerical data for each map and this can then be collated for the whole area.
Focus Group Discussion May be possible to organise one or two FGDs as part of initial rapid assessment	Information needs to be summarised and cross-checked with other information collected and presented in narrative format. This data cannot be interpreted in terms of percentages.	Subsequent focus groups should **not** identify the same groups. Organising focus groups should be an ongoing activity as this is an opportunity for community discussion and learning.
Three Pile Sorting Preparation of materials may take time but pictures may be used to make FGDs more interesting. May not be feasible to do for the rapid assessment	Can provide detailed information on how people perceive problems if careful recording is made. Cannot present this data in percentages – narrative required	Such activities should form part of ongoing training and group activities and key information should be recorded and feed into monitoring forms
Household questionnaire survey Not appropriate during rapid assessment. Need time to plan survey, train survey, train data collectors, pre-test questionnaire and analyse data.	Not usually appropriate where population in state of flux. Need to strike a balance between reliability and feasibility. Make questionnaire as short as possible. Useful method to use alongside other qualitative methods.	Repeat survey can be carried out at 6 monthly intervals if resources are available. Information should be cross-checked using qualitative methods.
Spot Check observations		

[18] Oxfam (2001) Guidelines for Public Health Promotion in Emergencies.

Stage I: Rapid Assessment	Stage II: Baseline Data Collection	Stage III: Ongoing Assessment & Monitoring
May be useful to visit one or two houses during exploratory walk if there is time, but will only yield impressionistic data and will not be a representative sample.	This method can be used to produce a large number of observations on specific issues such as number of school children washing hands after using latrines. Data can be presented statistically and percentages extrapolated with the qualification that the data is not necessarily statistically valid although the larger the number of observations, the more reliable the data. May be best used as a monitoring tool.	This tool can be used in various ways for monitoring: 1. A large number of observations may be repeated on particular indicators as with the number of school children washing hands after using latrine. 2. Spot checks should also be conducted on an ad hoc basis to verify if toilets are clean. 3. Checking if people coming to clinic or distribution know how to make up ORS etc. These activities should be carried out as part of regular programme activities.
Pocket Charts Not appropriate at this stage. May be difficult to organise in the first week.	Can provide some quantitative data on what people do but cannot be presented as percentages - notes should be taken on discussion as well as the outcome of voting.	Such activities should form part of ongoing training and key information should be recorded
Matrix Ranking Basic ranking of problems may be possible if situation not high risk	Should only be used if situation stable - pocket charts may be more useful in providing indicators. May provide deeper understanding of people's preferences for facilities such as latrines	Should only be used if situation stable - pocket charts may be more useful in providing indicators
Seasonal Calendar Time not usually available in high risk situation	May provide useful information on peak seasons for sickness and useful to make link between e.g. rainfall, sickness and food availability. More useful as a training tool than a monitoring tool	More useful as a training tool than a monitoring tool in emergency situations
Gender Analysis Some information should be sought from key informants on gender roles and relations etc. but time not usually available for comprehensive gender analysis	Baseline information on gender: may help to determine appropriate gender indicators for situation	May not be possible to view significant change in short time available but individual gender indicators should be monitored

Overview of Data Collection for Hygiene Promotion

	Timing	Essential Indicators/ Data Required	Methods of data collection	Co-ordination Tools	Level of Participation
1st Stage **Rapid Data Collection**	**1st Week**	• Use of safe drinking water • Environment free from faecal matter (adult, child and animal) • Men, Women and Children washing hands with soap at key times (after defaecating and prior to eating) • Key male and female members of the affected population have been consulted on the design of the response (including appropriate hygiene items)	Key Informant Interviews/ discussions, Exploratory Walks	Joint Assessment / Reporting Format	Information/ Consultation with Key Representatives
2nd Stage **Baseline Data Collection**	**Week 2 -12**	As above + context specific (see Menu of Indicators in Appendix) Assessment data will feed into baseline survey	Focus Group Discussions Questionnaire Survey (Other participatory methods as appropriate)	Joint Interagency Baseline Survey	Consultation with broader range of affected men and women/ greater input into design of new facilities
3rd Stage **Ongoing Assessment (and Monitoring)**	**Week 12 onwards**	As above + Community satisfaction with services provided	Mapping, pocket charts etc.	Joint Monitoring / Reporting Format	Increasing Involvement in decision making

Example of an observation guide used during an exploratory walk[19]

The purpose of an exploratory walk is to give a general impression of risk factors for water and sanitation related disease. Used together with household observation and focus group discussions it can give adequate baseline data for the purpose of emergency interventions. If you find any intriguing information from the exploratory walk or household observation make sure that you investigate it further.

Water

1. **What are the available water sources and are they protected?**
   a) Well
   b) Spring
   c) Rain water tank
   d) Seasonal Pond
   e) Public Stand Post
   f) Hand dug well
   g) River
2. **Who collects water?**
   a) women
   b) children
   c) men
3. **What utensils are used for fetching water?**
4. **What activities take place at or near the water source?**
   a) washing water containers
   b) washing clothes
   c) bathing/washing
   d)watering animals
   e) other
5. **How long do people have to queue for water?**
6. **How long does it take to fetch water?** (round trip) – try to accompany a few people back to their houses and time how long it takes or pace the distance
7. **Is water available continuously or at specific times only – give details.**
8. **Is there adequate drainage at water points?**

Sanitation

1. **Is there evidence of faecal contamination?**
   a) along the roads?
   b) along the foot paths?
   c) near the water source?
   d) in/near the fields?
   e) outside the houses / shelters?
2. **What is the contamination observed?**
   a) infants/young children's faeces
   b) adults' faeces
   c) cow dung and/or other animal faeces
   d) other
3. **Where is it observed**
   a) compounds
   b) water points
   c) defaecation areas
   d) indiscriminate
4. **How many houses / shelters have latrines?**
   a) none
   b) few
   c) many
5. **Are the latrines clean? If not are there:**
   a) flies
   b) faeces
   c) smell
   d) lid
6. **If clean is there evidence of use e.g. path leading to it used, recent faeces**
7. **Are there any hand washing facilities near to the latrine?**
   a) water
   b) water and soap/ash
8. **Are there public toilets in public places?**
   a) markets
   b) schools
   c) other
9. **How do people dispose of rubbish?**
   a) burn it
   b) bury it
   c) communal rubbish tip
   d) indiscriminate disposal
10. **Is there evidence of rubbish attracting flies?**
11. **Is there adequate rubbish disposal in the market?**
12. **Is there adequate water supply in the market?**

[19] Adapted from Almedom 1997 – Source: Oxfam Guidelines for Public Health Promotion in Emergencies

Example rapid assessment checklist

(adapted from British Red Cross ERU: MSM tools)

Purpose

This checklist is intended to help carry out a rapid field assessment following the deployment of the MSM, to identify the following:

- acute risks and needs associated with sanitation and hygiene, for prioritising initial actions;
- important physical, health, and social resources and conditions that need to be taken into account when designing an initial response;
- early baseline data for establishing a monitoring system;
- areas where more detailed assessment is required for designing a longer-term response.

The checklist is generic. It should be adapted for specific contexts.

Data sources / assessment methods

The following data sources / assessment methods are suggested for finding answers to the assessment questions (in the second column of the checklist table).

A. Existing reports, maps and other secondary data
B. Observation, transect walks
C. Interviews with community members and representatives
D. Interviews with local authorities, ministries, local and international NGOs, UN agencies, RC/RC staff and volunteers
E. Health-care facility reports and interviews
F. Visual inspection, sampling and testing
G. Focus-group discussions, mapping, three-pile sorting and other participatory techniques
H. Rapid counts and small sample surveys
I. Distribution records and post-distribution monitoring surveys

Recording data

It is suggested that data are recorded in a report that follows the same order as the headings in the assessment checklist, in the form of short notes, with a final section outlining conclusions and recommended actions.

Assessment question	Data source
Overall Situation	
What is the nature of the disaster and what are its main consequences for the affected population and the humanitarian response?	A,B,C,D,F
How many people are affected and where are they? Disaggregate the data as far as possible by sex, age, disability etc. What are people's likely movements?	A,C, D,H,I
What are the security factors for the people affected and for potential relief responses?	A,C,D
What special security risks exist for women and girls?	A,C,D,G
What are the current or threatened water and sanitation-related diseases (provide key mortality and morbidity data if possible)? What are the extent and expected evolution of problems?	A,C,D,E,G,H
Do people have adequate food to eat? Are there high rates of malnutrition?	A,C,D,E,I
Are there adequate health-care facilities and do people use them?	C,D,E
Do people have adequate shelter and non-food items?	A,B,C,D,H,I
Who are the main providers of shelter, food, non-food items, health-care and water?	A,B,C
General Water, Sanitation and Hygiene	
What other agencies are working in hygiene and water and sanitation and where? What resources are they able to share?	A,C,D
Who are the key people to consult, contact and work with?	C,D
Who are the vulnerable people in the population and why?	A,C,D,G,I
Is there equal access for all, to existing facilities?	A,B,C,D,G,H
What water, sanitation and hygiene practices were the population accustomed to before the emergency?	A,C,D,G,H
Is there sufficient water available for hygiene and sanitation?	B,C,D
What non-food items would enable better hygiene and maintenance of dignity?	C,D,G
How do mothers or caretakers manage diarrhoea in children under five? Are people familiar with ORT?	C,D,E,G
What do people know about the causes of diarrhoea? What are local names for diarrhoea?	A,B,C,G
What factors other than preventing diarrhoea might motivate people to practice improved hygiene?	A,B,C,G
Are there existing community structures such as (water and sanitation) committees? Community Health Workers etc?	B,C,G
Excreta disposal	
What is the current defecation practice? If it is open defecation, is there a designated area? Is the area secure?	B,C,F,G,H
What are current beliefs and practices, including gender-specific practices, concerning excreta disposal? What strong	A,B,C,D,F,G

Assessment question	Data source
cultural preferences are there?	
Are there any existing facilities? If so, are they used (and if not, why not?)? Are they sufficient (estimate number of people per toilet)? Are they operating successfully (cleanliness)? Can they be extended or adapted?	B,C,D,F,G
Are toilets sufficiently close to shelters? Is access to toilets safe? Is lighting provided for use at night?	B,C,G,H
Is the current defecation practice a threat to water supplies (surface or ground water) or living areas?	B,D,F
How do parents/caretakers manage children's and babies' excreta?	B,C,D,G
Do people wash their hands after defecation and before food preparation and eating? Are soap or other cleansing materials available? Are there handwashing points close to toilets? Are they in use? Is the water supply reliable?	B,C,D,F,G
Are people familiar with the construction and use of toilets?	A,B,C,D
What local materials are available for constructing toilets?	A,B,C,D
Are people prepared to use pit latrines, defecation fields, trenches, etc.?	B,C,G
Is there sufficient space for defecation fields, pit latrines, toilets, etc.?	A,B,C,D,G
Are there specific excreta-disposal needs of people who are elderly or disabled?	B,C,D,G
Are soil conditions suitable for on-site excreta disposal? What is the slope of the terrain? What is the level of the groundwater table?	A,B,C,D,F
Do current excreta-disposal arrangements encourage vectors?	B,C,D,F
What are the current and preferred methods of anal cleansing? Are there sufficient suitable materials or water available? How do people normally dispose of these materials?	C,D,G
How do women manage issues related to menstruation? Are there appropriate materials or facilities available for this?	C,D,G
Is there a significant quantity of livestock excreta in and around the settlement? Does this create a significant environmental health risk?	B,C,D
Water Supply	
What is the current water source used for drinking water? Is it likely to be contaminated?	B,C,E,F,G
How much water do people use per person per day?	B,C,F,G
Are water collection points close to where people live? Is security good?	B,C,F,G
Do people have adequate clean containers for collecting and storing water?	B,C,F,G
Are people used to treating water used for drinking?	B,C,F,G

Vector-borne disease	
What are the vector-borne disease risks and how serious are these risks?	A,C,D,E
What traditional beliefs and practices relate to vectors and vector-borne disease?	C,D,G
If vector-borne disease risks are high, do people at risk (particularly pregnant women and children under five) have access to individual protection?	C,D,I
Is it possible to make changes to the local environment to discourage vector breeding?	B,C,D,F
Is it necessary to control vectors by chemical means? What programmes, regulations and resources exist for vector control and the use of chemicals?	A,D,F
Is there a national vector control programme that needs to be taken into account?	A,D
What information and safety precautions need to be provided to households?	A,C,D,G
Solid waste disposal	
Is solid waste a problem? Is a large quantity of uncontrolled solid waste apparent in the settlement?	B,C
How do people dispose of their waste? What type and quantity of solid waste is produced, and where?	B,C,D
Can solid waste be disposed of on-site, or does it need to be collected and disposed of off-site?	B,C,F
What is the normal practice of solid waste disposal for the affected population?	C
How is health-care waste being disposed of? Who is responsible? Is additional support required?	A,B,D,E
Drainage	
Is there a drainage problem? What are the main consequences?	B,C,F
Do people have the means to protect their dwellings and toilets from local flooding?	B,C
Dead bodies	
Is there a significant health risk associated with the disposal of human remains (large numbers of bodies not disposed of, presence of communicable disease such as cholera)?	B,C,D
Who is responsible for dealing with human dead bodies? How effectively is the problem being managed?	A,C,D
What are the normal practices in the population for funerals and final disposal of the deceased? Are these practices possible with minimum health risk?	C,F
Are there many dead animals in and around the settlement? Do they create a significant health risk?	B,C,G

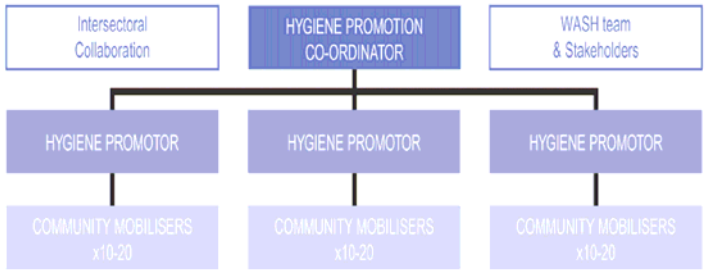
Leading Questions

- Shouldn't you cover your water storage pot?
- Do you think vomiting during diarrhoea is serious?
- Does it bother you that the latrines are smelly?
- Where do you dispose of your baby's nappies?
- Do you give your baby less food when he/she has diarrhoea?
- How do you get Malaria medicine?
- Is the water container hard for you to keep clean?
- When do you wash your hands with soap?

Information on Community Mobilisers and Example Job Description

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

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



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

Community Mobilisers

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

Normally Community Mobilisers will be identified or elected by the affected community themselves according to certain criteria such as the ability to communicate effectively and sympathetically with people or the ability to hold the trust of the community. Community Mobiliser positions may also be advertised by word of mouth or by posting information at public places such as health-care facilities, distribution points etc. Again, many applications should be expected and a system should be in place to short list promising applicants and inform unsuccessful ones. If possible, short interviews should be carried out by the Hygiene Promotion Coordinator and at least one Hygiene Promoter. If the recruitment of Community Mobilisers is rushed at the start if a response then it is likely that some will be found to be unsuited to the task. In this case the individuals concerned should be replaced.

Hygiene Promoters should be managed according to the normal policies and procedure of the implementing organisation. There is likely to be a lot of training during the first days and weeks of the emergency programme and thereafter, a programme of regular team meetings for planning and

reporting on activities and issues arising. Job descriptions should be reviewed early in the work period to ensure they are fully understood and that they provide adequate guidance for staff.

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

As for Hygiene Promoters, it is important that Community Mobilisers fully understand and are comfortable with their job (or task) descriptions and the reward/incentive system that will be used, to avoid disappointment and loss of motivation later on.

Community Mobilisers will be assigned to specific sections of the affected community. The most practical arrangement is for them to work in the area in which they live. If this is not possible then it may be necessary to provide transport to and from the area of work.

Community Mobilisers will require intensive training at the start of the programme. Thereafter, day-to-day supervision and on-the-job training should be provided by the Hygiene Promoters. This will commonly involve a daily meeting at community level and then the Hygiene Promoters may accompany Mobilisers in turn as they do their work.

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

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

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

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

The term ‘volunteer’ implies that a salary or fee is not paid for the work done but volunteers may be rewarded, compensated and encouraged for their work in many other ways, including the following:

- payment of per diems or daily allowances to cover costs incurred during their work such as travel;
- provision of a meal on working days;
- provision of materials and equipment that can be used outside the programme (e.g. a bicycle or wet-weather clothing);
- training courses with refreshments and certificates, particularly if training courses fit into a recognised national or organisational system of qualifications;
- the opportunity to learn and progress within an organisation, potentially to secure paid employment in a more formal role;
- the respect and goodwill of the community they are working in, the knowledge that they are fulfilling religious or social obligations, or other benefits related to social, cultural and belief systems.

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

Advantages and disadvantages of working with paid Community Mobilisers

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

WASH Cluster Generic Job Description

Hygiene Promotion Community Mobiliser

Job title:	**Hygiene Promotion Community Mobiliser**
Reports to:	Hygiene Promoter

Purpose:

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

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

Key tasks and responsibilities:

Information management

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

Implementation

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

Resources management

- Use programme resources effectively and with care.

Programme approach

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

Person specification:

Essential

1. Strong communication skills.
2. Good listening skills.
3. Sensitivity to the needs and priorities of different sectors of the community.
4. Trust and wide acceptance by the community.
5. Diplomacy, tact and negotiating skills.

Desirable

6. Some prior knowledge of health, hygiene, teaching or community development.
7. Literacy, numeracy and record keeping skills.

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.

Community Mobiliser Attributes[20]

Sense of responsibility	Capacity to make a rational decision	Resourcefulness
Capacity to generate new ideas	Skill in planning	Ability to work well in a group
Initiative	Confidence in Articulating ideas	Confidence in Relating to authority figures
Willingness to take risks	Ability to sort out priorities	Technical know-how
Skill in maintenance of hardware	Leadership	Political connections
Willingness to accept advice without questioning	Willingness to deviate from community values. beliefs and customs	Sense of humour
Humility	Willingness to provide free labour or materials	Acceptance of women's roles in Community decision making
Ability to participate in constructive group discussions	Skills in problem solving	Managerial skills
Ability to work well on committees	Enthusiasm	

[20] Taken from Tools for Community Participation. L.Srinivasan. Prowwess/UNDP 1993

WASH related non-food items: A briefing paper

Maximising the benefits of the distribution of hygiene items

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

Encouraging women, men and children to make the best use of hygiene items is often the remit of hygiene promoters but items are often selected and distributed by relief teams headed by logisticians. It is recommended that Hygiene Promoters and Logisticians work together to ensure an effective and efficient system is put in place. Large-scale distributions may need to rely on the expertise of logisticians but smaller distributions of tools or cleaning materials could be carried out with the help of community mobilisers.

- **It is critical to involve hygiene promoters in the selection and distribution of hygiene items, especially where items may not be used for their intended purpose**

- **Cluster co-ordinators, hygiene promoters, and logisticians must work together to ensure the efficient distribution and maximum impact of NFIs**

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

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

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

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

Selection of hygiene items

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

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

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

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

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

Personal Hygiene

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

Communal Hygiene

- Tools and equipment for digging and/or cleaning latrines or digging drainage (e.g. shovels, picks, wheelbarrows, buckets, boots etc.)[21]

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

1st PHASE
2 water containers (1 collection & 1 storage)
Soap for laundry and personal hygiene for 2 weeks (225gms)

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

2nd PHASE
Additional water container (see water treatment agent in the next column)
Soap for one month (see Sphere)
Cloth (ideally for menstrual hygiene but could be used for other purposes, 1x3m either dark or light cotton cloth per woman)
Water treatment agent for household usage for 15-30 days minimum – including instructions on use and water treatment and storage container (can be provided in 1st Phase if people are already familiar with this)
Potties for young children

3rd PHASE
Locally defined and purchased hygiene items

[21] Each situation must be judged according to accepted norms and considerations of health and safety. Discussion with the engineers will also be important in deciding what items to provide for these activities

Catalogues from other agencies

UNICEF Emergency Relief Items: Compendium of Generic Specifications (2 volumes) 1999-2000
www.ungm.org/Pages/Information/Documents/erc_vol1.pdf
UNICEF www.supply.unicef.dk/catalogue
ICRC – Emergency Items Catalogue 2004 www.icrc.org/emergency-items
Oxfam GB Catalogue – section on Health & Hygiene – CD only
IRC – Emergency Hygiene Promotion Kit – CD only
ACF catalogue – CD only

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

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

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

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

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

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

Monitoring of the acceptance and use of the hygiene kits should take place as soon as possible after the distribution, and modifications made, as necessary, prior to the next distribution.
If distribution is done through an intermediary e.g. community leaders or partner NGO, follow up is also vital. Support may be needed to ensure adequate and systematic monitoring and follow up.

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

Tips for improving the distribution of hygiene items

Before distribution

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

During distribution

- Ensure that beneficiaries understand the criteria for beneficiary selection, NFI content and use, in order to encourage transparency. They will also need to made aware of

their rights in regard to distribution (specifically that the distribution is free) and the complaints procedure, should the need arise.

- Try to address queries or complaints as they arise and ensure that disruptions to the distribution are dealt with quickly and effectively.
- Where possible, ensure that the materials distributed are intact and functioning e.g. that buckets have lids and taps, and that water filters have all the component parts.

After distribution

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

Suggestions for improving co-ordination

- Expertise in setting up distribution mechanisms is required for effective distribution to large populations and may be best managed by logistics teams.

- Hygiene Promotion teams should include an assessment of the hygiene kit requirements of women, men, and children in the initial rapid assessment and ensure that feedback is provided to the Shelter/NFI cluster leads.

- Hygiene Promotion co-ordinators/WASH programme managers should attend the NFI coordination meetings and explain their remit and what they can offer in terms of maximising the benefits of hygiene NFIs e.g.:

    - *selection of appropriate items*
    - *content of relevant information that should be provided with hygiene items*
    - *information/hygiene activities during or soon after distributions*
    - *monitoring of use and acceptability of distributed items*

- Shelter/NFI cluster leads should ask each agency to provide a plan of when distributions will take place and what items will be distributed so that they can be shared with Hygiene Promotion teams.

- Shelter/NFI cluster leads should recommend that each agency that will distribute hygiene items should consult with the WASH agency operating in their area to discuss the best way to provide supporting information and how the distribution will be monitored

December 2007

Hygiene Kit Monitoring Form[22]

Village/Camp	Did you receive a hygiene kit? (Y/N)	Did you receive any of the items from other NGO's? (list)	Were there sufficient items in the kit? (explain)	What other hygiene items would have been useful?	Were there items that were not useful and why?	Was the distribution fairly carried out? (did anyone not receive etc.)

[22] Courtesy of Oxfam PHP team.

Child Protection Good Practice Guide[23]

It is important for all adults in contact with children to:

1. **Be visible** to others when working with children, whenever possible
2. **Respect each child's boundaries**
3. **Be aware** of situations which may present risks and manage these
4. **Plan and organize** the work and workplace to minimize risks
5. **Be open.** Create and maintain a non-defensive attitude and an open culture in which to discuss issues & concerns
6. Create a culture of **mutual accountability** so that any potential abusive behaviour can be challenged

In general it is **inappropriate** to:

- Spend excessive time alone with children
- Take children to your own home, especially when they will be alone with you

Adults must never:

1. Develop physical/sexual relationships with children
2. Develop relationships with children which could be deemed as exploitative or abusive
3. Act in ways that may be abusive or may place a child at risk of abuse
4. Act in ways intended to shame, humiliate, belittle or degrade children
5. Use language which is inappropriate, offensive or abusive

Adults should avoid actions or behaviour that could be seen as poor practice or potentially abusive

UN Convention on the Rights of the Child states that a child is under the age of 18. All countries, except the USA & Somalia, have signed in agreement with this convention.

[23] Taken from Tearfund Child Health Club Training Manual

Child Protection Scenarios[24]

Situation A Score:	What factors are important in deciding if this is abuse?
I don't like to interfere, but I live right beside them so I hear it all. She just goes out and leaves little Huda in the house on her own. She's just turned three last month. Anyway sometimes I hear her start crying and sobbing. Went for hours sometimes. It was terrible, night after night. So in the end, I asked can I go in and sort it out. She's a sweet little girl and only needs a bit of a cuddle, so I don't mind that much. But the thing is, I'm going to stay with my sister for a bit, so I worry, who's going to see to her now?	

Situation B Score:	What factors are important in deciding if this is abuse?
Yeah, he was being cheeky so I hit him with the stick. He deserved it, the little rat. His mother has let him walk all over her, so now I'm here she wants to get him under some sort of control. It's the only language the little toe-rag understands. I didn't mean to leave any bruises, like, but if he does it again tomorrow, he'll get the same again until he learns some respect.	

Situation C Score:	What factors are important in deciding if this is abuse?
I'm a teacher in the local school. The children in my school are very bold and never listen to me. If I shout they usually listen to me but the best way to keep them quiet is to beat them. Not too hard but I make sure it hurts.	

Situation D Score:	What factors are important in deciding if this is abuse?
No one likes that child - he is from a different tribe. I don't let him join in the games because he will just cause trouble. I make him sit on his own in the corner. The other children call him names and make fun of him because he looks different. I don't try and stop them.	

Situation E Score:	What factors are important in deciding if this is abuse?
I've known the family for years, they're distant relatives. I don't like to say it but the family has a lot of problems. The kids have always been described as smelly but happy and the compound has always been a pigsty and that's on a good day. Every now and then things get really bad, and there's a crisis. They really do seem to try for a while and things get half-decent for a bit and we all get encouraged, but it always seems to slip back.	

[24] Taken from Tear Fund Child Health Training Manual

Working with Children[25]

Children don't have the breadth of life experience and analytical skills of adults but their ideas and attitudes may be more flexible. They are often inquisitive and enjoy opportunities to find things out for themselves. The ways they learn will depend on their developmental stage. For example, infants like to imitate and learn by copying whereas small children enjoy learning through play. As children grow older they are able to accommodate increasingly complex and abstract ideas.

Children in school are a 'captive audience' and learning about hygiene can be integrated into the curriculum or incorporated in the form of specific projects reaching out to the community and forming an effective link between the school and home-learning environments. Where schools are not functioning or when many children do not attend school, they may be reached in other settings, e.g. church or youth groups or perhaps simply in the places where they gather daily to play. Adolescents in particular are often very influenced by their peers and can be helped to become effective peer group educators.

In the Occupied Palestinian Territories, an Oxfam programme worked with schools to help them make optimum use of their water supplies that were frequently disrupted. Additional water storage capacity was provided in the schools and water was recycled from drinking water fountains and hand washing facilities in the bathrooms for use in flushing the toilets. In one school there was initially some anxiety amongst the pupils about using the recycled water as they mistakenly thought it was being pumped into their drinking water tanks. Hygiene awareness activities were carried out through a school health club to encourage them to conserve water and to reassure them about the recycling system. As a result of this, use of the recycled water increased and pupils reported that they were much less likely to leave taps dripping than before. The school also made some savings on its water bills.

The Child-to-Child approach recognizes the role that many children have in caring for siblings and the potential of children to learn from each other. It seeks to make learning enjoyable for children. They are encouraged to learn through experience and to apply what they learn in a practical way to improve the hygiene conditions within their own family and community. Through sharing and helping each other, they become more aware of their own ability to improve their situation. The Child-to-Child approach can be successfully implemented in schools and can reach out to non-attendees through activities carried out at home or in the community. A series of resource books, stories and activities is available from the Child-to-Child Trust and TALC in London.

Tips for working with children

Begin by contacting parents, teachers and community leaders to discuss the project idea. Seek their permission and collaboration and find out from them what they think are the major issues of importance in the community. Some countries and organisations may have child protection policies in place that restrict who can work with children. Find out about these from the Ministry of Social Welfare or children's organisations such as Save the Children.

Work with groups of children of a similar age and include them when deciding the topics to be covered. Children of different ages will have different priorities and learning capacities. Find out about their experiences and ideas, for example on the subject of diarrhoea. Use games, stories, discussions and drawings to help them understand and encourage a sense of sharing and learning through co-operation.

Ask children to find out more about the topic by talking to their families and other community members. For example, they can find out what people believe about the causes of diarrhoea, how many are affected by it, and/or what they do to prevent or treat it.

[25] Adapted from Hygiene Promotion: a practical manual for relief and development

Help children to share their discoveries with each other and to design activities to help tackle the problems identified. How can they overcome problems that may arise in sharing this information at home and apply it in a practical way when looking after their siblings? What ways can they use to communicate what they have learned to others? For example, they could invent songs or games, produce posters or perform street theatre to put their message across.

Review the activities and encourage the children to think about what success they have had and how they might do things differently next time. Decide how to involve teachers and parents in evaluating the success of the project. There will be many things to consider besides the health impact on children, such as the effect it had on their confidence as agents for change and the health of other family members. The challenge posed by the Child-to-Child approach lies in seeking ways to make learning active and constructive for the child and his/her family. Encouraging children to think, observe, experiment and invent can make learning fun and can help them to apply what they learned into their daily lives.

The following box gives an example of child-to-child in action in an emergency setting:

A project in a refugee camp in Goma was working with thousands of unaccompanied Rwandan children of different ages. Clean water was available but not easily accessible to the children aged under 5 years, and the latrine building project was making slow progress. Many of the children were susceptible to illness because of poor nutrition. In August 1994 there was an outbreak of bacterial dysentery which was followed by an outbreak of non-bloody diarrhoea. A tent-to-tent treatment project combined with health education was commenced in the hope that it would limit the spread of the disease, but with little effect. It was decided to abandon this didactic approach to health education and to involve the children more actively in learning. They were encouraged to make up songs and rhymes about the spread of the disease and these were presented at a group concert which was broadcast on the UNHCR radio station to other camps. Within a week, the incidence of diarrhoeal disease had begun to fall and while the staff knew that they could not prove that this was a result of the dysentery song, they and the children were convinced that their innovative approach to health education had been effective.
MERLIN, 1994 (internal report)

Example Activities for Working with Children

Games for Children[26]
Example of game from Sudan
Game 2: Spread the Germ
Topic: Diarrhoea & Dehydration (or any other communicable diseases)
Key Message: Diseases can spread to lots of people quickly.

Version 1: have chalk/ash/charcoal available.

1. Cover one child's hands in the substance.
2. They then have to shake hands with two other people, and colour their hands with the same substance.
3. These two people each shake hands with two more people.
4. See how many handshakes it takes until everyone's hands are covered.

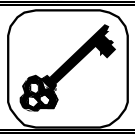
Version 2: alternatively could do this with a big piece of paper and ripping it in half and giving to two people to rip in half again. See how long it takes everyone to have a piece of paper.

Games for Children
Example of game from Sudan
Game 5: Sugar and salt solution
Topic: Diarrhoea and dehydration
Key message: How to make ORS (Rehydration Drink)

1. Tell the children that holding their index fingers in a cross represent ½ a Teaspoon of salt and 4 fingers represents 4 teaspoons of sugar.
2. Holding 6 fingers up represents 6 'Usman Hussein' Glasses of water (1 litre).
3. After the children have understood this the facilitator calls out sugar/salt/water alternatively in a fast and tricky manner. The children have to respond by holding up the correct number of fingers.
4. Children who take the wrong action are eliminated from the game!
5. Confuse children by throwing a few silly questions eg. 'How many teaspoons of flour?' 'How many teaspoons of water?' 'How many Osman Hussein Glasses of sugar?'

Games for Children
Example of game from Sudan
Game 6: The spread of diarrhoea
Topic: Diarrhoea and dehydration
Key message: The game illustrates how quickly diarrhoea can spread from one person to another.

[26] Taken from Child Health Club Trainers Guide. Draft. 2007. Tearfund.

Game 6		The spread of diarrhoea
Topic		Diarrhoea and Dehydration
Key Message		The game illustrates how quickly diarrhoea can spread from one person to another

1. One person – 'with diarrhoea' stands in the front of a tree, facing a line of 10 children standing about 15m away.
2. After the person 'with diarrhoea' says 'GO!' all 10 children start hopping towards the tree, trying to avoid the person 'with diarrhoea.
3. The person 'with diarrhoea' also hops towards the 10 children, and tries 'tag' them.
4. Any child that gets touched by the person 'with diarrhoea' instantly changes direction and tries to 'tag' others before they reach the tree.
5. In turn, those children that get caught by these children 'with diarrhoea', also instantly try to catch others.

Other Activities for Working with Children[27]

Rubbish Pick Up. Children are placed in two teams. There are two rubbish bins with lids at the head of each line (about 5 metres distance). Each team has 20 pieces of rubbish (two different colours for each team. The team member at the front of the line picks up a piece of rubbish and runs to the bin, puts it in the bin and closes the lid. They then run back to the line, touch the team member next in line who does the same thing, while the first runner goes to the back of the line. The winner is the team that puts all their rubbish in the bin first.

Lucky Dip – each child chooses a note from the lucky dip box. They must do the action that is written on the page. The actions can be core messages or they can be silly, fun actions, eg, bark like a dog, hop like a kangaroo, wash your hands with soap etc

"Tulli Says " - this game is played like "Simple Simon". One promoter stands in the middle of a circle with children all around. If he says "Tulli says… brush your teeth", then all of the group must mime the action. If he says, "Brush your teeth" without saying "Tulli says" and the children do the action, they are out of the game. The HP tries to trick the children by shouting the instructions quickly and mixing them up. It is important that "Tulli" should always say something that is linked to good hygienic practices and to part of the core messages.

[27] Taken from: Action Contre La Faim, Sri Lanka: Leonie Barnes, An Integrated WatSan/Hygiene Promotion Manual in the Post-Tsunami context

Experiments[28]

Wilted plant experiment

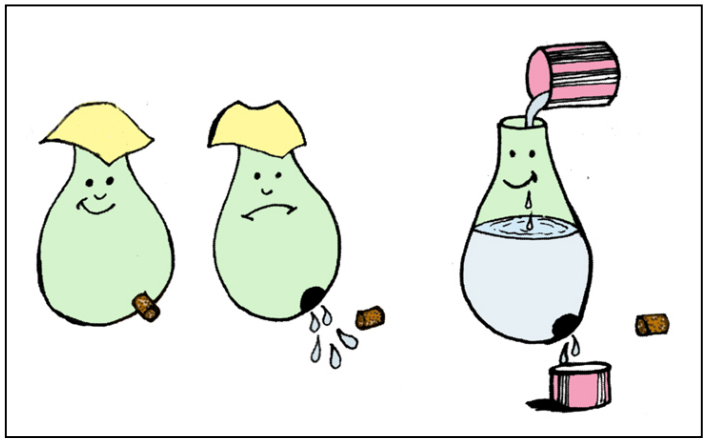
The purpose of this exercise is to show children that water is necessary for life. Plants, like people, suffer and die when they do not have sufficient water.

- Cut two flowers or plants
- Put flower in a container of water and leave the other without water for a few hours
- Discuss with the children why the plant without water is wilting

Hollow gourd experiment

A hollow gourd or container can be used to show how fluid is lost through episodes of diarrhoea.

- Make a hole in the top of a gourd and another small hole with a plug in the bottom.
- Draw a mouth and eyes on the gourd. Fill it with water and cover the top opening with a small thin damp cloth. Pull out the plug and let the children see how the cloth sinks into the hole.
- Discuss how this compares to the soft spot on the baby's head which will be sunken when the baby is dehydrated.
- Mark a water level line on the gourd and explain that the fluid inside the body should never fall below this or the baby will become dehydrated and may die.



- Show how each cup of water that is lost must be replaced by another which is poured in (swallowed) to prevent dehydration

Coloured rice experiment

This experimentdemonstrates how fliescan spread dirt and can contaminated food. It is most effective when the food used is white or when it is considered to be pure in the culture of the participants.

- Put cooked rice on one plate near the participants. Put some faeces on leaf some 10 meters from the participants (a pit latrine nearby might also be effective). Cover the faeces in red powder (the red powder used by Hindu women for tikka or to put in their hair).
- Leave the rice and the faeces for 30 minutes.
- Flies will move from the faeces to the food and gradually turn the white rice red.
- Discuss the implications of the results with the participants.

[28] Hygiene Promotion. A Manual for Relief and Development

Example Hygiene Promotion Monitoring Form[29]

Indicator	Change[30]				Current Situation	Action Required
	Major 	Some 	None 	Negative 		
Mortality and morbidity rates for all diseases are within normal limits						
Increase in families disposing of young children's faeces safely						
Toilets are clean following spot checks						
Increase in number of families digging their own latrines						
Hand washing facilities are next to the latrine and in use						
More people are washing hands with soap or ash at key times						
Mothers know how to make and use salt/sugar solution or ORS						
People collect water from the protected						

[29] Adapted from Oxfam Hygiene Promotion Guidelines

[30] A rough estimate of the change that has occurred can be made following the results of FGDs, Observations etc. and by compiling the volunteer monitoring forms. A negative change indicates where the situation has deteriorated. A scoring system using between 1 and 4 + signs can be used to represent the degree of change.

source						
Families store drinking water in a covered container						
Maximum of 20 people per toilet (proportional provision of toilets for women)						
Toilets are both safe and private for women especially						
At least 15 litres of water per person per day is collected and used						
Water point and latrine attendants have been selected, trained and are operating						
Outreach workers have been trained, supervised and their performance is being monitored						
Shower /laundry areas are constructed and men and women are satisfied with these						

Example logical framework matrix (following the ECHO format)

	Intervention Logic	*Objectively Verifiable Indicators*	*Sources of Verification*	*Risks and Assumptions*
Principal Objective ***(IMPACT)***	Contribute to the recovery, protection and sustainable improvement of the health and dignity of the target community over X months for X,000 people in X location	Mortality and morbidity data within accepted limits (see WHO) No major outbreaks of sanitation and hygiene-related diseases in target area Local capacity for managing sanitation services is re-established'	UN & Government reports Other agency reports Health facility data Community consultation e.g. pocket voting, FGD	
Specific Objective ***(OUTCOME)***	Men, women and children in the target population (x no) have sufficient access to, and make optimal use of, sanitation and hygiene facilities, and take effective action to protect themselves against threats to public health	Areas within X m radius of all dwelling and water points free from observable excreta by end of Phase 1 X% of the target population using sanitary latrines by the end of Phase 1 X% of latrines are clean on spot inspections X% of the target population washing hands with soap / alternatives by the end of Phase 1 At least X% of households dispose of solid waste safely by mid Phase 2[31] The project target area is free from	Exploratory walks reports Focus group discussions Information from other NGOs. Surveys Community monitoring tools[32]	Absence of major further conflict/secondary hazards. Population has access to sufficient water, food and non-food items.

[31] Safely will need to be defined according to chosen disposal system

[32] These would be worked out with the community at the same time as establishment of community indicators. Some tools could be pocket voting, tally sheets (with pictures if literacy is low) or ranking

		solid waste and stagnant water by mid Phase 2 In malaria-prevalent zones, X% of pregnant women and children under five are sleeping under LLINs by the end of Phase 1		
Results ***(OUPUTS)***	1. X no of men, women and children have access to safe sanitary facilities within six months. 2. X no of men, women and children have access to safe drinking water according to Sphere standards within x months 3. X no of men, women and children are enabled to practice safer hygiene in a dignified and culturally appropriate manner	1 latrine constructed per 20 people after community consultation No faecal matter observed in the target area At least 80% of target group accesses at least 15 litres water/day per person. Maximum distance from shelter/home to water points is 500m. Water meets international quality standards (Sphere) Queuing time at water sources no more than 15 minutes At least 80% of trained PHP's are holding at least two meetings/10 household visits per week[33] Hand washing facilities are provided at all latrines and a system is in place to replenish them Each household reports the presence of soap on random weekly visits On weekly observation at water points at least 80% of jerry cans meet the criteria of a clean jerry	Latrine monitoring forms. Reports by latrine assistants. Observation Weekly random transect walk Focus group discussions with women and girls held monthly with two groups of 12 people Engineers monitoring and output records. Records from water point attendants. Weekly water testing records Surveys Observation. Random household Visits Reports from latrine attendants and water point attendants. Hand washing demonstrations with children Focus group discussions, surveys, and interviews. Weekly random transect walks	Government border guards are able to improve security to reduce/prevent rebel raids. Refugees stay in the camp.

[33] If doing Child-to-Child or other activities, the indicator needs to state what is expected of the promoter over a given period

		can[34] All women and girls have access to appropriate sanitary materials and underwear At least 80% households dig and use garbage pit The project target area is free from solid waste and stagnant water		
Activities ***(INPUTS)***	**Result 1 – Adequate sanitary facilities in the camp** • Set up temporary defecation areas. • 400 gender-segregated latrines constructed in line with international standards. • 100 hand-washing facilities constructed and being refilled daily • 50 latrine attendants trained and equipped. • Construction of 200 gender-segregated bathing facilities. • Construction of 80 community-washing facilities (laundry). • Consultation with female and male refugees to identify design and suitable sites for sanitation facilities. • Provision of potties for under-five • Monitoring system established **Result 2 – Adequate clean water** • Trucking of water (first phase only) • Installation of six bladders • Installation of 32 water points in the refugee camp. • Training of 32 water point attendants in camp. • Construction of 20 hand pumps in local	***Means*** **Material resources** Building materials Cleaning materials Potties **Human resources** Engineers Public health promoters Community promoters Trained attendants **Material resources** WatSan equipment Spare parts Promotional materials Oxfam Delagua testing kit Transport **Human resources**	***Costs*** WatSan equipment Hygiene kits Promotional material Promotional activities Transport costs International staff Local staff Capital expenditure	Construction materials remain available in adequate amounts.

[34] A definition of clean: no visible dirt, no cracks, lid intact

	village. • Training of 20 hand pump attendants in village. • Establishment of a stock of community spares for water pumps in village. • Establishment of water management committee in local village • Monitoring system established _____ **Result 3 – Improved hygiene practices in camp** • Training of 16 community hygiene promoters in camp • House-to-house visits, community meetings, water point meetings carried out • Child-to-Child activities carried out • Provision of 4000 water containers. • Provision of 200 community hygiene packs. • Provision of 2000 household hygiene packs every month for six months (soap, disinfectant, laundry soap, etc, for one family for one month). • Provision of sanitary towels and underwear to women • Production of hygiene promotion materials • Solid waste management plan in place • Provision of bins • Provision of cleaning materials • Clean up campaigns • Monitoring system established	Engineers – international and national Public health promoters – international and national Interpreter for international staff Water pump attendants Volunteers **Material resources** Hygiene materials Water containers Sanitary materials for women Cleaning materials Bins Promotional materials Community theatre Puppet shows Child-to-Child activities Transport **Human resources** Public health promoters – both international and national Volunteers Interpreter for international staff		
				Preconditions National government gives NGO registration to work in the country.

Example SMART and Not so SMART Indicators

Not so SMART	**SMART**
X% of the population uses safe water for drinking	X% of the population uses safe water for drinking *within 3 months of the start of the project*
The environment is free from all faecal matter	*Areas within X m radius of all dwelling and water points* free from *observable* excreta *by the end of Phase 1*
The affected population wash their hands with soap or ash at least after contact with faecal matter and before handling food	*X% of* the affected population wash their hands with soap or ash at least after contact with faecal matter and before handling food *within 6 months*
Women are enabled to deal with menstrual hygiene issues in privacy and with dignity	*At least 90%* of women are enabled to deal with menstrual hygiene issues in privacy and with dignity *by January xxxx*
children's and babies' faeces are safely disposed of	*x% of* children's and babies' faeces are safely disposed *of within 3 months (safely must also be defined)*
Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day	Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day *within 3 mo*nths
Each household has at least two clean water collecting containers of 10-20 litres, plus enough clean water storage containers to ensure there is always water in the household	Each household has at least two clean water collecting containers of 10-20 litres, plus *enough* clean water storage containers to ensure there is always water in the household *within 2 weeks (define enough)*
People have enough soap for personal hygiene and laundry	There is at least 250g of soap available for personal hygiene per person per month. Each person has access to 200g of laundry soap per month
adequate water handling practices to minimize contamination practised by x% of the population	*adequate* water handling practices to minimize contamination practised by x% of the population *within 6 months (define adequate)*
Toilets are no more than 50 metres from dwellings	Toilets are no more than 50 metres from dwellings
Latrines are clean when checked	*X% of* latrines are clean *on spot inspections once in use (define clean)*

Monitoring Tools For Phast Facilitators/RC Volunteers (Quarterly)[35]

THREE ESSENTIAL INDICATORS

The following PHAST monitoring sheets includes examples of the three essential indicators which should be included in monitoring any PHAST programmes and the corresponding tools used.

The PHAST Monitoring Sheets can be filled in for the first time during the initial implementation of the PHAST steps by the PHAST facilitator and then subsequently during discussions with the same PHAST group members during one day every quarter.

PHAST Quarterly Monitoring Sheet

Three Essential Indicators

• use of safe water for drinking	*(use of Pocket chart - water uses/sources)*
• use of latrines	*(use of Pocket chart - sanitation options)*
• hand washing at key times (after contact with faecal matter & before handling food)	*(3 pile sorting - good & bad hygiene behaviours)* *(blocking the routes - how disease is spread)* *(selecting the barriers - barriers chart)*
Household management of diarrhoea	
• knowledge of ORT - (use of salt/sugar or ORS)	*(3 pile sorting - good & bad hygiene behaviours)*
• use of ORS sachets	*(3 pile sorting - good and bad hygiene behaviours)*

PHAST MONITORING TOOLS FOR PHAST FACILITATORS/RC VOLUNTEERS

In addition to undertaking a base-line survey and following it up on a regular basis additional regular monitoring of the impact of PHAST can also be undertaken on a quarterly basis. This can be done by PHAST facilitators in their own communities and results can then be compared and used to track changes related to each intervention.

During the quarterly meetings PHAST facilitators should ensure that all the key indicators selected for the PHAST programme are measured and recorded. This can be achieved by information gathered during discussions with the PHAST group members and the completion of PHAST monitoring sheets below as well as by observation of households.

The PHAST Step-by-Step Guide contains all of the activities and tools which should be used to complete the PHAST programme. Included below are some more additional simple ways to record discussions of the groups and can be kept to compare data every quarter. These sheets may help to make it clear how to record group discussions.

GOOD AND BAD HYGIENE BEHAVIOUR- (3 PILE SORTING)

The purpose of this tool is to help the group to look more closely at their common hygiene and sanitation practices and decide which maybe good or bad for health.

[35] Source:IFRC

1. In the drawing column of the recording chart fill in the name of your pictures.
2. Put a cross in the box to show if the group thinks the picture is a 'good' hygiene behaviour, a 'bad' hygiene behaviour, 'in- between' hygiene behaviour or if the group does not know what the picture represents.

An example of a recording chart:-

Drawing of hygiene practice	Good	Bad	In between	Don't know
Open defecation		X		
Hand washing with soap	X			
Adult wiping baby's bottom	X			
Adult cleaning toilet	X			
Children playing in water etc.			X	

INVESTIGATING COMMUNITY PRACTICES- POCKET CHART (SANITATION OPTIONS)

The purpose of this tool is help the group to collect, organize and analyse information on individual sanitation practices in the community. This is done by using drawings.

Fill in the recording format as follows:-

1. In the left hand column, place the drawings of different community members.
2. On the top row, add drawings of different sanitation options used by members of your community.
3. Enter the number of votes that each type of person uses as a sanitation option.

For example:-

Sanitation options ***Community members***	**Open defecation**	**Latrine**	**Burying of faecal matte**	**VIP latrine etc (all options on your pocket chart)**
Infant				
Toddler (about 2-7 years)				
Boy (between 7 and 15 years)	5 votes			
Girls (between 7 and 15 yea		5 votes		
Women				
men	10 votes			
Disabled				
Old man etc. (All other optio on your pocket chart.				

INVESTIGATING COMMUNITY PRACTICES- POCKET CHART (WATER USES/SOURCES)

This tool can be used to help the group collect, organize and analyse information on where they collect their water from and what they use if for. Pictures are used.

Fill in the recording format as follows:-

1. In the left hand column list possible uses for water.
2. On the top row list the water sources available to the community
3. Put a cross in the box which shows what water from different water sources is used for.

For example:-

Water sources ***Water uses***	**Flowing river**	**Unprotected spring**	**Hand dug well**	**Piped water etc (all options of water sources available)**
Drinking			X	
Household chores		X		
Watering animals	X			
Other activities on your pocket chart.				

HOW DISEASES ARE SPREAD

This tool can be used to help participants discover by using pictures to analyse how diarrhoeal diseases can be spread through the environment.

Fill in the recording chart as follows:-

List the various flow charts that the PHAST group creates to show how faeces can get to the mouth.

1.
2.
3.
4.

TASKS FOR WOMEN, MEN & CHILDREN IN THE COMMUNITY- GENDER ROLE ANALYSIS

The purpose of this tool is to raise awareness and understanding of which household and community tasks are done by different people at different times of day.

TIME	**MEN**	**WOMEN**	**CHILDREN**
Morning			
Afternoon			
Evening			

Fill in the recording chart which tasks that men, women and children perform in one day.

PLANNING FOR CHANGE:- PLANNING POSTERS/PLANNING WHO DOES WHAT

This tool helps the group plan the action steps for implementing the solutions it has decided upon and to assign responsibility for each action step. The group can identify the resources which they require to carry out the tasks. Planning posters are used.

The following recording sheet can record and combine data from Activity 1 and Activity 2 :-

Task	**Who**	**When**	**With What**
Planning posters			

NOTE

Monitoring activities can be carried out which enable baseline information to be collected (health problems, mapping, good and bad behaviour, investigating hygiene practice and selecting the barriers) in order to compare what existed before with the current situation. For the activity on health problems it is possible to check changes in the priority of health problems, problems that are no longer experienced etc. When mapping, check for changes in spatial analysis. Good and bad hygiene behaviours can be checked, in particular which habits were perceived as good or bad in the past, but are now considered otherwise. When investigating hygiene behaviour, check for the reduction in the gap between knowledge and practice.

During each PHAST activity, it is important to listen to the discussions that go on among community members as they reach decisions/or make suggestions and make and keep a record of these. The discussions will help to understand the community's perception on different issues.

Keep a record of both the discussions during the activity and the final conclusions at the end of the activity. The charts included above will help the project implementer to collect baseline data and record what is agreed after every PHAST activity. All data should be kept e.g. the community map should be kept to be used for indicating physical changes that occur.

Pocket charts are particularly helpful to identify and record the gap between knowledge and practice. A record of the pocket chart votes can be kept for the different sanitation options that different people in the community use as well for what activities are undertaken using water from various sources (water sources versus water uses). The number of votes for each sanitation option should be entered.

Indicators for monitoring Hygiene Promotion in Emergencies

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

During the initial stages of hygiene promotion programme planning, objectives are set and accompanying indicators of achievement defined. A logical framework can be used as an active tool to guide monitoring. Monitoring can include measuring ***impact*** and assessing whether the project purpose has been achieved and significant change has occurred. This includes reviewing the projects appropriateness, outcomes and outputs (facilities provided or systems set in place) and activities (toilets or water points constructed)[36]. It is also important to monitor participation of communities and whether all those affected are adequately represented e.g. women, men, the poorest and disabled people. Monitoring can be used to measure progress against the baseline data gathered during the initial stages of an emergency, as well as faults in project design and unrealistic objectives.[37]

Process monitoring can include how the project is being developed and for identifying and solving problems.[38]

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

Indicators

Indicators are identified in order to be able to monitor and evaluate. Indicators are how you measure whether you have achieved your objective and how this has been done. Indicators can be qualitative or quantitative and are identified when the project plan is initially written. They are either impact indicators or process indicators. Process indicators are found in the Logical Framework at (activity & result level), compared to impact indicators which are found at (purpose or specific objective level).[39] It is also important to measure participation of people and gather health clinic data where possible.

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

Direct and Proxy (indirect or substitute) Indicators

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

Whilst the ultimate aim of hygiene promotion projects is to reduce the mortality and morbidity of WASH related diseases, it is widely recognised that it can be difficult to establish a direct relationship as the incidence of disease is affected by many factors.

[36] Oxfam (2001). Guidelines for Public Health Promotion in Emergencies.
[37] Ferron, S., Morgan, J., O'Reilly, M. Hygiene Promotion. A Practical Manual for Relief & Development
[38] Oxfam (2007) Revised Guidelines for Public Health Promotion in Emergencies.
[39] Oxfam (2007) Revised Guidelines for Public Health Promotion in Emergencies.

This is partly due to the difficulty of obtaining accurate data, especially in an emergency situation. For this reason indirect or 'proxy' indicators are considered an acceptable alternative to monitor project impact e.g. hand washing with soap has been proven to have a significant impact on the reduction of diarrhoeal diseases.

Indicators to use in an emergency
A short list of essential indicators is included here which should always be included in any situation.

A list of more general priority indicators which can be used in emergencies is included in the table below with indicators for excreta disposal, water supply, hygiene practices and the environment.
The table provides a comprehensive list of indicators that may all require monitoring at some point during most WASH programmes. However, the particular indicators chosen for monitoring in any given situation, and the frequency with which those indicators are measured, should reflect specific priorities identified during assessment and planning and the practicalities of collecting and managing the data required to measure them.

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

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

Essential indicators for monitoring Hygiene Promotion in emergencies

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

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

(X% = depends on the situation)

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

Hygiene Behaviour	Indicators
Safe drinking water	• adequate water handling practices to minimize contamination practised by x% of the population
Safe excreta disposal	• x% of children's and babies' faeces are safely disposed of • toilets are used by the majority of men, women and children
Hygiene Practices	• soap or ash for hand washing is available in all households • hand washing facilities are available at 100 % of communal latrines or in the majority of homes and in use
Women's privacy and dignity around menstrual hygiene	• appropriate sanitary materials and underwear for all women and girls are available
Community participation & representation	• all sections of the community, including vulnerable groups, are consulted and represented at all stages of the project • the majority of community members are satisfied[40] with the provision of facilities • users take responsibility for the management and maintenance of water supply and sanitation facilities

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

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

Adapted from:

* International Rescue Committee (2005). Environmental Health Field Guide
* Walden, V., Nixon Achieng, O., Shirlaw, L., Malile, M. (2007). Minimum standards for public health promotion monitoring during the first three months of a rapid-onset emergency. A guide for field staff.

Note:

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

[40] Satisfaction will need to be defined in terms of access, safety, privacy, systems for cleaning etc.

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

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

Hygiene Behaviour	Indicators	Relevant Sphere Indicators
Safe drinking water	adequate water handling practices to minimize contamination practised by x% of the population	Each household has at least two clean water collecting containers of 10-20 litres, plus enough clean water storage containers to ensure there is always water in the household Water collection and storage containers have narrow necks and/or covers, or other safe means of storage, drawing and handling, and are demonstrably used
Safe excreta disposal	x% of children's and babies' faeces are safely disposed of toilets are used by the majority of men, women and children	Use of toilets is arranged by household(s) and/or segregated by sex Toilets are designed, built and located with the following features: - used by all sections of the population - sited to minimise threats to users, especially women - sufficiently easy to keep clean - to provide a degree of privacy Users (especially women) have been consulted and approve of the siting and design of the toilet Separate toilets for women and men are available in public places (markets, distribution centres, health centres, etc.) Shared or public toilets are cleaned and maintained in such a way that they are used by all intended users Toilets are used in the most hygienic way and children's faeces are disposed of immediately and hygienically Infants and children up to two years old have 12 washable nappies or diapers where these are typically used. People are provided with tools and materials for constructing, maintaining and cleaning their own toilets if appropriate
Hygiene Practices	Soap or ash for hand washing is available in all households Hand washing facilities are available at 100 % of	People wash their hands after defecation and before eating and food preparation There is at least 250g of soap available for personal hygiene per person per month.

	communal latrines or in the majority of homes and in use	Each person has access to 200g of laundry soap per month Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day (water quantity)
Women's privacy and dignity around menstrual hygiene	Appropriate sanitary materials and underwear for all women and girls are available	Women and girls have sanitary materials for menstruation
Community participation & Representation	All sections of the community, including vulnerable groups, are consulted and represented at all stages of the project The majority of community members are satisfied[41] with the provision of facilities Users take responsibility for the management and maintenance of water supply and sanitation facilities	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.

December 2007

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

[41] Satisfaction will need to be defined in terms of access, safety, privacy, systems for cleaning etc.

Review & Evaluation

Example review session

Example Hygiene Promotion Quiz

1. Name 6 factors that influence health in this emergency (from the Public Health Model)

2. What are the key water and sanitation priorities in this context?

3. What sort of data is collected from a focus group discussion?

4. How do you make up and administer ORS to a baby?

5. What factors are necessary for effective communication?

6. You get a bonus point for explaining what a probing question is!

7. How will you monitor the distribution of hygiene items in this emergency?

8. What factors do you need to think about when training adults?

9. How do children learn differently from adults?

10. What is the reason for using the three pile sorting exercise?

11. How would you use a pocket chart?

12. What hygiene promotion approaches will you use in this current emergency situation?

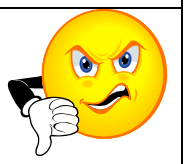
13. What outcomes do you expect to see as a result of your work?

14. What is protection?

15. What does the term gender refer to and how will you mainstream it in your work?

16. What does the term participation refer to and how will you encourage participation in this context?

Hygiene Promotion Training Evaluation

Please tell me:				
Two things that you learned from the training.				
Was there anything that was unclear or that you need more discussion on?				
Were there any sessions that you felt were not necessary? Tell me why.				
After this training do you feel you……	YES (PLEASE		TICK)	NO
				
….understand what hygiene promotion is?				
…..know how to assess hygiene promotion issues?				
…..know how to identify community mobilisers?				
…..know how to train community mobilisers?				
…..know how to monitor your WASH project?				
…..know how to use participatory methods?				
….know where you can go for further help on hygiene promotion?				

Any other comments (please continue on the reverse if necessary)

Example Certificate

This is to certify that

Has completed the introductory training course for field hygiene promoters

Briefing Paper: Introduction to Hygiene Promotion

WASH | Hygiene Promotion

HYGIENE PROMOTION IN EMERGENCIES

A BRIEFING PAPER

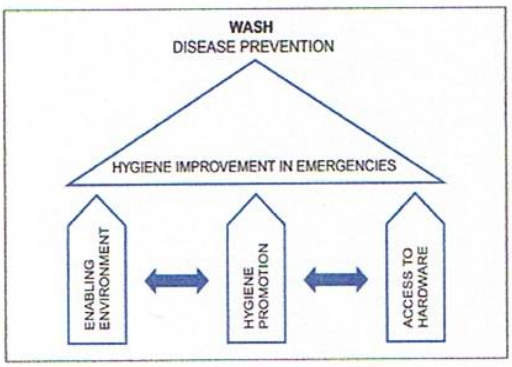
This briefing paper is aimed at all those involved in facilitating hygiene improvement in an acute emergency context, especially WASH co-ordinators and programme managers. It aims to provide an overview of the focus and content of Hygiene Promotion interventions and why they must be integrated with hardware 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.

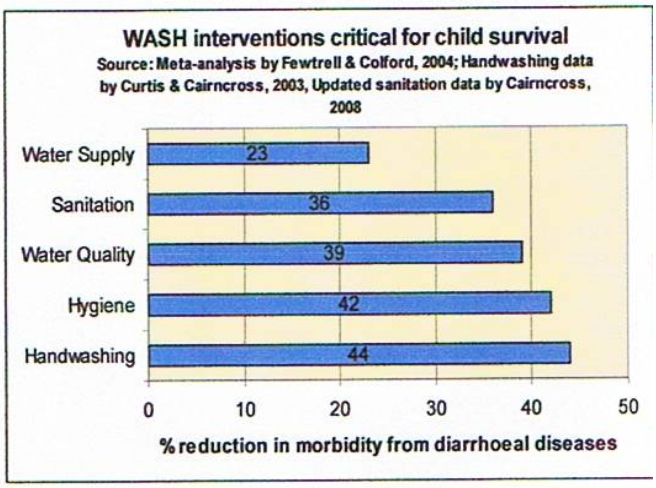


Hygiene Promotion also involves ensuring that **optimal use** is made **of the water, sanitation and hygiene enabling facilities that are provided**. Previous experience has shown **that facilities are frequently not used in an effective and sustainable manner** unless Hygiene Promotion is carried out. 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]**

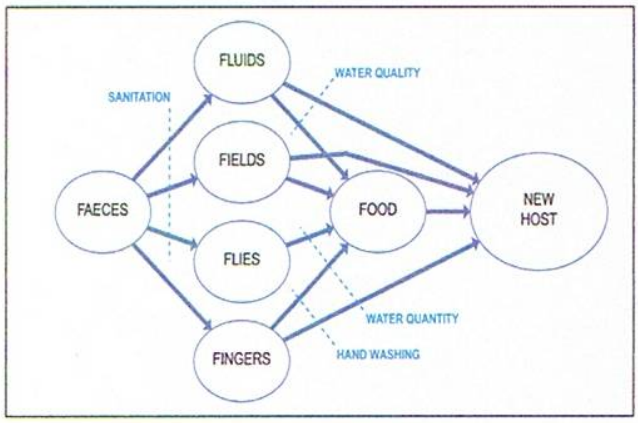
The diagram below shows the relative importance of different WASH interventions and the need for Hygiene Promotion.



[1] See Sphere Standards

[2] Example indicators for these objectives can be found in the List of Indicators

Best practice materials produced through the WASH Cluster HP project 2007, amended 2008 c/- UNICEF



The 'F' diagram (left) illustrates the transmission routes of most diarrhoeal diseases and how the transmission routes can be interrupted. Although the main focus of Hygiene Promotion should be the prevention or reduction of diarrhoea, the methods employed may also be used to address other public health issues such as malaria or other water and sanitation related diseases.

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

Components of Hygiene Promotion

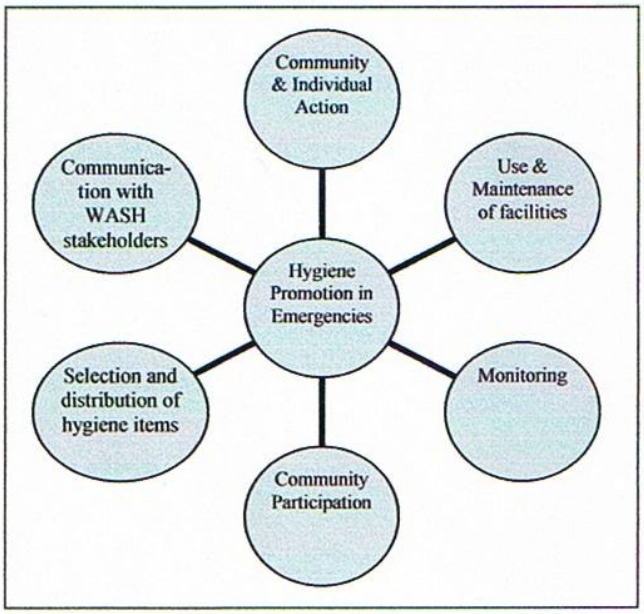
The diagram below represents the different components of Hygiene Promotion in an emergency situation and examples of the specific activities related to each component are then provided.

Community Participation e.g.:

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

Use and Maintenance of facilities e.g.:

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



Selection and distribution of hygiene items e.g.:

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

Community and Individual Action e.g.:

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

Communication with WASH stakeholders e.g.:

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

Monitoring:

Collect, analyse and use data on:

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

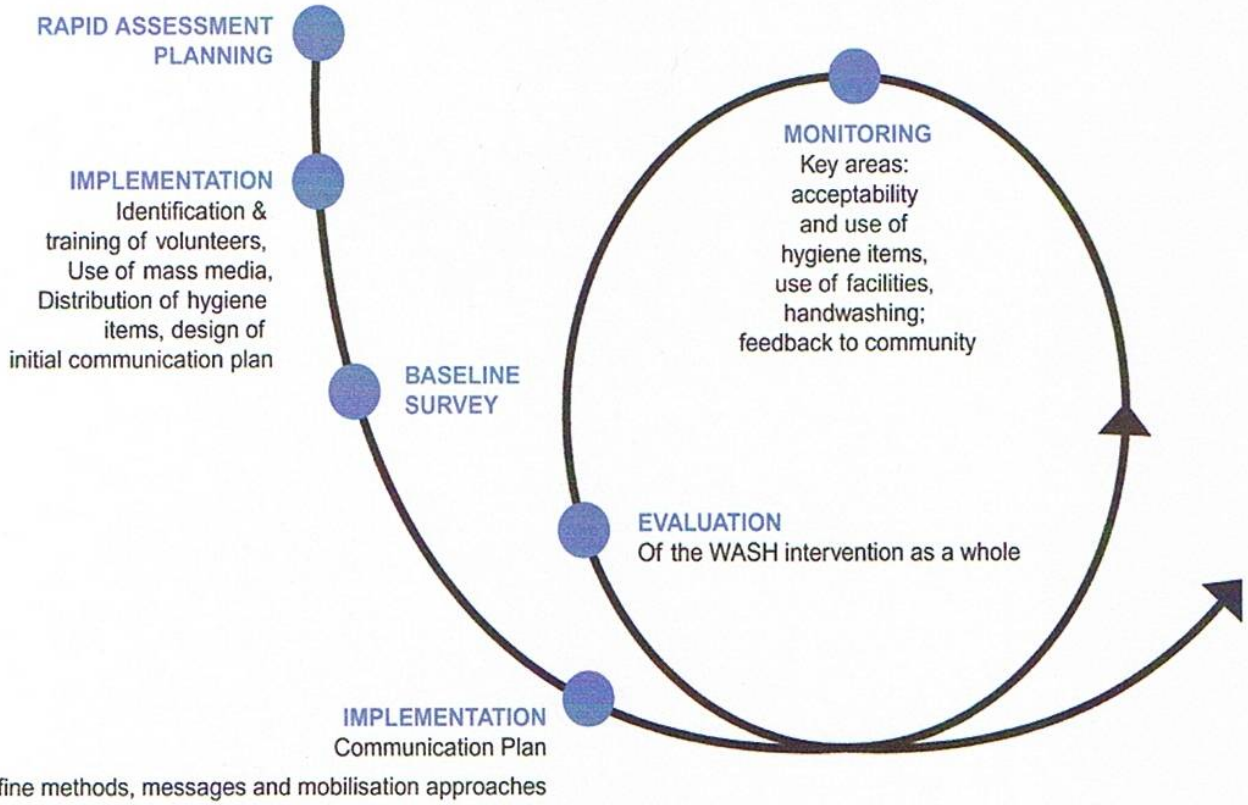
Action & Information

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

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

How do you do Hygiene Promotion in an emergency?

A simplified model of the Project Cycle



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.

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 Conduct rapid assessment to identify risk practices and get an initial idea of what the community knows, does, and understands about water, sanitation, and hygiene.	Government WASH team	Which specific practices allow diarrhoeal microbes/other diseases to be transmitted? Which practices are the most harmful?	*See Information Management Guidelines (WASH Cluster 2008)*
Step 2 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 Select practice(s) and hardware for intervention (define objectives and indicators)	All WASH team	Which risk practices are most widespread? Which will have the biggest impact on public health? Which risk practices are alterable? What can be done **to enable** change of risky practice?	*See List of Indicators*
Step 4 Define target audiences (this may be all the affected community with priority focus on those who care for young children) and stakeholders		Who employs these practices? Who influences the people who employ these practices? E.g. teachers, community leaders, Traditional Birth Attendants etc.	*See Annotated Bibliography*
Step 5 Define initial mode of intervention 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 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 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)* *See WASH HP Visual Aids Library (planned 2008)*
Step 7 Implementation Begin implementation and continue assessing situation	Logisticians Government Engineers	Distribute hygiene kits Emphasis initially on providing information and use of mass media e.g. radio spots, campaigns, and home visits by volunteers Organise group meetings/interviews and discussions with key informants and stakeholders to initiate a more interactive approach.	*See Annotated Bibliography* *See WASH HP Visual Aids Library (planned 2008)*
Step 8 Ongoing assessment Develop baseline Understand motivational factors/ refine key messages	Engineers	Obtain quantitative data where feasible. Carry out systematic collection of qualitative data using participatory methods (co-ordinate with others and be careful not to overwhelm communities with over questioning) What motivates those who currently use safe practices? What are the advantages of the safe practices?	*See Information Management Guidelines (WASH Cluster 2008)*
Step 9 Monitor	Engineers	Are hygiene kits being used/are people satisfied with them? Are toilets being used/are people satisfied with them? Do men and women feel safe when accessing facilities? Are people washing their hands? Is drinking water in the home free from contamination?	*See List of Indicators* *See Sphere (summary in WASH HP Orientation Workshop Supplementary Materials or www.sphereproject.org)*
Step 10 Implementation Refine communication plan Rapidly adapt intervention according to outcome of monitoring Continue training Continue monitoring	WASH team	Emphasis more on interactive methods e.g. group discussions using mapping, three pile sorting etc. Identify and train (with engineers) longer term structures e.g. committees	

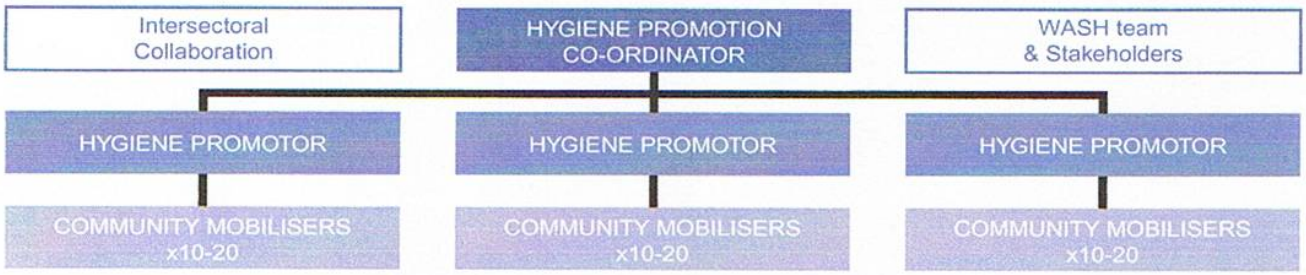
*** Adapted from Guidance Manual on Water Supply and Sanitation: LSHTM/WEDC 1998**

Hygiene Promotion approaches and methods

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

A cascade system, where outreach workers (at least 1:500 per population or **more if intensive work is required** or if populations are spread out)[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.

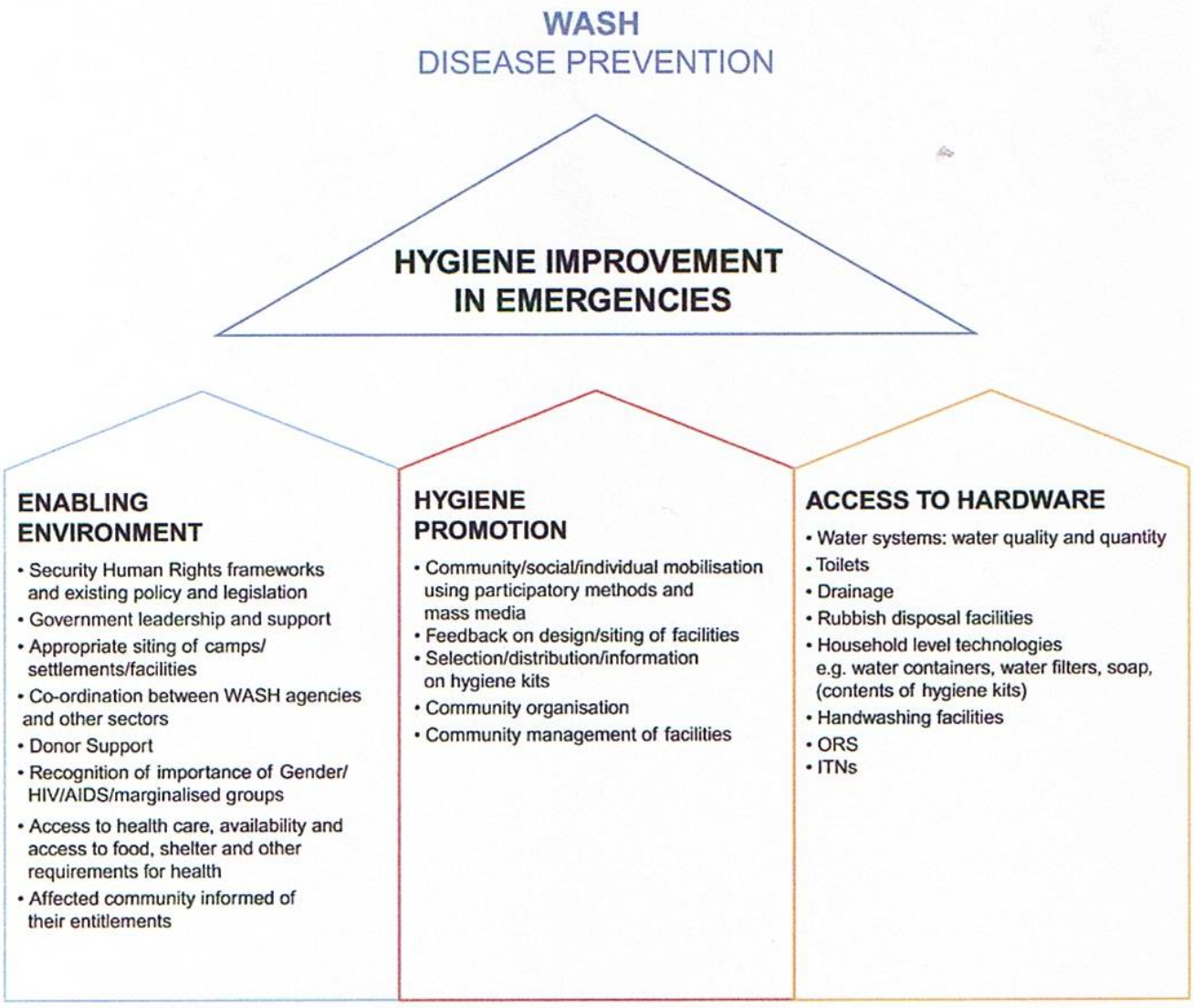
- **List of Essential Hygiene Promotion Equipment for Communication** to inform WASH coordinators and guide field implementing agencies.

- **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.



*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

(for reference)

WASH | Hygiene Promotion

Training for Hygiene Promotion

Part 1: Essential to Know

PowerPoint

Best practice materials produced through the Global WASH Cluster Hygiene Promotion project (Water, Sanitation and Hygiene), 2009 c/o UNICEF

Cluster Lead Area of Activity

Technical clusters	
Nutrition	UNICEF
Water/Sanitation	UNICEF
Health	WHO
Shelter *(conflict, IDPs)*	UNHCR
Shelter *(natural disasters)*	IFRC 'Convenor'
Cross-cutting clusters	
Camp Coordination & Mgmt *(conflict, IDPs)*	UNHCR
Camp Co-ord & Mgmt *(natural disasters)*	IOM
Protection *(conflict, IDPs and affected)*	UNHCR
Protection *(natural disasters)*	UNHCR/OHCHR/UNICEF
Early Recovery	UNDP
Common service clusters	
Logistics	WFP
Telecommunications	OCHA/UNICEF/WFP

N.B. *Four 'sectors' also agreed: Food, Education, Agriculture and Refugees*

WASH Cluster & Co-ordination

WASH Cluster Projects

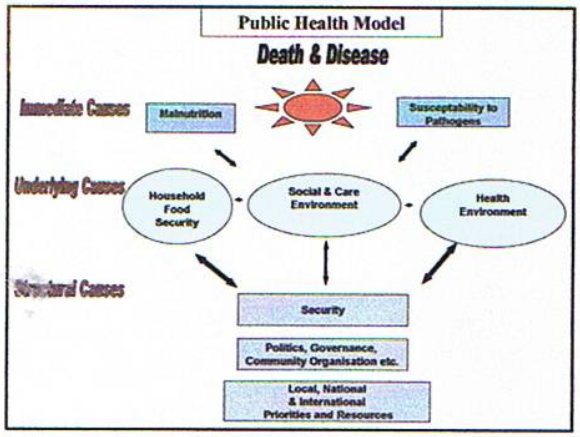
Eight projects were developed to strengthen WASH cluster capacity

- Project 1 Cluster Co-ordination
- Project 2 Information Management
- Project 3 Hygiene Promotion
- Project 4 Capacity Mapping
- Project 5 WASH Stockpile
- Project 6 Training for Capacity Building
- Project 7 Learning
- Project 8 Advocacy & Resource Mobilisation

Cluster Approach

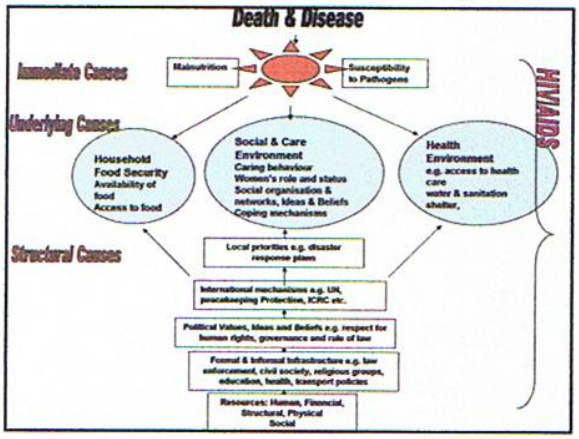
- Established as part of humanitarian reform process by IASC June 2006
- Global Aim – to strengthen system-wide preparedness & technical capacity to respond to humanitarian emergencies
- Country Level – division of roles and responsibilities, prioritisation of resources
- Improve Predictability, Accountability and Partnership

Public Health in Emergencies

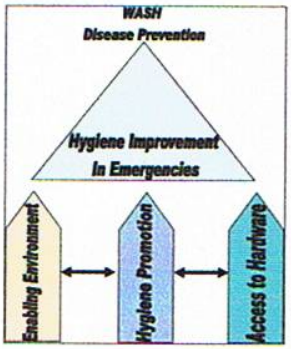


Example Aims & Objectives of WASH Programme

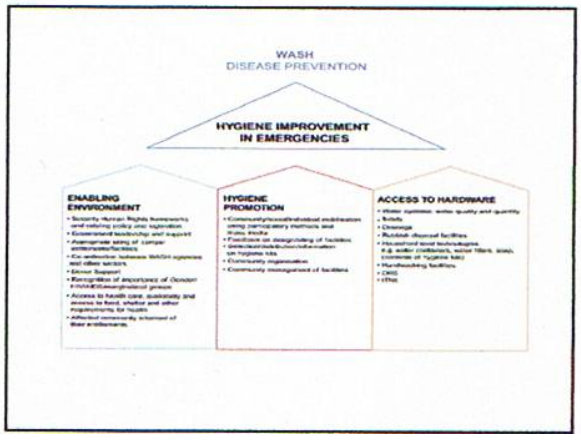
- Contribute to the recovery, protection and sustainable improvement of the health and dignity of the target community (women, men and children) over X months for X,000 people in X location
- Men, women and children in the target population (x number) have sufficient access to, and make optimal use of, sanitation and hygiene facilities, and take effective action to protect themselves against threats to public health



Hygiene Improvement Framework



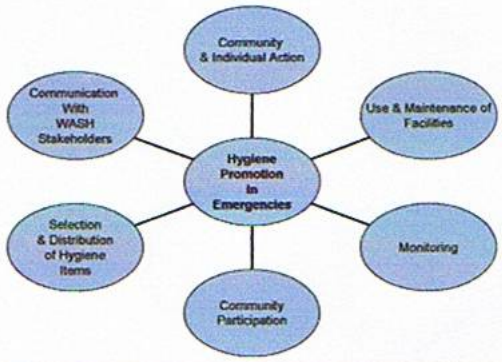
Hygiene Promotion in Emergencies



Hygiene Promotion

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

Components of Hygiene Promotion



Hygiene Promotion is not just about message dissemination and behaviour change

Why do we need Hygiene Promotion?

1.Optimal Use of Facilities

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

Effective Hygiene Promotion emphasises:

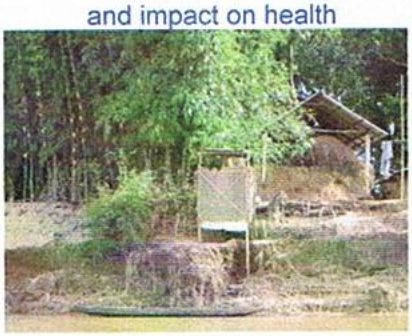
Action and Dialogue

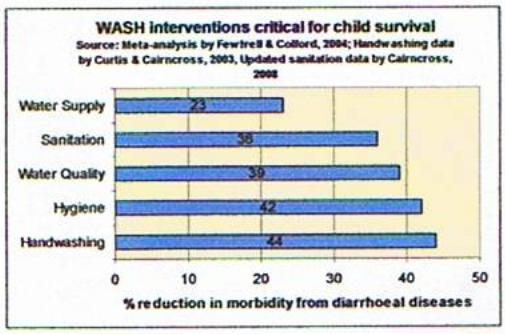
Why do we need Hygiene Promotion?

2. To Support Participation and Accountability

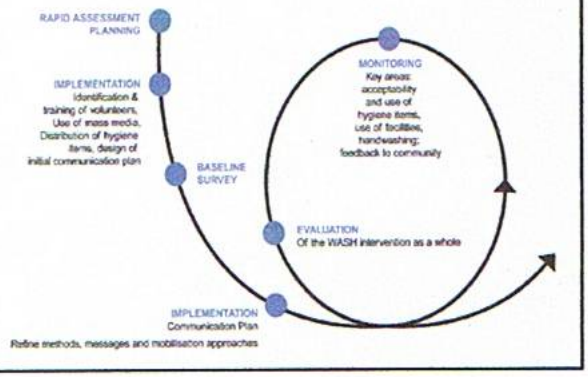
Why do we need Hygiene Promotion?

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





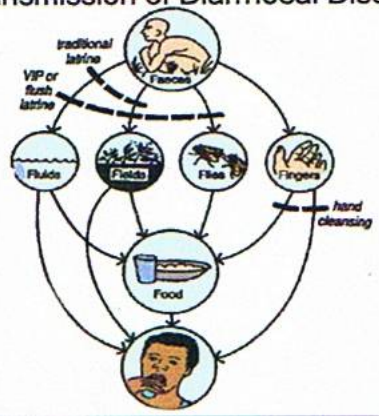
Hygiene Promotion Project Cycle



Key Actions to Prevent Diarrhoea

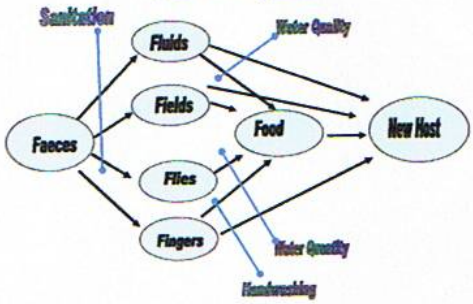
Key Water and Sanitation Priorities

Transmission of Diarrhoeal Disease



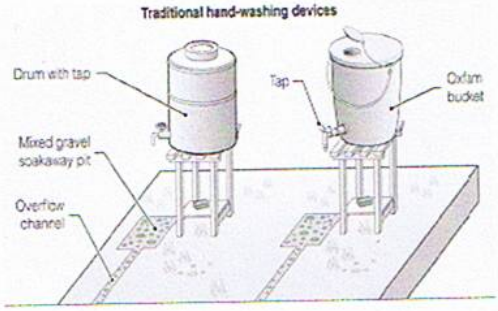
Transmission of Diarrhoeal Disease

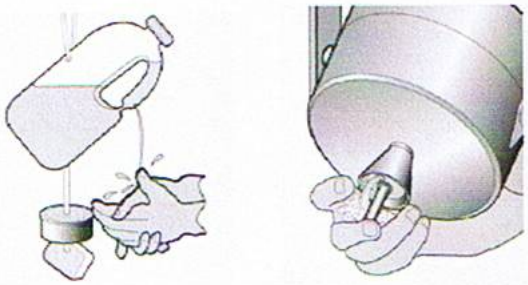
The 'F' Diagram



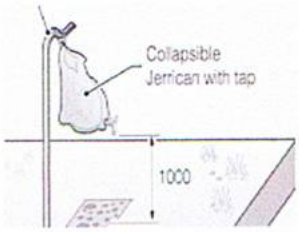
According to Curtis and Cairncross (2003), hand washing with soap and water after contact with faecal material can reduce diarrhoeal diseases by 42% or more.

Curtis, V. and Cairncross, S. (2003). Effect of washing hands with soap on diarrhoea risk in the community: a systematic review. Lancet Infectious Diseases 3: 275-281.





Participation and Accountability



Activities to promote participation & accountability

- 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
- Monitor intervention – including satisfaction and acceptability of facilities and impact on health

Hand Washing Rap:

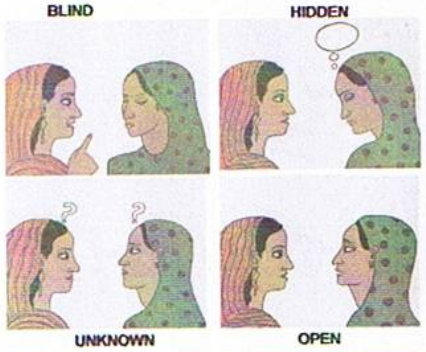
You gotta wash your hands, you gotta wash them right;
don't give in to germs without a fight.

Use water that's warm and lots of soapy bubbles;
these are your weapons for preventing germ troubles.
Don't cut short your time, your fingers get between;
it takes 20 seconds to make sure they're clean.

Gotta wash, gotta wash, gotta wash your hands.
You gotta wash, gotta wash, gotta wash your hands

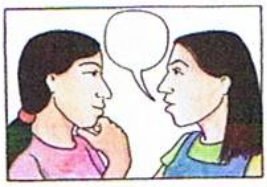
Communication

Johari's Window



Adult Learning

Ways to support communication

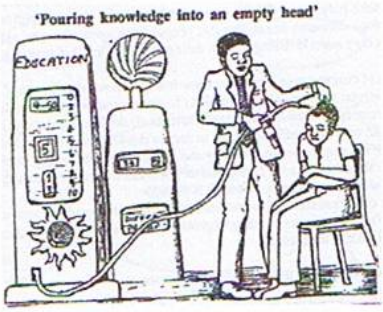


Active Listening

Using visual aids to stimulate discussion

The Traditional Approach to Learning

'Pouring knowledge into an empty head'



Observation & Listening

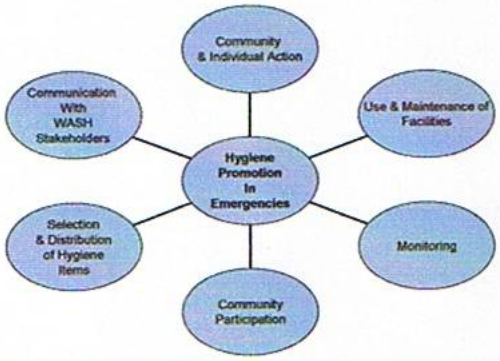
Big Ears to listen, Big Eyes to See and a Small Mouth to Speak

Maclean Sosono

Source: Hygiene Promotion a practical manual for relief and development

Job Description

Components of Hygiene Promotion



Observation & Listening

Big Ears to listen, Big Eyes to See and a Small Mouth to Speak

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Source: Hygiene Promotion a practical manual for relief and development

Introduction to Assessment

That's a good question!

- Close end questions limit the answer to yes or no
- Open end questions allow the responder total freedom in answering
- Direct questions ask for specific information; limit answers to brief fact statements
- Probing questions follow up other questions to solicit additional information
- Hypothetical questions present a theoretical situation to which receiver responds

See examples of each on the next slide...

The power of listening

The philosopher Epictetus stressed the power of listening in this quote:

"Nature gave us one tongue and two ears so we could hear twice as much as we speak."

That's a good question! - examples

Close end question
"Do you have a latrine"?

Open end question
"What made you decide to build a latrine"?

Direct question
"How many people use the latrine"?

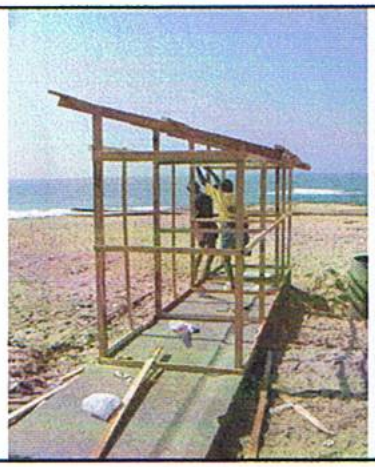
Probing question
"Can you tell me more about what made you decide to have a latrine"?

Hypothetical question
"What might encourage your neighbours to build a latrine"?

Community Involvement in Design of Facilities

Working with Children

Picture 1



Child Abuse

- According to the **World Health Organisation:**

"Child abuse" or "maltreatment" constitutes 'all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.'

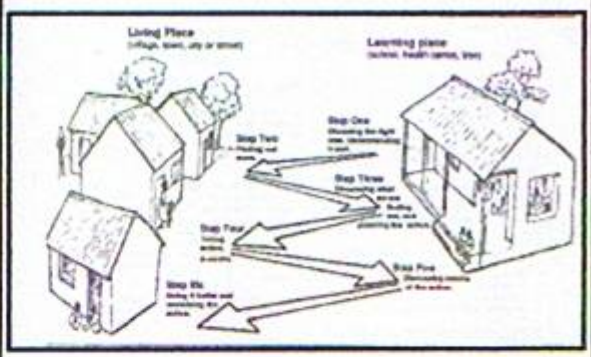
Picture 2

Child Protection

- Some countries may require police checks for people working with children
- Even where checks are not required staff should be aware of issues of child exploitation and child abuse
- Activities with children must be arranged with parent's consent
- They should be arranged in public spaces
- Parents and/or teachers could be involved in helping to supervise activity sessions
- The Ministry of Social Welfare (or equivalent) or Save the Children can usually provide more information

Child to Child

Photo: IFRC



CHAST

Children's Hygiene and Sanitation training

Five steps for changing children's hygiene behavior

STEPS	ACTIVITIES	TOOLS
1. Introduction	1. Introducing yourself 2. Stories about everyday life	1. Character poster 2. The puppet LULU 3. Drawings for coloring
2. Problem identification	1. Good and bad hygienic behavior	1. Two-pile sorting
3. Problem analysis	1. Review of hygienic behavior 2. How diseases are spread 3. How flies spread diseases	1. Memory games 2. Short story 3. The 'flies' role - play
4. Practising good behavior	1. Blocking the spread of disease 2. Review of disease blocking 3. Hand washing Tooth brushing Food handling	1. Practical hygiene demonstrations and exercises 2. Role-plays 3. Puppet shows 4. Awarding of stickers
5. Monitoring	1. Baseline survey 2. Collection of data 3. Review and adaptation of tools	1. Interviews 2. Observation of children's hyg & san practices