

The purpose of Technical Issue Papers (TIP) is to provide an easy and up-to-date point of reference on technical issues relevant for humanitarian interventions through the consolidation of field experience and current research. TIP aim at providing information to assist in funding decisions and monitoring of humanitarian projects and not at providing definitive answers. WASH TIP are developed by the Aquarius Working Group for internal use only and do not represent an official position of DG ECHO or the European Commission. This TIP was last updated on 4/11/09.

SUMMARY: The provision of basic Water, Sanitation, and Hygiene (WASH) services and commodities during humanitarian crisis is essential to reduce the risk of epidemics associated with the spread of faecal contamination and water related diseases. In particular, the promotion of adequate personal hygiene habits and environmental hygiene conditions is considered one of the three pillars of WASH interventions. The purpose of this TIP is to provide support for the appraisal and the monitoring of “Hygiene Promotion” activities implemented within the scope of humanitarian aid interventions.

MAIN RECOMMENDATIONS FOR ECHO FUNDED OPERATIONS

1. APPRAISAL:

HP interventions should be based on the following principles: 1) Assessing needs, 2) Sharing responsibility, 3) Reaching all sections of the population, 4) Targeting priority hygiene risks and behaviours, 5) Managing (WASH) facilities and 6) Acknowledging the potential for overburdening (usually of women).

The following questions are meant to help you assess the basis and viability of hygiene promotion (HP) activities, usually as a component of a WASH action proposal.

1.1 General appraisal:

- Are the main hygiene practices and environmental sanitation risks well identified? Are the practices and risks likely to cause or enhance epidemics? Which particular hygiene behaviour(s) will be encouraged?
- How will beneficiaries be involved in the design and execution of safe alternatives to their current practices and environmental risks?
- Is the action clearly focused on community mobilization?
- Are the HP strategy and communication plan clear and well focused?
- Are the proposed methodology, time frame and resources adequate?

HP interventions should be developed around these 6 basic components:



1.2 Appraisal per project component:

1.2.1 Community Participation: Have the main vulnerability group been identified / targeted? Will existing community organizations/communicators be involved? Will affected men, women, and children be consulted on the design of facilities, hygiene kits, and outreach system?

1.2.2 Use and Maintenance of facilities: Will the action enhance the user's acceptability of WASH facilities? Will it promote user's dignity and sense of ownership towards the facilities? Will it promote access of all users to the facilities? Is a system foreseen for cleaning & maintaining the facilities?

1.2.3 Selection and distribution of hygiene items: Has the availability of household water containers/soap been assessed? Has the acceptability & suitability of proposed hygiene kits items been established? Will the distribution of items coordinated with logistics (and other NFI)?

1.2.4 Community and Individual Action: Is there any existing Outreach Workers (OW) in the community? How will OW be selected? Will OW be paid or will they be asked to volunteer? Will/Can OW work full-time or do they have other responsibilities? Will OW be trained to conduct home visits? Will community dramas and/or other type of group activities with adults and children be organized? How will OW be equipped? Is this equipment suitable? Is there enough OW in relation to the number of beneficiaries? Will adequate logistic means be provided to allow the mobilization of OW? Are HP messages sufficiently attractive and dynamic? Will mass media be used for HP? Which and How?

1.2.5 Communication with WASH stakeholders: Are WASH facility operators involved? Are local institutions, women's groups, primary schools, markets involved or trained? How? What communication channels (radio, etc) and supports will be used?

1.2.6 Monitoring: Will the optimal use of hygiene (kit) items and WASH facilities be measured? Will community satisfaction of WASH facilities be measured? Will changes in risk practices be measured? How, and what is the partner's capacity to conduct proper monitoring.

2. MONITORING: The following questions can be used to facilitate a field monitoring visit of an HP intervention.

2.1. Assessing the hygiene in-situ

2.1.1 Environmental hygiene (general overview of site cleanliness)

- Solid waste: Is there a waste collection system? Is it working? Are garbage sites/pits in use? Are they well located and protected?
- Drainage of rainwater runoff: Are storm water drains available and maintained?
- Excreta: Is there evidence of open field defecation? Are sufficient latrines/defecation fields available? Are they used? By whom?
- Do the particular circumstances of the living conditions make the use of latrines mandatory and how can the beneficiaries be made using them?
- Are the facilities safe, clean, open at all time and close to household? Are the facilities properly maintained?
- Are WASH committees organised and functioning? What is their role? Are they trained? Equipped? Motivated?
- Hygiene in key sites: Inspect hygiene conditions in health structures; nutritional centres, schools, markets, etc.

2.1.2. Personal hygiene: assessment at household level (conduct two to three households with OW)

- Related diseases and diarrhoeas during the lasts months (particularly under 5)? Use of water (Quantity of water collected per day (ratio l/p/d) – identification of source)?
- Is seasonal availability of water a problem? How is water used for domestic consumption? Who normally collects water? How long does it take to fetch water?
- Inspection of containers: Capacity for transport and storage? Are the containers enough and adequate? Is water properly handled and stored? Does the partner practice water quality analysis at household level?
- Ask permission to inspect the latrine. Is there a facility for hand washing? What do they use for hand washing (soap/ashes/etc)? How is the child excreta disposed of?
- Do all household members have access to bathing facilities?
- Is soap (or ashes) and other hygiene related NFI' available in the household?
- Do household members participate to HP event/activities (cleaning campaigns, etc)? If so, which ones? What is useful? Why?
- Ask beneficiaries if hygiene conditions (in the camp/site) have changed in the past few months (relate timing to intervention)? How?

2.2. Organisation/monitoring of activities – available means and resources (meeting with HP coordinator and some OW).

- Is HP integrated with the water supply and sanitation activities? If so, how?
- What is the organizational structure of the HP action? Who is responsible? Is the personnel trained? Is the team gender balanced? Is there enough OW to mobilize the beneficiaries? Are OW motivated? Are OW sufficiently knowledgeable trained to carry out their responsibilities? How much time do OW allocate to conduct their tasks? Are OW accepted and respected by beneficiaries? Are OW well equipped? Are transport means available for OW?
- Are budgetary needs well defined and readily available?
- Monitoring: Is regular monitoring of HP done? How? What indicators are used and how are these measured?

2.3 Messages , Methodologies and material used (attend 1 or 2 HP event)

- Is the proposed HP methodology adequate and adapted to the context? Is it gender sensitive?
- Messages: Are messages focused on the main hygiene risks? Are messages few, context specific, understandable, simple and expressed in the local language? Are messages repeated and easily accessible?
- Communication plan: Are the most adequate communication channels and supports used?
- Participation: Is community mobilisation done on a voluntary basis or through incentives? Is community participation adequate? Are some (target) group less participative / accessible? Why?
- How was the event perceived by the participants?

Sample of proxy indicators for monitoring purposes.

Hygiene Behavior	Indicators
Safe drinking water	<ul style="list-style-type: none"> • X% of the population demonstrating safe water handling practices (observed at water point or households). • Number of contaminated household water sample (tested)
Safe excreta disposal	<ul style="list-style-type: none"> • X% of children's and babies' faeces safely disposed off. • % of toilets used (by the majority of men, women and children). • % of toilets properly maintained
Hygiene Practices	<ul style="list-style-type: none"> • Availability of soap or ash for hand washing in households (%). • Availability (%) of hand washing facilities in communal latrines and/ or households and in use (%).
Women's security, privacy and dignity around menstrual hygiene.	<ul style="list-style-type: none"> • Availability of adequate sanitary materials and underwear for all women and girls are available (%). • Sufficient lightening provided at night (%)
Community participation & representation.	<ul style="list-style-type: none"> • Sections of the community, including vulnerable groups, consulted and represented at all stages of the project (%). • Community members satisfied with the provision of WASH facilities (%). • Users taking responsibility for the management and maintenance of water supply and sanitation facilities (%).

OVERVIEW OF THE ISSUE

1. Basics on Hygiene Promotion:

- Hygiene Promotion (HP) is the planned, systematic attempt to enable people to take action to prevent or mitigate Water, Sanitation, and Hygiene (WASH) related diseases. It is an inherent component of WASH programming.
- HP as a stand alone action is not sufficient to achieve the desirable "hygiene improvements". **Hygiene Improvement Frameworks** in emergencies must be based on:
 - 1) *An enabling environment,*
 - 2) *Hygiene Promotion (HP) and*
 - 3) *Access to hardware (basic WASH services and commodities).*
- According to SPHERE **Hygiene Promotion (HP) Programming** should be based on:
 - 1) *Mutual sharing of information & knowledge,*
 - 2) *Mobilisation of communities and*
 - 3) *Provision & maintenance of basic (WASH) material & facilities*
- The primary focus of HP in emergencies is to strengthen the prevention of diarrhoea through: 1) Effective hand washing and personal hygiene, 2) Safe disposal of excreta; 3) Reducing the risk of contamination of household drinking water. Other focuses may be added depending on the situation.

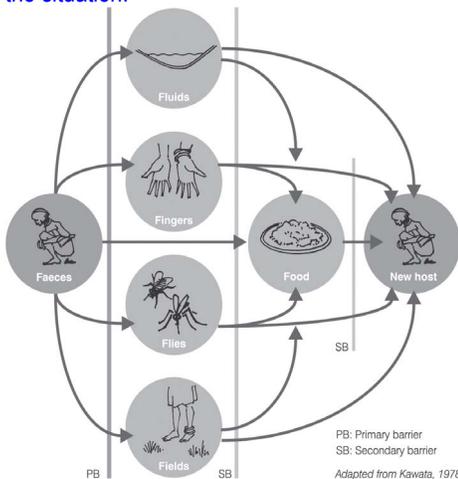


Fig.1: HP primary and secondary barriers in relation to faecal-oral transmission routes.

- HP provides a practical way to facilitate community participation and accountability in WASH projects.
- The availability of water in sufficient quantity (rather than quality) is a crucial factor to improve personal hygiene.
- HP is not to be confused with Hygiene Education (HE) which is the (culturally adapted) provision of information to encourage beneficiaries to maintain good

hygiene. HE is part of HP. It can be implemented as part of an IEC (Information, Education and Communication) initiative but usually not during the acute emergency phase.

2. Assessment phase:

A rapid assessment of the locally available resources for HP actions is crucial. Even in an acute emergency some initial discussions with individuals and community groups should take place. As the emergency evolves more widespread use of participatory methods that foster discussion should be encouraged ('community mapping' exercises, focus group discussions, etc.).

The following elements should be considered in the assessment:

- Identify main risk practices
- Identify target audience & groups at higher risk
- Identify key people & responsible(s) of community mobilization
- Identify the most commonly used communication channels
- Assess availability of hygiene facilities and items

Different investigative techniques can be used to assess hygiene conditions and risk-prone habits. The choice depends on the available capacities and time constraints.

Examples of some techniques: Health walk; structured observations, key informant interviews, KAP survey, focus group discussions, three pile sorting, history line, community mapping, seasonal calendar, gender roles, water quality analysis in all the water use chain, etc.

2.1 Assessing Hygiene Education needs:

- Hygiene habits depends on the beliefs and taboos of the people, their knowledge and perception of the risks, the existing behaviours and the availability and access to related facilities and essential items.
- Knowing does not mean doing: People are not empty vessels into which new ideas can simply be poured. However, changes in practices or behaviour can happen quickly if they are properly enabled (e.g. if hand washing facilities are provided simultaneously to hand washing education).
- 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 be stronger driving forces than health arguments.

- KAP (knowledge-Attitudes-Practice) surveys: Generally the main objectives of these surveys is to a) identify priority actions that meet the environmental, social, sanitary, economic and political context, respect local culture and traditions, and respond to the needs expressed by the population and b) provide a reference document for actors working in the area to help them justify, define, implement and/or consolidate programmes in the area of HP. These tools can be useful, but only once the emergency has stabilized.

2.2 Assessing Hygiene Items needs:

An assessment of hygiene items requirements of women, men, and children should be included in the initial rapid assessment. The contents of hygiene "kit" will depend on specific circumstances. In general it will include:

a) Personal Hygiene items: The 3 most important items are soap (for laundry and personal hygiene), water collection and storage containers and bleach. Depending on the context other items may be considered. These include washable/disposable sanitary towels for women, underwear for women/men/children, 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, etc.

b) Communal Hygiene items: Tools and equipment for digging, maintaining and/or cleaning latrines, drainage channels, etc. (e.g. shovels, picks, wheelbarrows, buckets, boots etc.)

3. Design phase:

HP interventions should be devised considering the intensity and scale of the emergency and what is feasible in terms of population customs, culture, level of education, resources and timing (because of the short duration of DG ECHO funded operations).

The emphasis should be on mobilising beneficiaries to take action. In practice, the early stages of the emergency may be characterised by limiting oneself to provide key messages to the affected population, but as soon as possible a more interactive approach should be used.

This means that the HP mechanics is normally more “intensive” and “prescriptive” (using more hygiene promoters, etc) during emergencies than during protracted crisis.

The objective during emergencies is to discourage risky habits, without necessarily aiming to permanently change these habits. People will adopt less risky habits because there is external pressure to do so, but some of the induced changes may not be irreversible. It's important to keep this in mind and avoid focusing on longer term HP goals, unless the situation allows for it (such as in protracted crisis).

Common pitfalls should be avoided. These include: not basing efforts on what people know, do and want; believing that health education does not have to be tailored to the audience; assuming that people can learn “germ theory” in a few health centre sessions; not considering other incentives for good hygiene behaviour; not targeting just a few key feasible hygiene behaviour changes; turning off potential audiences with talk of “dirt, death and diarrhoea”; not offering positive, attractive solutions, not setting realistic and measurable behaviour change objectives, and not facilitating behaviour change to occur.

HP project design should at least include:

- Selection of targeting practices: from the identification of major risks
- Selection of target audience: targeting the groups at higher risk and separated by gender
- Design of messages: selection of few concrete messages, use of local languages, easy to understand,
- Define community mobilisation - actions
- Define communication channels (Door to door, Group discussions, Mass media, etc.)
- Define the communication supports: pictures, panels, theatre, storyboard, contests, songs, videos, etc.
- Define the type activities: attractive and dynamics, participative, promoting discussion, repetition of messages, showing by examples, etc.

In addition one should consider that:

- Although participatory methods that focus on interaction with the affected community are often more successful in achieving changes in practices, there is a trade off between “reach” and “effectiveness” which depends on the type and phase of the emergency.

- HP interventions should make use of available mass media (e.g. radio or leaflets) and other interactive methods.
- HP interventions should always be gender balanced and sensitive. Although women's role in promoting hygiene should be recognized (particularly with small children), it should not over lead to the over-burdening of women with related duties. In that respect the need out to reach out to men is critical.
- Children under five years of age are most at risk from communicable diseases since their immune systems have not developed fully. Malnutrition resulting from food insecurity and chronic emergencies increases this risk further. Since young children are unaware of the health risks associated with contact with faeces, it is essential that faeces are safely contained. Severely malnourished children and adults are at increased risk from diarrhoeal disease, as are elderly people, especially if exhausted after travelling considerable distances.

Choosing the right methodology for HP interventions:

Most existing methodologies come from the development context and may not be directly applied to emergencies. Nevertheless some of these methodologies have been successfully adapted. Amongst these we find:

- *PHAST* (Participatory Hygiene and Sanitation Transformation) which is a 7 steps evidence base method. PHAST may be difficult to apply because of the amount of preparation work required. However, some of its tools (three-pile sorting, mapping) may be still used particularly in post-emergency scenarios. A child-friendly version of PHAST promoted by Caritas is called CHAST
- *FAST PHAST*: In some emergencies, IFRC, OXFAM and UNICEF have been known to promote a shorter version called Fast PHAST. However FAST PHAST may still be problematic during the early stages of an acute emergency (and may only work where extension workers have already been trained).
- *Social Marketing*: Not possible in a rapid onset emergency. However in some protracted crisis where cyclical emergencies occur (e.g. cholera outbreak), it has been used to good effect with the necessary formative research.
- *Child to child overview* (based on continual interaction between school and the community): not suitable during

emergencies, but may be used in chronic humanitarian crisis contexts.

- Some methodologies do not focus exclusively on HP but integrate aspects of water supply, excreta disposal and HP. One such methodology is “*Community Lead Total Sanitation*” (CLTS) which encourages rural households to use their initiatives to build basic sanitary toilets, while allocating funds on important software activities. Although CLTS is not applicable in emergencies, it may be used in during disaster preparedness or post-emergency phases.

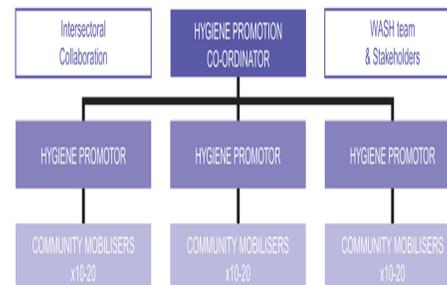
4. Implementation Phase:

HP in emergencies requires ready staff, tools, materials and methodologies. Standard materials should take into account different context and should be easy to adapt. In those contexts it is important to consider what has been done in the past in order to avoid duplication of work.

Staffing structure for HP interventions:

Hygiene Promotion activities require dedicated and specialised staff. In emergencies, the most commonly used “staffing structure” of HP projects to access the population is of a cascade system, where Community Outreach Workers (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 a HP Coordinator. In order to be efficient, Hygiene Promoters should be well integrated and accepted by the beneficiaries.

Fig. 2 Generic organizational structure of HP interventions



Other systems are possible and may include networks of *peer educators* (e.g. teenagers or young mothers), *hygiene clubs*, etc. However in some contexts (e.g. non-displaced population), it may be more efficient and appropriate to use existing community structures (*WASH/Health Committees*, etc.) instead of creating parallel ones.

The issue of payment of Community OW is complex and needs to be dealt with coherently (usually through a coordination mechanism such as the WASH cluster). However, it is generally accepted that payment to OW during rapid onset emergencies is not only legitimate but also preferable to quickly tackle hygiene related risks (on the ground that it is difficult to expect this work to be carried out properly on a voluntary basis).

Coordination amongst water, sanitation and HP staff is crucial to tackle 'hardware' and 'software' requirements of WASH projects in an integrated manner. All personnel (engineers, technicians, hygiene promoters, etc.) need to work together to achieve maximum impact on public health. Joint work planning, field visits, and training as well as shared monitoring and reporting mechanisms is highly recommended.

Mass distribution of hygiene items:

- HP coordinators/WASH programme managers should coordinate the distribution of hygiene items with NFI/shelter cluster leads (and other agencies involved in NFI distribution).
- Expertise in setting up distribution mechanisms is required for effective distribution to large populations and may be best managed by logistics teams.
- A phased approach to distribution is recommended. Only items that are not culturally sensitive, such as soap (for laundry and personal hygiene) and water containers should be stockpiled for mass distribution in the first few days of an emergency. For other more culturally sensitive items (e.g. sanitary pads, etc) pre-assessment is critical.
- It is beneficial to procure some items locally, where possible, to ensure that they are acceptable. 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.

- It is important to consider quality as well as cost – the cheapest items do not always last very long.
- In some cases, it may be possible to organise the provision of cash or vouchers to enable people to make their own decisions about the purchase of hygiene items (but only after a proper assessment is done and in full compliance with DG ECHO cash & vouchers guidelines).
- Some items (e.g. soap) will need repeated distributions to replenish supplies.
- In areas of high literacy it may be possible to provide a written leaflet to 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.

Equipment & materials for the HP team:

Typically the following equipment and material will be required: Megaphones, 'Hygiene Promoter' printed T-shirts/hats/caps, Banners, Flip charts with illustrations of generic hygiene practices, Training & Visual Aids Kit, Office tent/equipments including a computer, laminator, guidelines, promotion materials for training and distribution in target communities, equipment for HP communication (Video/DVD player, musical instruments, digital projector, Portable screen, camcorder, cassette recorder for recording HP songs, Hand-held digital recorder or digital voice recorder (to download to computer), Generator, electrical equipment, etc.

5. Monitoring and evaluation phases:

Regular monitoring of HP intervention allows projects to be modified and improved over its lifetime. It can also be used to measure progress against the baseline data (if

available), as well as faults in project design and unrealistic objectives.

HP indicators should be simple, few in number and suitable for use at community level where possible. They should measure behaviour changes, participation of communities and whether all those affected are adequately represented (e.g. women, etc.). A balance should be achieved in the process of collecting data for monitoring, as too much data may be difficult to collect and in emergencies.

Monitoring should focus on the collection, analysis and use of data on:

- Appropriate use of hygiene items,
- Safe hygiene practices / habits,
- Optimal use of WASH facilities,
- Community satisfaction with WASH facilities.

Whilst the ultimate aim of HP 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. For this reason indirect or 'proxy' indicators (indirect or substitute) are considered an acceptable alternative to monitor project impact (e.g. hand washing with soap). In that respect the reduction of mortality or even morbidity rates should not be used as project indicators.

HP projects can be evaluated using structured observation to determine how much behaviour change has occurred in target practices. KAP (Knowledge, Attitude and Practice) surveys can be used as baseline and as evaluation tools but it is important to follow some indicators as well during the monitoring process. KAP surveys are mainly based on questionnaires which include direct interviews, however direct observation and quantitative indicators should also be included.

References

- ✚ *Best practice materials produced through the WASH Cluster Hygiene Promotion Project 2007, amended 2008c/-UNICEF*
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