Hygiene promotion in emergencies

Asia Pacific Surge Training: Emergency WASH

Learning objectives

- What is hygiene promotion
- Why do we do hygiene promotion in emergencies
- How do we do hygiene promotion in emergencies

Your experience in hygiene promotion

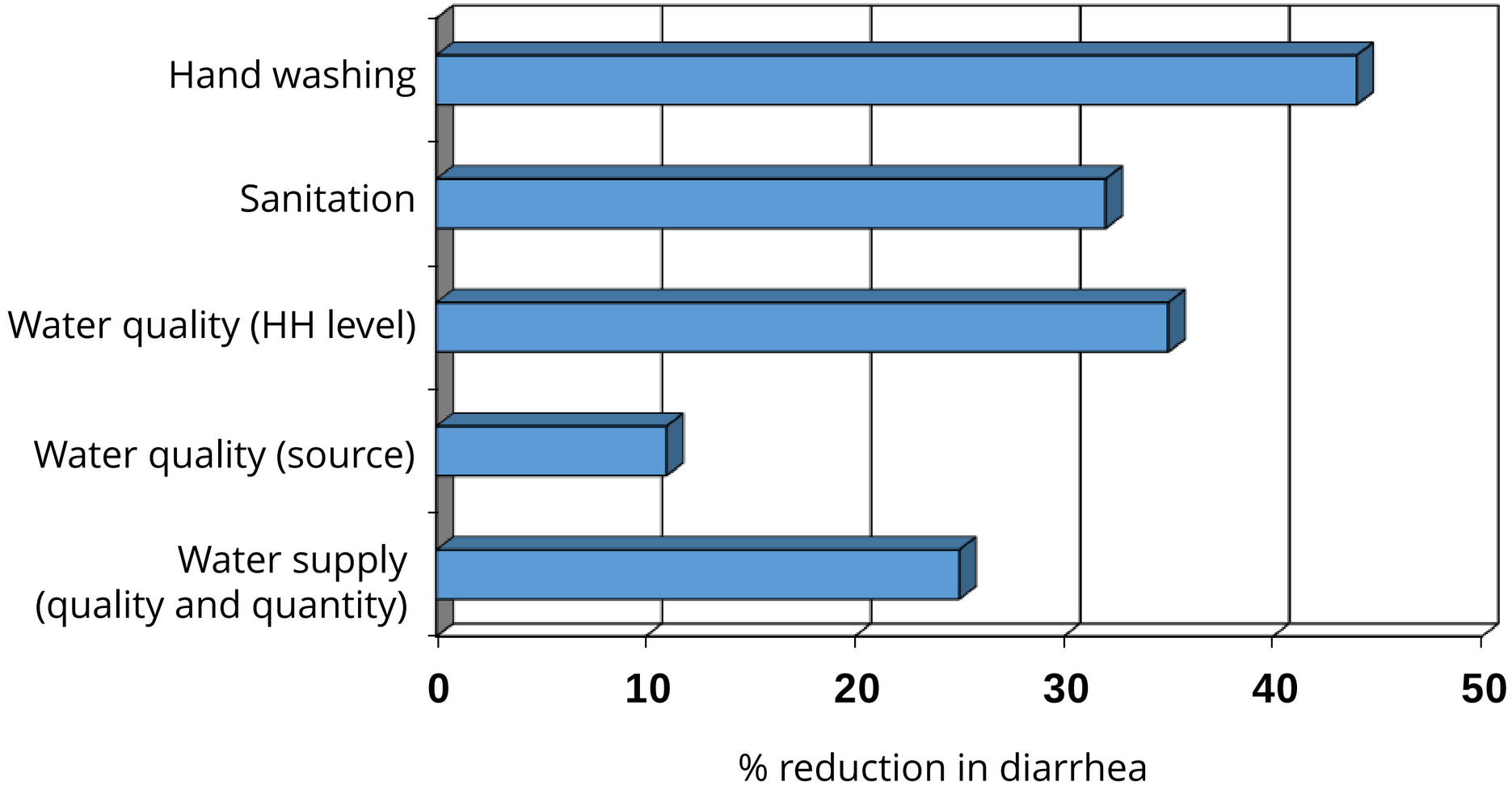
Which is the most important?

Water

Sanitation

Hygiene promotion

Water, sanitation and hygiene interventions to reduce diarrhea in less developed countries: A systematic review and meta-analysis (Fewtrell et al., 2005)



Hygiene promotion priorities

Risky behaviours → HP → Good hygiene behaviours

Unsafe excreta disposal	**Safe excreta disposal**
Not washing hands with soap	**Effective hand washing with soap**
Unsafe handling of water	**Reducing contamination of household drinking water**

Why do we do hygiene promotion?

- **Optimal use of hardware facilities**
  - Ensure facilities are used in the intended way
  - Discussions with users can improve design of facilities
  - Systems need to be set up to ensure maintenance of facilities

- **Enable participation and accountability**
  - Inculcate a sense of ownership
  - As a way to gain beneficiary feedback and to gauge satisfaction

Why do we do hygiene promotion?

- **Linkage with health condition/status**
  - Close linkage between health status/condition with HP activities for e.g. link between the practice of hand washing with soap with incidence of diarrheal cases → 50% reduction

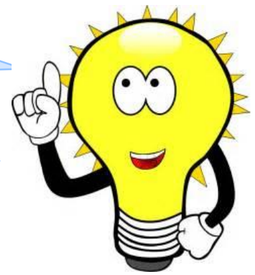
- **Facilitate behavioural change**
  - Gradual process of working closely with communities
  - Building on local knowledge
  - Studying and promoting existing beliefs/traditional practices
  - Designing appropriate communication tools
  - Defining motivation strategies and encouraging practical steps towards positive practices

Behavioural change in emergencies

Can behaviour change happen quickly?

Yes it can!
(when people are enabled to change)

Be realistic of what you can change – focus on key risky behaviours
KEEP IT SIMPLE AND ACTIONABLE!



Often driven by fear of diseases – may be a strong motivator initially but people often go back to old habits and behaviours

Common pitfalls in hygiene promotion

Too much focus on…	Not enough focus on…
• 1-way messages without listening to different groups in the population • Designing promotional materials (e.g., posters, leaflets) before understanding the problems properly • Personal hygiene	• Practical actions that people can take and how to communicate • How to address many behaviours and audiences at the same time • Listening and having discussions or dialogues for people to clarify issues and specific needs • Appropriate communication methods or tools • Operation and maintenance of facilities • Understanding and building on existing local knowledge, beliefs or traditional practices

8 Steps of Hygiene Promotion in Emergencies

A brief look at the 8 steps

Step 1: Identifying the problem

Step 2: Identifying target groups

Step 3: Analysing barriers and motivators for behaviour change

Step 4: Formulating hygiene behaviour change objectives

Step 5: Planning

Step 6: Implementation

Step 7: Monitoring and evaluation

Step 8: Review, re-adjust

IFRC WASH guidelines for hygiene promotion in emergency operations

Step 1: Identifying the problem

- The aim of assessment is to understand the situation in order to identify:
  - Problems
  - Source of the problems
  - Consequences of the problems
  - Needs and capacities of the affected population

- An assessment should consider:
  - Critical information that is needed
  - Sources of this information
  - Data collection methods

While good information does not guarantee a good programme, poor information almost certainly guarantee a bad one

- An initial rapid assessment is essential to identify key risky behaviour and messages to address those behaviours

Step 1: Identifying the problem – a quick discussion

What information is needed, after a disaster?

What are the different methods for collecting information: Who? Where?

What are some of the main challenges of doing an assessment?

What info is needed?

- **Quantitative and qualitative information**:
  - What the community knows, does and understands
  - What are their needs, risks and practices
  - What is the impact of the disaster on hygiene practices and behaviour

- **Rapid assessment should provide information about:**
  - Demographics
  - Priority/vulnerable groups
  - Accessibility and logistics
  - Public health situation
  - Existing WASH facilities/resources
  - Existing WASH behaviour
  - Menstrual hygiene practices
  - Community structure
  - Influential figures
  - Social structures, norms, religious beliefs
  - Family dynamics
  - Key active WASH and Health actors
  - Literacy level
  - Communication channels
  - Market function
  - National Society capacity
  - **...**

What are some of the methods?

- Other active local and INGOs, WASH Cluster, local government authorities such as MoH/DM, online resources and from the media

- Use/involve different groups of the affected populations, respected elders, local leaders, health clinics at the district, Red Cross Branch/District staff and volunteers

- Participatory methods/tools:
  - Mapping and transect walks
  - Focus group discussions
  - Key informant interviews
  - Community tools such as three-pile sorting and pocket chart voting
  - Observations

What are some of the challenges?

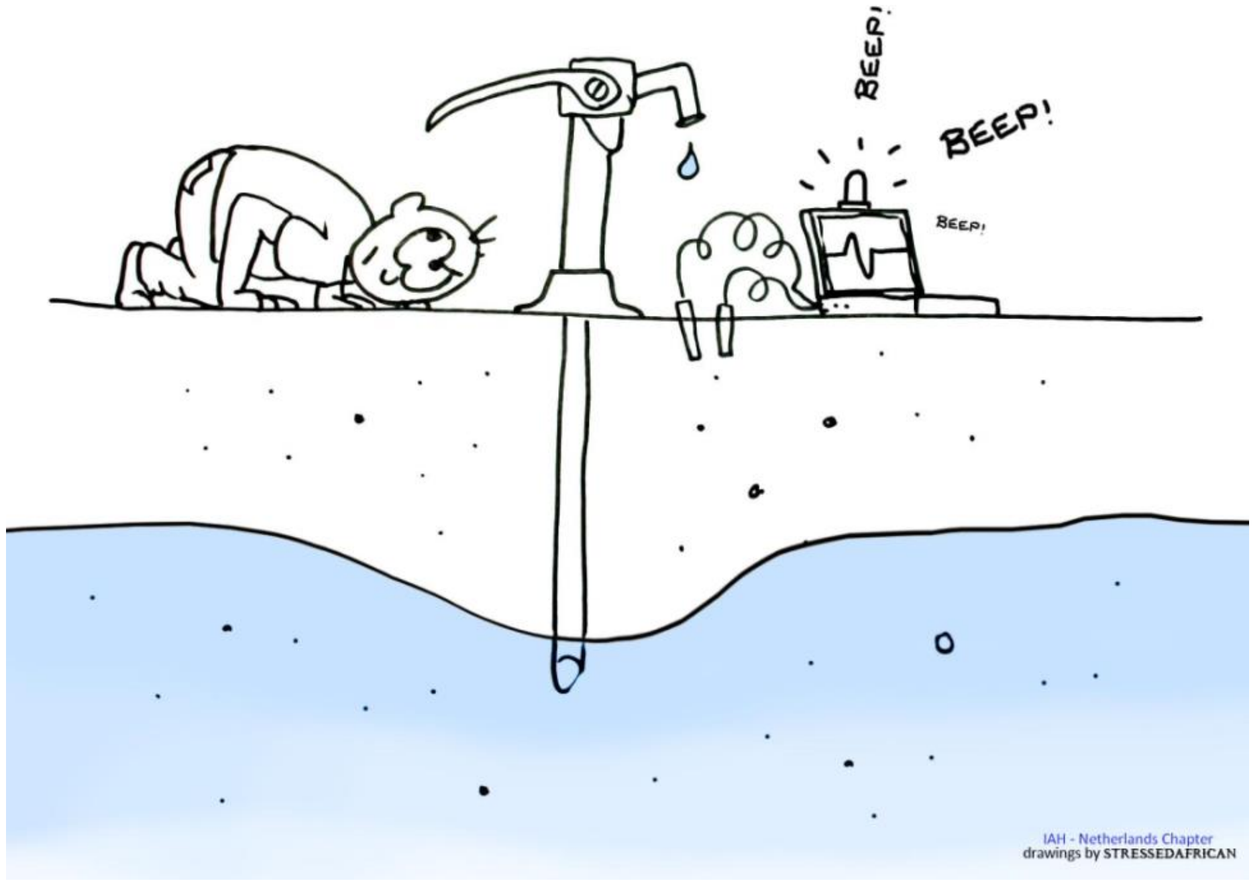
- Language
- Cultural/behaviour
- Religion/religious beliefs
- Assessment fatigue
- Lack of coordination with NGOs/other actors
- Internal coordination within the RCRC Movement
- Unclear community structure
- Power dynamics in a household or community
- Unidentified stakeholders and beneficiaries
- Accessibility constraint
- Outdated data
- Overload of information
- High level of stress
- Understaffing
- Lack of volunteers
- Time constraint
- Conflict between (sub)-groups

Step 2: Identifying the target groups

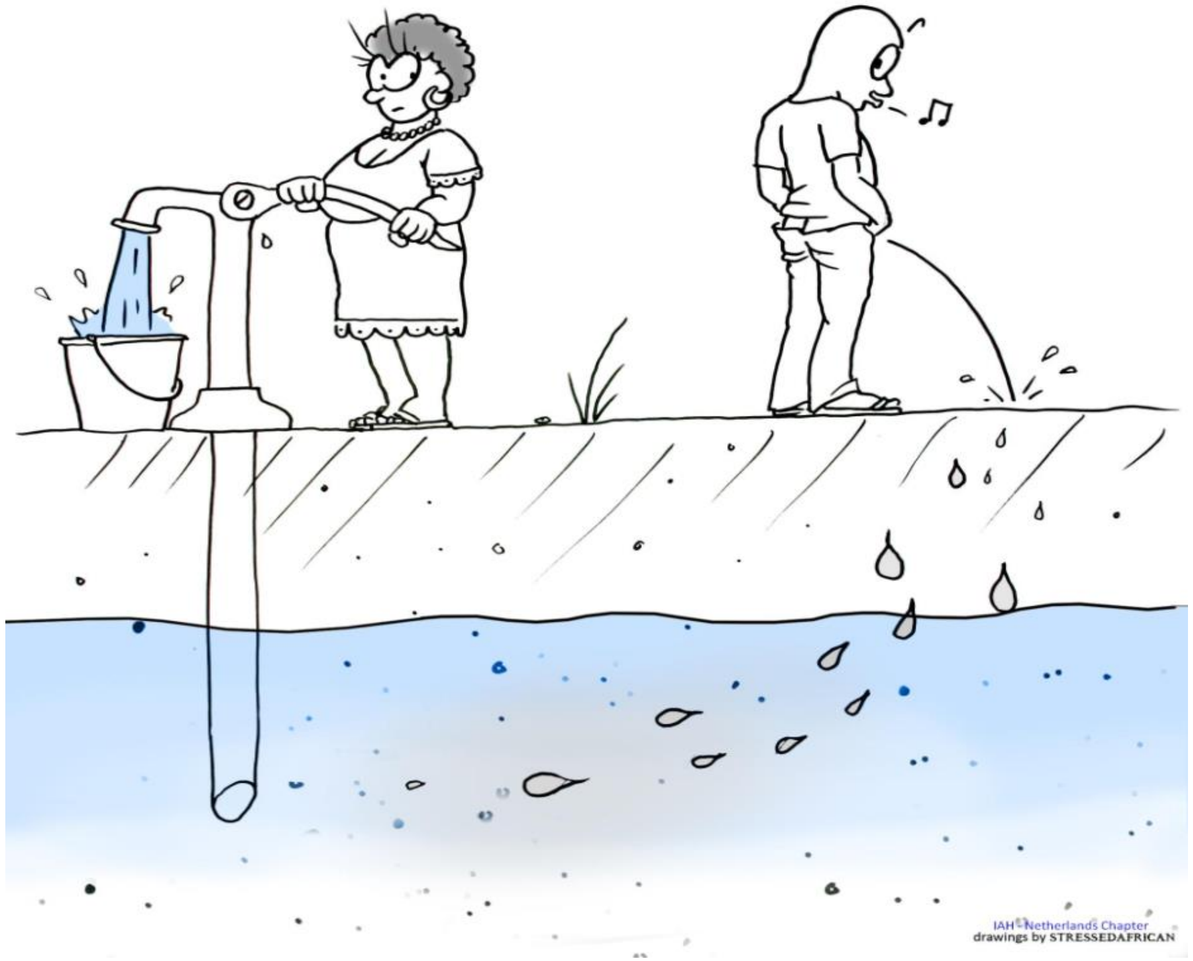
- Important considerations:

- Identify those who are most at risk/different sections of the affected community
- Find out how the target groups communicate pre- and post-disaster, to determine the most appropriate communication channel.
- If working in a camp setting, may be appropriate to consider surrounding host population
- Identify who are the influencers
- Special emphasis on needs of babies and young children
- Menstrual hygiene management needs
- Hardware and software to link together; work with the engineers

Hardware



Software



Identifying the target groups: Exercise

A mother with her children

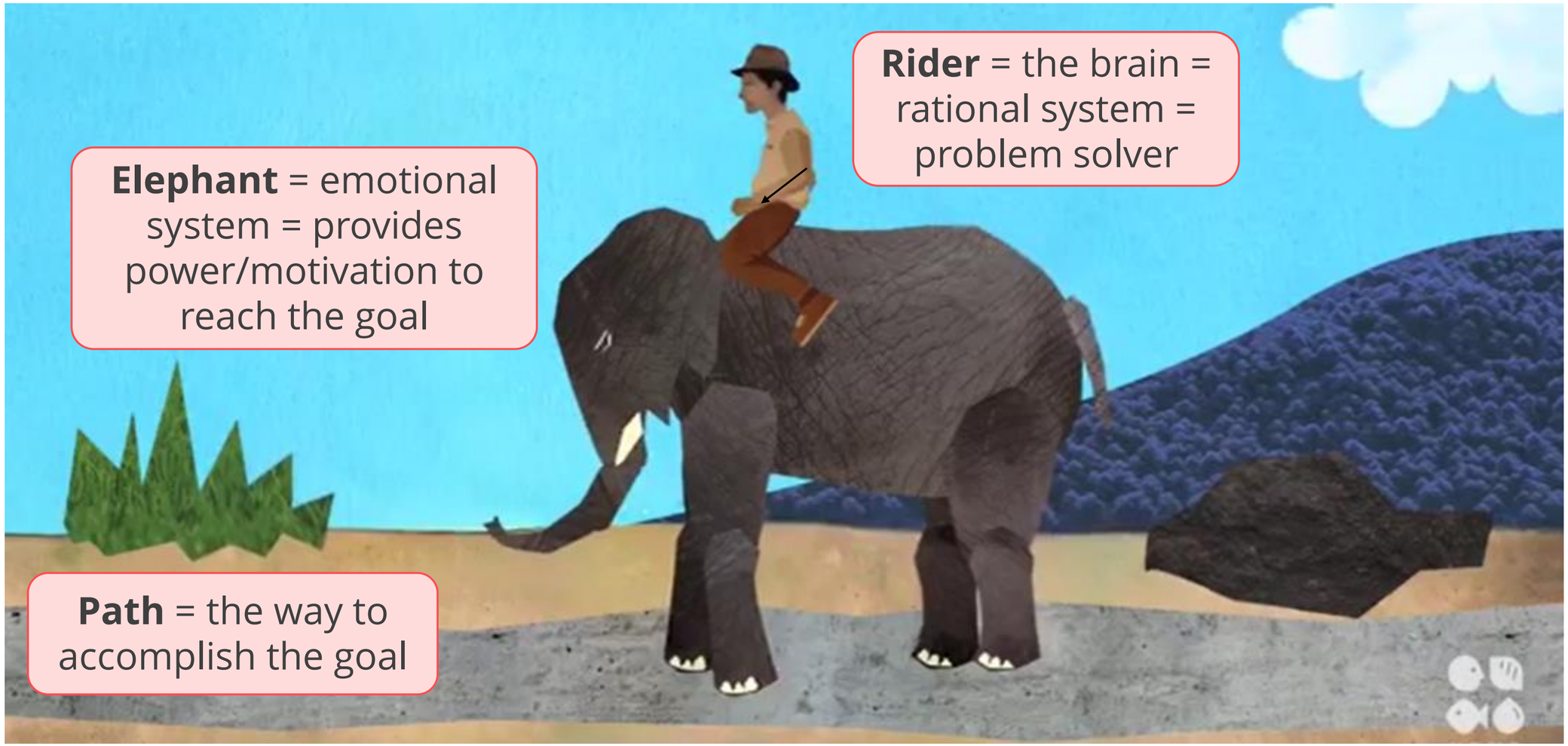
Person with disability

What are your vulnerabilities and concerns, after a disaster?

How do you think you can participate in a WASH programme and how would you like to receive information about it?

- Pair up with the person next to you - think in the position of the person above and discuss
- Each pair take 15 min to discuss. One example of each “target group” to present.
- The rest to listen and provide comment/feedback.

The rider, the elephant and the path



https://www.youtube.com/watch?v=X9KP8uiGZTs

Step 3: Analysing barriers and motivators

Motivators	Barriers
Anything that would motivate people to practice correct hygiene behaviours 1. Fear 2. Disgust 3. Status 4. Affiliation 5. Attraction 6. Nurture 7. Comfort	Anything that would hamper people from practicing correct hygiene behaviours 1. Socio-cultural 2. Physical 3. Biological

Analysing barriers and motivators: Exercise

Many of us in this village, especially women like me, don't really wash our hands with soap. We only come to know some information about this when the RC volunteer visited us after the recent floods we had. Even though we now know why we need to wash our hands, it's hard to practice that because we don't have enough water, especially when all of our water sources are dirty. Soap is also expensive for us. It is better if we use the money to buy food instead.

A few mothers told me that if I wash my hands with soap, bad luck with come to my unborn child. What should I do? We just want to do what is best for our children – we want to be good mothers and be accepted in our community. I don't really agree with this belief, and we need more knowledge about hygiene so that we as mothers, understand what we should do in order to take better care of our family.

Analysing barriers and motivators:

Behaviour	Barriers	Approaches to reduce barriers	Motivators	Approaches to increase motivators
Do not use soap for washing hands				

Analysing barriers and motivators: Exercise

- Target group → pregnant women

Behaviour	Barriers	Approaches to reduce barriers	Motivators	Approaches to increase motivators
Do not use soap for washing hands	**Socio-cultural barrier:** Belief that soap brings back luck and is harmful to the unborn child	Explain about misconceptions about using soap with help from community leaders/health workers	**Nurturing**: Desire to protect children	Emphasis that women are perceived as 'good mothers' washing their hands with soap
	Physical barrier: No access to soap	Distribute soap	**Affiliation**: Desire to fit in with others and be perceived as a good mother	Promote the idea that everyone is doing it

Step 4: Formulating hygiene behaviour change objectives

- Formulating hygiene behaviour objectives means setting up specific directions for HP activities to focus on the most important things to enable people to change behaviour

- The objectives can be related to hygiene behaviour e.g., increasing handwashing practice at key times or an enabling factor e.g., availability of handwashing facilities with soap (therefore engineers need to be part of the process)

- Link your objectives with the outputs and activities given in the EPoA template:
  - WASH Output 1.4: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population
  - WASH Output 1.5: Hygiene-related goods (NFIs) which meet Sphere standards and training on how to use those goods is provided to the target population

Step 5: Planning

- **Plan of action**
  - Make a plan of action to achieve your hygiene behaviour change objectives identified in Step 4, taking into consideration what you know from Steps 1 to 3.
  - Refer to the EPoA template and incorporate outputs, activities and indictors which are relevant.

- **Baseline survey**
  - A baseline survey needs to be done to establish the current situation and to enable the programme impacts to be measured.
  - The survey will be developed based on indicators agreed by the programme team. It should collect information disaggregated by sex, age and disability.
  - The questionnaire should include those changes that you are hoping to achieve e.g., water storage, use of latrines, etc., and avoid closed ended questions.
  - Questionnaire should be 10 to 15 questions, and can be done manually or using mobile survey questionnaire.

Step 5: Planning

- **Recruitment of HP team**
  - A HP team may consist of a HP coordinator, hygiene promoters, community mobilizers/outreach workers and community level volunteers
  - The number of team members depends on context, usually it is between 7 to 10 people.

- **Designing the HP methods, tools and materials**
  - Analysis of barriers and motivators from Step 3 will inform your selection of promotional approaches/methods and development of messages and supporting IEC materials
  - Approach should focus on 'enabling the community'
  - Separate consultations with women and other vulnerable groups might be needed as they might not be willing to share in larger groups
  - Communication channels used should be tailored to the target group and participatory, and should be organized at appropriate locations

When sharing information with the affected community: DON'T DISSEMINATE – COMMUNICATE!

Step 5: Planning

- **Messages** should be:
  - Simple, tailored, feasible, participatory, accurate and consistent, and contain a mix of information and emotional motivators.
  - Emphasizing on benefits of practicing a certain behaviour e.g., better health, convenience, comforts, privacy, etc.

- **Pilot and pre-test the materials and methods**
- Once methodologies to be used are agreed, important to pilot and pre-test with small groups from each target group to check for clarity and understanding
- Lookout for any misunderstandings or unintended impacts, whether people were able to remember the information and whether any wordings or pictures used were offensive or have misled them

Step 6: Implementation

- Implementation needs to start quickly in an emergency response

- Hygiene promoters may cover key elements in Steps 1 to 5 and move to implementation - however, plans need to be re-visited and implementation, re-adjusted

- **Pre-test materials and methods** to ensure they are realistic and appropriate

- **Recruitment, training and management of HP team**
  - With pressure of responding quickly, it is not realistic to have a long training programme, instead start with 1 day training covering essential points and build on skills with additional trainings
  - Practice daily or weekly debriefing of volunteers
  - Every team member should be aware of the objectives of HP i.e., know how to implement selected methodologies, key messages to be communicated and how to do so, and engaging with the affected communities

Step 6: Implementation

- **Choose appropriate setting and timing**
  - Consider most appropriate way, time and place to reach different groups, where they are able to participate in the activity and feel comfortable enough
  - Think of other demands on the time and when people are likely to be most receptive
  - In conjunction with distribution of hygiene items, carry out HP activities

- **Working together with engineers and other specialists**
  - Hygiene promoters are part of a wider WASH team, and therefore we should all work together and not overlap with one another (or create a gap)
  - The construction and promotional activities need to be connected e.g., there is no point constructing a latrine that is technically sound but in the views of the population inappropriate for their use
  - Hygiene promoters are responsible for translating people's preferences, desires and aspirations related to design and siting of WASH facilities
  - HP team works with engineers to ensure there is acceptability, accessibility, security and inclusion

Step 7: Monitoring and evaluation

- **Monitoring:**
  - To demonstrate progress – whether the objectives are being achieved and feedback is heard and acted upon
  - Involve the affected population in monitoring – not only in collecting information but also analysis

- **Methods for monitoring:**
  - Transect walks, observations, talking to affected communities
  - Focus group discussions
  - Pocket chart voting
  - Community meetings

- Should not only focus on **quantitative indicators** (e.g. number of latrines) but also **qualitative indicators** (e.g. feedback and satisfaction level)

Step 7: Monitoring and evaluation

Indicator	Means of verification	Frequency
Users take responsibility for the management and maintenance of sanitation facilities	Observing communal latrines	Daily or every 2 days
Women are enabled to deal with menstrual hygiene issues in privacy and with dignity	FGD	Monthly
Environment free from all faecal matter	Transect walk	Daily or every 2 days
% of the targeted population wash their hands with soap after using the latrine	Observing hand washing points near latrines	Weekly
Water is stored safely in the home (i.e. appear to be clean and in a covered container)	Spot-check of households	Weekly

Step 7: Monitoring and evaluation

- **Evaluation:**
  - Focus on learning i.e. documenting lessons learnt, and on accountability i.e. reporting to others what has been achieved
  - Logical framework forms the basis of the evaluation, considering the inputs, activities, outputs, outcomes and the impact

- **Different types depending on context:**
  - Internal vs. external
  - Real time evaluation
  - Mid term/final evaluation

- **Key criteria generally used for evaluation of humanitarian action:**
  - Relevance/appropriateness
  - Efficiency
  - Effectiveness
  - Impact

- As described in Step 5, a baseline survey should be conducted at the beginning of the programme, and using the same methodology and questions, an end line survey should be done

Step 8: Review, re-adjust

- The process is iterative, as with every project cycle
- Ensure HP programme is still relevant to the identified needs, especially so during emergency operations where situation changes
- Continuous assessment, re-planning and re-adjust!
- You are a WASH RDRT at the end of your 1-month deployment, where you have worked closely with the host NS:
  - What did you do as part of your handover?
  - Who did you handover to?
  - How are you going to decide whether to continue the response or end it?
  - What would you do internally, after returning to your NS?

Key messages

- **Don’t assume** – talk to and listen to the affected people. There are many steps before you can begin to plan for hygiene promotion interventions.
- **Software and hardware activities** need to go hand-in-hand, and with **other related sectors** for e.g. Health and Logistics
- As the HP team, we also need to provide inputs to the overall emergency WASH programme or emergency operations **to avoid gaps/overlapping** with the other active sectors
- We need HP to help **change risky habits**, to ensure WASH facilities are utilised, and promote participation and accountability.
- HP messaging needs to be **simple, targeted and calls people to action**

- Utilize existing resources – IEC materials, community participatory tools, standard list of indicators and objectives, assessment questionnaires, surveys, etc. – don’t reinvent the wheel, instead adapt and contextualize from existing resources

Thank you! Questions?