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The UN Refugee Agency

UNHCR Hygiene Promotion Guidelines 2017

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Table of Contents

List of Acronyms Used 4

1: Introduction 6

Who is this manual for? 6
How it was developed and evidence base 6
How to use the guidelines 6
Public Health and Health Promotion 7
Common Pitfalls in Hygiene Promotion 7
Principles and Components of Hygiene Promotion 8
Overall Cross Cutting Principles of Hygiene Promotion for all Phases of the Response 11
Integrated WASH 16
What's in a message? 19

2: HP in different Phases & Contexts 21

Emergency Phase and Outbreak Response (0 – 6 months) 21
Transition Phase (6 months up to 2 years) 36
Post emergency and protracted (2 years to 26 years +) 46
Relevant Standards 56

3: Human Resources 57

Introduction 57
Selection of Community Mobilisers 57
Motivation 58
Staffing Levels 58
Importance of Co-ordination 59
Job/task descriptions 59
Training and support 61

4: HP Approaches and Methods 62

Introduction 62
Key Hygiene Promotion Approaches 62
Recent Innovations in Theory and Practice 63

Example Tools for Hygiene Promotion....68
Working with Children....71
Working with Women and Girls....74
Hygiene Promotion Troubleshooting....75

5: Behaviour change models, theories and frameworks....76
Introduction....76
Key Concepts....77
How does change happen?....78
Key Behaviour Change Models....79

6: Appendix....81
Example Formative Assessment Questions....81
Hygiene Promotion Review Checklist....83
Matrix of Hygiene Promotion Methods and Approaches....86
Example Communication Analysis in Emergency Response....87
Example Community Mobiliser Monitoring Form....89
Example Hygiene Promotion Strategy....90
Example weekly work plan for hygiene promotion officer....91
Individual Level Behaviour Change Models....92
Interpersonal Level Behaviour Change Models....95
Community Level Behaviour Change Models....96
WASH Models and Frameworks....97
References....103
Websites....106

List of Acronymes Used

BCC	Behaviour change communication
BCD	Behaviour Centred Design
CATS	Community approaches to total sanitation
CBO	Community based organization
CBW	Community Based Workforce
CHAST	Children's hygiene and sanitation for transformation
CHW	Community health worker
CLTS	Community led total sanitation
COMBI	Communication for Behavioural Impact
DFID	Department for International Development
EAST	Easy, Attractive, Social, Timely
FGD	Focus Group Discussion
FRC	Free Residual Chlorine
HH	Household
HP	Hygiene Promotion
HWTSS	Household water treatment and safe storage
IBM	Integrated behaviour model
IDP	Internally displaced person
IEC	Information, education and communication
IP	Implementing Partner
KAP	Knowledge, Attitudes and Practice
MHM	Menstrual Hygiene Management
MI	Motivational Interviewing
MPG	Multi Purpose Grants
NFI	Non food item

NGO	Non-governmental organization
OARS	Open ended questions, Affirmations, Reflective Listening, Summaries
ORS	Oral Rehydration Solution
PHAST	Participatory hygiene and sanitation for transformation
PDM	Post Distribution Monitoring
PoC	Persons of concern
PRA/PLA	Participatory Rural Assessment/Participatory Learning and Action
RANAS	Risks Attitudes Norms Abilities Self Regulation
RBA	Rights-based approach
SIDA	Small Immediate Doable Actions
SLTS	School led Total Sanitation
TBA	Traditional birth attendant
TL	Team Leader
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and hygiene
WHO	World health organization

Introduction

Who is this manual for?

These guidelines were developed for use by all UNHCR staff and implementing partners (IP) working at field level with persons of concern to UNHCR.

They are particularly aimed at those working in the WASH sector and those who need more detailed information on hygiene promotion than is currently given in the HP Chapter of the UNHCR WASH Manual.

The guidelines may also be of use to those working in Community Services, Health, Nutrition and Education who are incorporating some elements of water, sanitation and hygiene into their programmes.

How it was developed and evidence base

Hygiene promotion is an area of intervention that is developing all the time and much of the evidence for practice has previously been underpinned by the available research into health promotion.

The amount of research examining WASH and hygiene promotion specifically has increased in the last ten years and this has also been used to inform the manual where possible. However, research in emergency contexts and urban areas still remains very limited and numerous methodological issues have been encountered when attempting to conduct systematic reviews in both emergency and longer-term contexts. Relevant research findings are summarized in text boxes within the guidelines. References to relevant, recent systematic reviews are included in the appendices.

The guidelines also reflect work undertaken by the WASH Cluster Hygiene Promotion Working Group, field visits to UNHCR supported programmes undertaken in 2010, and recent published work undertaken by a variety of WASH agencies.

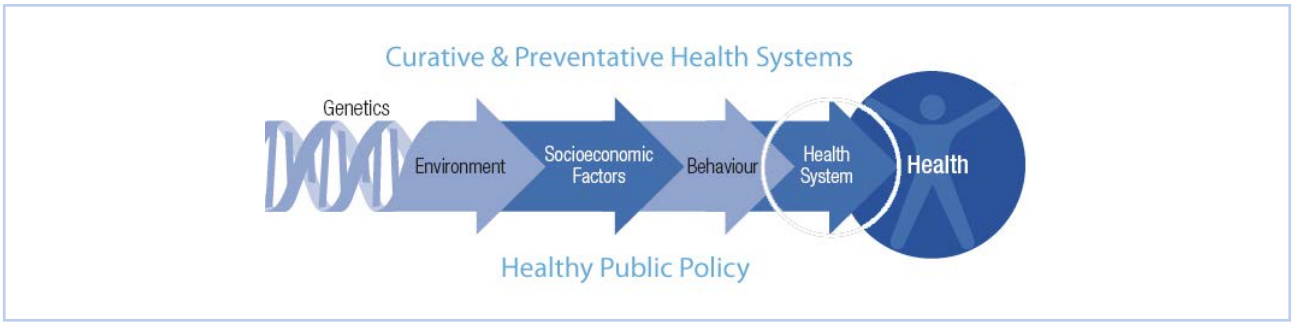
How to use the guidelines

The guidelines provide additional support and information on designing and implementing hygiene promotion programmes or elements of hygiene promotion in the programmes of other sectors. It should be used in conjunction with the UNHCR WASH Manual and the summary guidance in the Hygiene Promotion Chapter of this manual.

Public Health and Health Promotion

Ensuring the health of the public is a complex and multifaceted task as shown in the diagram below.

Figure 1: Influences on health[1]



An understanding of all of the factors shown in the diagram is important in helping to understand how the health of individuals, communities and societies can be influenced. A public health approach examines the health of populations rather than individuals and attempts to prioritise the key interventions that will promote the health of the greatest number of people.

What is the difference between Education and Promotion?

Health or Hygiene Education focus on increasing knowledge and skills whereas 'Promotion' addresses not only knowledge and skills but also considers all of the other determinants of health and hygiene such as socio-economic and environmental barriers and enablers.

Hygiene and health promotion are key aspects of public health and at the heart of the concept of 'promotion' is an emphasis on healthy public policy – ensuring that people have the means to be healthy rather than only focusing on an individual's behaviour. This requires the engagement of not just the health sector but also ALL other policy sectors and therefore advocacy with other stakeholders is a key element of both health and hygiene promotion. Ensuring access to water, sanitation and hygiene facilities is as much a part of hygiene promotion as influencing attitudes and mind-sets and is a vital element in influencing health and hygiene practices.

Common Pitfalls in Hygiene Promotion

Several reports, reviews and guidelines have observed a variety of pitfalls in hygiene promotion:[2]

- Too much focus on disseminating one-way messages without listening to the perspective of different groups in the population
- Too much focus on designing promotional materials such as posters and leaflets before understanding the problem properly
- Too much focus on personal hygiene and not enough on the use, operation and maintenance of facilities

1 Adapted from World Economic Forum (no date) From funding to action: strengthening health care systems in Africa: white paper for consultation. World Economic Forum; Geneva.

2 Adapted from: SNV (2016) WHO (2012) UNHCR (2010)

- Not enough focus on practical actions that people can take and how to communicate these
- Trying to address too many behaviours and audiences at the same time
- Not enough use of motivations such as nurture, disgust and affiliation and the mistaken belief that people will always be motivated by the promise of better health in the future
- Not enough emphasis on listening, discussion and dialogue so that people can clarify issues and work out how to adapt required changes to their specific situation

Principles and Components of Hygiene Promotion

Hygiene Promotion can be defined as 'the planned, systematic approach to enable people to take action to ensure that water, sanitation and hygiene facilities and services have an impact on health'. It can be seen as a subset of *Health Promotion*.

It can also provide a practical way to facilitate participation, accountability and monitoring because it emphasizes the importance of listening to affected communities and the use of dialogue and discussion rather than simply relying on the development of materials and the dissemination of one-way messages.

The diagram below illustrates some key components of hygiene promotion.

Hygiene Promotion is NOT:

Hygiene Promotion should NOT be reduced to encouraging personal hygiene and handwashing only as it's main aim is to ensure the effective and sustained use of WASH facilities and to promote community capacity and action in order to improve public health.

Figure 2: Components of Hygiene Promotion

Below are some examples of what actions might be included under these different components:

Table 1: Activities relating to Key Components of Hygiene Promotion

1. Understanding, assessment & monitoring Asking questions, monitoring and obtaining feedback from affected communities. Undertaking in depth formative research and using this to shape and adapt the programme	**2. Design, use & maintenance of facilities** Ensuring that facilities are acceptable to different users, well maintained and used sustainably. Encouraging ownership, responsibility, self reliance and sustainability
3. Communication for action Listening, advocating, mobilizing and motivating using a variety of methods that stimulate, inspire the action of individuals, households, leaders and different community groups.	**4. Access to hygiene items** Distribution of hygiene items or cash alternatives to ensure that people are enabled to maintain their hygiene and dignity. Involving women and men in the selection process and obtaining feedback on use and satisfaction.
5. Participation & accountability Understanding the needs of different groups and allowing them to make decisions about the WASH intervention. Providing clear information on who you are, what you can offer and the resources available.	**6. Co-ordination & collaboration** Collaborating with UNHCR health and nutrition partners, other WASH partners and the government to prevent duplication and ensure the most cost effective use of resources.
7. Advocacy Influencing decision makers within the government and other agencies to recognise the different WASH needs of the population and to ensure greater accountability to them e.g. incorporating MHM into all WASH responses	**8. Research** Recognising the need for an improved evidence base in hygiene promotion to support future decision-making about what works and what doesn't. Adhering to research guidelines so that results are comparable.
	

Photos: WASH Visual Aids Library

These components cover the emergency, transition and prolonged phases of engagement but the emphasis and modus operandi will be different in different phases. For example in the prolonged phase the mass distribution of hygiene items will not be appropriate unless there is a sudden outbreak of diarrhoeal diseases but there may be a need to promote the use of e.g. potties for young children.

Overall Cross Cutting Principles of Hygiene Promotion for all Phases of the Response

Coordination and collaboration

Hygiene Promotion is an essential part of a WASH response and as such should be integrated into the overall WASH strategy ensuring that where possible refugees are involved in making decisions about the design and siting of facilities, so that they are used in the most effective way possible.

Coordination between different WASH stakeholders is vital to minimize duplication and to maximize resources and an HP working group should meet regularly to share information and develop a hygiene promotion strategy.

Coordination is also important between the different sectors and departments working to improve the public health of refugees. Health, nutrition, community services, shelter and education all have a role to play in promoting refugee health and hygiene but there will need to be agreement about who does what and how to minimize duplication and overlap – especially with regard to the community-based workforce. Joint training can help to ensure improved collaboration. It will meet the needs of the refugees better if all members of the community-based workforce are able to provide some basic information on how to access other services.

Integration with the hardware provision

WASH actors must ensure that hygiene promotion and the provision of' the 'hardware' complement each other and that the WASH response is not just driven by the provision of facilities without involvement of the users.

The affected population must have access to sufficient numbers of latrines, handwashing stations, water collection points, laundry points, bathing cubicles and clothes drying facilities but at the same time all of this WASH hardware must be culturally acceptable, comfortable, clean, functional, convenient and accessible to all users including for example pregnant women, children and people with limited mobility.

Mechanisms must also be in place to ensure that facilities are kept in good working order, are regularly maintained and do not deter use because they are dirty, do not work or lack privacy. (See page 14 on integrated WASH for more information).

Hygiene promotion as a means to ensure participation, ownership and responsibility for WASH facilities

Those involved in the refugee response should clearly understand that refugees are not just passive recipients of humanitarian aid but that they have rights, responsibilities and capacities and can be active participants in ensuring a more dignified sanitary environment.

UNHCR and WASH actors should aim to:

1. Support the refugee community to take action to address WASH related problems
2. Involve refugees in making decisions about the design of facilities and how services are provided.

Hygiene promoters (and especially the community based workforce) are the primary point of contact with the refugee community and not only can they help promote the effective use and maintenance of facilities but they can seek feedback on the WASH programme and on ways to make it more effective. They can also pass on concerns to other sectors and convey important information about services and entitlements to refugees.

UNHCR's WASH Protection Principles

All hygiene promotion programmes should also be designed and carried out in full accordance with UNHCR's WASH protection principles including:

- **Principle 1: Consultation, Participation and Accountability**
- **Principle 2: Equitable Access to WASH**
- **Principle 3: Protection, Privacy, and Safety**
- **Principle 4: Menstrual Hygiene Management**
- **Principle 5: Cross-Sector Collaboration**

See **Chapter 1** of the **UNHCR WASH Manual** and the **WASH Protection and Accountability Paper** on http://wash.unhcr.org/ for more information.

WASH Accountability

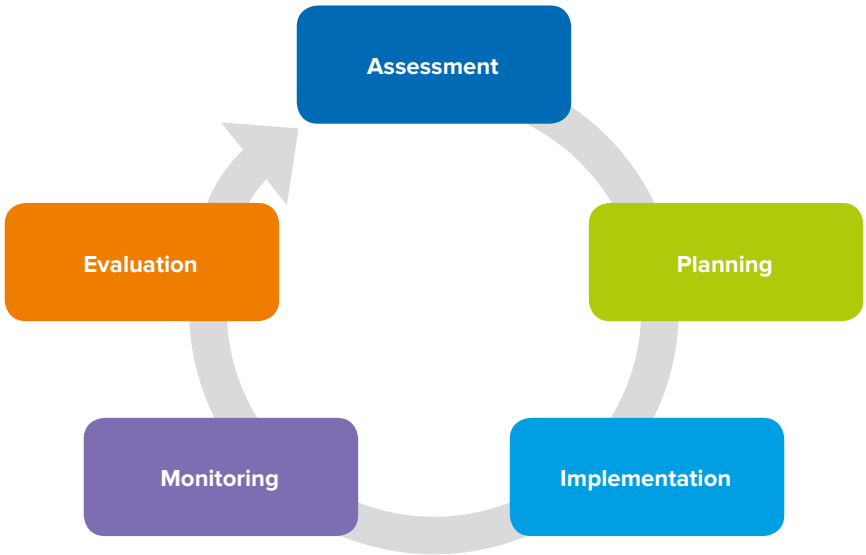
Accountability to communities is sometimes considered to have five dimensions: Participation, Transparency, Feedback and Complaints, Monitoring and Evaluation and Staff Competencies and Attitudes.

Transparency is about sharing information with communities. Ask yourself 'who makes the decisions about this intervention?' 'What say do refugees get in this?' There may be ways to share planning information such as community budgets or involve people in decisions about new infrastructure. Accountability is also about putting yourself in the shoes of affected populations and asking: 'what would I want to happen?' 'How would I want people to communicate with and support me?' Developing an open and trusting relationship with community members is at the heart of accountability.

The Hygiene Promotion Project Cycle

As with any intervention the project cycle provides a useful model for all phases of the response. However in an acute situation some stages may have to be carried out in parallel, in order to respond quickly to people's immediate needs. It is important that in each stage there is a re-appraisal of the intervention and how it is going – even if a formal evaluation is not carried out.

Figure 3: Hygiene Promotion Project Cycle



A Communication Plan

In all phases of the response it is also important to define what you are hoping to achieve and how you will go about communicating with community members. Ideally this planning exercise should be undertaken with the whole hygiene promotion team - so that the specific changes that are being sought are clear to all implementers. This should be part of the planning stage of the project cycle.

A communication plan should provide an outline of the following:

1. **Problem to be addressed**
2. **Behavioural Objectives (the practical changes that are required)**
1. **Audience(s) (primary and secondary)**
2. **Channels of communication**
3. **Key concepts and ideas to convey (communication objectives)**
4. **Communication methods and approaches that will be used**
5. **The resources required**
6. **How they will be used (by whom and for how long)**
7. **How you will monitor and evaluate the intervention**

Analysing the communication networks used by different participant groups will help in the process of compiling a communication matrix or table that forms part of a more detailed communication plan. See page 90 for an example of a communication analysis.

It is preferable to use a phased approach to the implementation of the communication plan so that a few key issues are targeted initially and then others are introduced over time – so as not to overload people with too much information.

Accountability

Participation is at the heart of ensuring greater accountability to affected populations. Understanding community dynamics will help to identify power relations and ensure that those who might be most vulnerable are identified and supported by UNHCR and its implementing partners.

Participation is about giving affected populations greater control over the way a response is carried out. In order to be able to do this people need to have access to information on what resources are available and the objectives of organisations.

The **UNHCR guide to 'A Community Based Approach'** gives many ideas on how to enable greater participation in programmes. Staff attitudes and body language are all important when trying to gain people's trust and working in an open and respectful way with people will ensure that hygiene communication interventions build people's confidence and self-esteem rather than undermine them - as has often been the case with didactic approaches to health and hygiene education.

An example community leaflet to help promote greater transparency and accountability in the WASH sector is shown below.[3]

More information on accountability for the WASH sector can also be found in the WASH Accountability Resources Pack developed by the WASH Cluster, available from: https://www.humanitarianresponse.info/system/files/documents/files/wash-accountability-handbook.pdf

3 Source: WASH Cluster Accountability Project www.humanitarianreform.org

Which method do I use?

INFORM	MOTIVATE	MOBILISE	ADVOCATE
Radio Television Films Leaflets Posters Text messages Internet Home visiting Community meeting **Use especially early in first phase emergency**	Use interactive mass media. Participatory group training Structured home visiting E.g. Child to child, Peer groups, home visitors **Set up interactive networks as soon as possible**	Use interactive approaches that encourage community or groups to critically examine their situation & take action E.g., Discussion groups & community meetings, Triggering tools (from CLTS) or interactive tools from PHAST **Concentrate on action**	Target decision makers & influential people or groups E.g. government officials, community leaders, politicians, donors, religious leaders, celebrities **Look at the big picture**

Remember there is NO magic bullet
but DIALOGUE and community involvement are key

Use a variety of methods and approaches for different participant groups

Integrated WASH

A WASH engineer is also a hygiene promoter in the sense that their goal is to enable and promote better health and hygiene.

In order to ensure that WASH facilities are used for their intended purpose, by all sections of the community - and maintained for use as long as possible, it will be necessary to consult with the community via the hygiene promotion team before designing any structures or systems.

This process of consultation can also help to ensure that not only are facilities appropriate, accessible and safe but also that users develop a greater sense of ownership and responsibility for their maintenance and upkeep.

Design of water, sanitation and hygiene facilities for:

- Young children
- Older men and women
- Pregnant women
- Men and women with disabilities
- Women and adolescent girls

Design of toilets - Consider:

- How can different groups be involved in planning and design?
- Can the community be involved in construction?
- How will they be used effectively?
- How will they be maintained?
- How will you ensure menstrual hygiene management?
- How will you enable handwashing?

Design of water supply - Consider:

- What do men and women expect – what are they used to –what is possible in the circumstances?
- How can they be involved in the planning and design?
- Are changes in water use required?
- Is household treatment of water required?
- What information do people need?
- How will the system be operated and maintained?
- How will information on the plans and progress of work be communicated?
- Can the community be involved in construction?
- Can they be involved in water testing?

Design of drainage - Consider:

- What is expected of the community?
- Can they be involved in construction?
- What information do they need?
- How will systems be maintained?

Tips for the practical integration of software and hardware implementation

- **Ensure that engineers and hygiene promoters carry out initial assessments together and train integrated teams to share the initial assessment workload.**
- **Arrange exchange visits between engineers and hygiene promoters so that they learn about each other's work.**
- **Invite engineers to community meetings so that they can understand the community perspective and help the hygiene promotion team to answer questions about any technical water and sanitation issues.**
- **Involve male and female community members when designing new facilities and invite them to provide feedback on proposed plans**
- **Use prototype latrine designs to initiate discussions with male and female community members about the kind of facilities that will be required; engineers and hygiene promoters should both be involved in these discussions.**
- **Involve women and men in the siting of water and sanitation facilities**
- **Plan and conduct the training and support for WASH committees as an integrated team**
- **Involve community members and particularly the WASH committees in collecting and analysing water samples (where this is done in the field e.g. residual chlorine or using a portable water testing kit)**
- **Ensure regular team meetings and a policy of daily feedback on WASH issues arising in the camp or settlement.**

WASH not WATSAN: making the hardware work harder

Nutrition and food hygiene issues

Breastfeeding, weaning and good feeding practice can all influence rates of diarrhoeal disease and their inclusion in hygiene communication activities will make an important contribution to child health.

Babies should be exclusively breastfed for the first six months of life. From 6 months of age, infants need a variety of additional foods that are hygienically prepared but breastfeeding should continue for as long as possible, preferably until the child is at least 2 years old.

Many infants are given alternative liquids, such as water or juice, before the age of six months and weaning (giving the child solid food) is often commenced too early.

Risks associated with food hygiene should be identified in the initial assessment. Unsafe practices can be responsible for not only the spread of diarrhoeal disease due to a variety of organisms including salmonella, shigella and cholera but also many other diseases such as tape worm and avian influenza.

The main food hygiene risks occur due to the following reasons:

- Preparing food too long in advance
- Storing or cooling food for too long without refrigeration
- Not reheating food to an adequate temperature
- Using contaminated food
- Undercooking meat and poultry
- Cross contamination between raw and cooked food
- Infected food handlers
- Insufficient and ineffective handwashing

Outbreaks of diarrhoeal disease can occur as a result of poor food hygiene in hospitals, schools, and community kitchens or at mass gatherings such as funerals or marriages. The response to such outbreaks might involve training of key personnel such as cooks or kitchen workers and enabling better handwashing by providing accessible and adequate handwashing facilities (if these are not conveniently sited or if people have to queue, or if soap is not replenished or towels not available, rates of handwashing will be adversely affected).

Context specific interventions may also be required to raise awareness amongst the general public. Environmental health workers in many countries are responsible for overseeing food hygiene in public areas and there will usually be national legislation governing food safety issues that should be adhered to.

Using Public Health Data

A cross-sectional study was conducted to investigate the potential link between food-hygiene practices of mothers and the prevalence of diarrhoea among their children. Mothers who had children aged 6 months–5 years were recruited in a hamlet in Viet Nam. The food-hygiene practices included hand-washing, method of washing utensils, separation of utensils for raw and cooked food, and the location where foods were prepared for cooking. A face-to-face interview was conducted, and data on 206 mothers were analysed. The risk of diarrhoea was significantly higher among children whose mothers prepared food for cooking somewhere other than the table (typically on the ground) compared to children whose mothers prepared food on the table. The results indicate that food-hygiene practices of mothers, such as avoiding preparing food for cooking on the ground, has a potential impact in preventing diarrhoea among children in Viet Nam.

Source: Journal Health, Pop & Nutrition, Oct. 2009, P. 602-611

What's in a message?

A 'message' is a piece of information conveyed to someone else but it can often be a type of one-way communication only that does not allow for discussion, debate or questioning. It represents what the 'messenger' sees as important and relevant and often does not take into account individual circumstances and context.

Hygiene promotion recognises that there is often a place for the mass dissemination of information but that this approach often has limited success and must be backed up by the use of more effective, interactive communication methods.

DON'T DISSEMINATE – COMMUNICATE!

It is important that the information we share with affected populations:

- Is based on an assessment of the risks of the specific context
- Is useful and provides practical actions that people can take to reduce those specific risks
- Is not contradictory - so that all actors are conveying consistent ideas and concepts
- Does not overwhelm people by providing too much information at one time
- Encourages people to take action

We can use a variety of means to convey such information such as:

- Mass communication – radio, TV, mobile phones, social media, posters, leaflets, newspapers
- Interpersonal communication: home visits, discussion groups, workshops, counselling – via community or health mobilisers/change agents, peer groups, religious leaders
- Traditional media: songs, theatre, folk drama, puppets, parades etc.

Ideally we are encouraging learning and therefore the way information is presented should:

- Allow people the opportunity to question, discuss and learn how to apply the information to their specific context

Mass communication methods can be made more interactive by e.g. having a radio phone in, allowing people to ask questions using mobile phones, combining mass communication with a discussion group or home visits.

2: HP in different Phases & Contex

Emergency Phase and Outbreak Response (0 – 6 months)

During the emergency phase of any response, overcrowding, a lack of access to basic water and sanitation services, difficult living conditions, and a lack of basic hygiene items (for example soap, or water containers) pose a significant risk to health.

In some cases there may be WASH related disease outbreaks – especially in the early stages of an emergency. Disease outbreaks are also possible after this time and any outbreak may constitute a return to the emergency period.

Hygiene promotion is an essential activity not only to ensure that the population has information, resources and motivation to prevent WASH related disease transmission but also to support conditions for life with dignity.

Many of the people of concern to UNHCR will have suffered immeasurably and be grieving for the loss of loved ones or because they have lost their home and possessions or their sense of identity and belonging. They may feel bereft of any sense of purpose and be highly vulnerable because of both their mental state and because the protective mechanisms normally afforded by family ties and networks are not working effectively.

Traditional roles and responsibilities may also be disrupted and people may be forced to take on new and unfamiliar roles. Many women may become heads of household or men may be obliged to take on child rearing or caring practices that they have little experience of. Some people may neglect their responsibilities and feel a sense of hopelessness.

Host communities may not always be welcoming or may show outright hostility blaming the new arrivals for various negative repercussions, including outbreaks of disease.

All of these factors can present challenges when working to promote health. Mobilising communities can be difficult when community structures have broken down and engaging men and women may not be easy if they are grieving for what they have lost.

However, not everyone responds in the same way to traumatic events and there will always be some people who will adapt faster than others and be ready to become involved in HP initiatives. Enabling people to help to shape the response can also give them a sense of purpose and meaning in their lives again.

The approach to hygiene and health communication outlined in these guidelines, aims to establish and develop trust and mutual respect between agencies and affected populations. Listening to people's concerns and anxieties (not necessarily about WASH) can be a necessary part of a community oriented approach and can contribute to ensuring a more holistic response to people's needs.

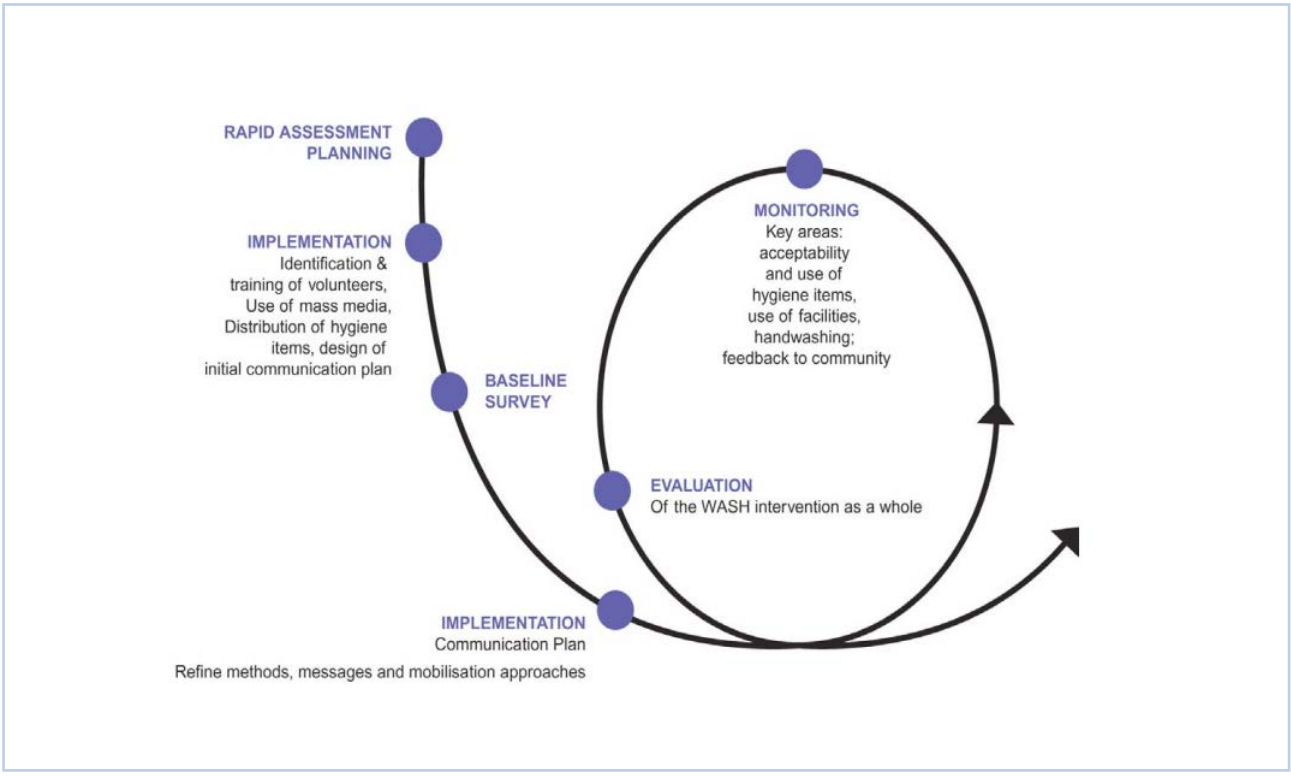
Emergency Hygiene Promotion Project Cycle

Hygiene Promotion in the Emergency Phase follows the project cycle but some stages will need to be carried out in parallel.

For example recruitment, training of key staff and the initial assessment will often need to progress in parallel so that meeting refugee needs can begin immediately.

Strategies and approaches will need to be flexible in order to take into account new information and a gradually deepening understanding of the context.

Figure 4: Emergency Hygiene Promotion Project Cycle Source: WASH Cluster HP Project



Initial responsibilities will involve coordination with others, recruitment, training and rapid assessment and this will need to be seen as an on-going process with training done in short chunks and continuing assessment built into the implementation.

Human resources issues, including recruitment and training are covered in Chapter 3 on page 55 of these guidelines.

Assessment

A rapid assessment of obstacles to hygiene and ways to reduce risks should be carried out within the first few days of the emergency and should identify the priority practical actions that different groups e.g. men, women, children, teenagers, older people, people with disabilities etc. can take as well as the best means to communicate effectively with these various audiences – based on their communication preferences.

The assessment should be coordinated with other WASH actors and health teams and should use a combination of observation walks, key informant interviews and focus group discussions.

Key Questions

The **WASH Assessment Primer** (http://wash.unhcr.org/download/wash-assessment-primer-questions/) provides details of appropriate questions to understand how different people are currently meeting their WASH needs.

Analysis of this data can then help to identify the public health risks and potential immediate and short-term solutions. The questions also try to identify what refugees see as possible solutions and responses.

It will be useful to try and organize small group discussions if possible with mothers of young children, older men and women, people with disabilities and adolescents as a minimum, as well as with any specifically marginalized groups such as different ethnic groups or those with different religions from the majority of the population.

Using pictures (such as a 3 pile sorting picture set) during these discussions provides an open ended means to understand different people's viewpoints and understanding of different hygiene issues.

Additional questions will also need to be asked about menstrual hygiene management (MHM). See **A Toolkit for integrating MHM into Humanitarian Response** by Columbia/IRC (**https://www.rescue.org/resource/menstrual-hygiene-management-mhm-emergencies-toolkit**) for useful information including assessment questions.

It is also important to ask questions about formal and informal channels of communication, what people's communications preferences are and what channels they feel they can trust. For example:

- How do people normally obtain information about health and hygiene?
- Who are influential people in the community who are trusted to provide information?
- Do refugees own radios/TVs and if so who listens to or watches them?
- Do refugees have mobile / smart phones? What percentage approximately and who uses them?
- Do refugees use and trust social media?
- Are there existing outreach systems (volunteers, health workers, clubs, religious institutions etc.)
- Are there people with experience of working in outreach work?
- Do people trust existing networks?
- What local media or media organizations exist and what languages do they broadcast in (e.g. newspapers, community radio, NGOs)?
- Do refugees trust these sources of information?
- Are there WASH/ hygiene information materials that can be readily adapted for different population groups?

In an acute situation where there are significant public health risks, it may not be possible to obtain all of the information before starting to implement the programme but some attempt must be made to listen to different voices in the affected community.

Assumptions will often have to be made about the situation in order to start work as quickly as possible but assessment should be an on-going process and implementation plans must be flexible and able to adapt to the needs that are subsequently identified.

Age, education, income, culture and background will have varying levels of influence on behaviour and different people will have different needs and perceptions about sanitation and hygiene. It will be useful to understand something about what people have been used to and how they are now adapting to their new context.

People will also have different levels of confidence in themselves and their capacity for change (also known as self-efficacy; see page 78) and different levels of belief in the effectiveness of the proposed changes (action efficacy). These factors should be taken into account during the assessment process by asking different groups of people about their perceived confidence and capacity.

Planning and Design

Planning and setting objectives is crucial in a hygiene promotion intervention, as it will give direction and focus to the work and ensure that it is easier to monitor, evaluate and adapt.

A hygiene promotion action or communication plan should outline the key priorities and who will do what, when, where and how. The plan should be dependent on the specific context and based on an analysis of communication channels, methods and settings. This plan must be updated at regular intervals to reflect changes in the context and the results of on going assessment.

There is a tendency when doing hygiene promotion to simply 'dive in' and begin *'disseminating hygiene messages'* before the specific problems and required behavioural changes and specific feasible actions that the population can take have been identified.

It is vital that the initial planning and design remains flexible so that it can adapt to developing knowledge and understanding about the situation.

Evidence

A review focussing on risk communication in low and middle income country settings identified a lack of well designed studies but concluded that,

> ***"community-based and participatory interventions*** *seemed to be central within epidemic and emerging disease settings, particularly in low-resource settings."*

But they also stressed that, "more conclusive evidence is needed on different approaches for community mobilization and citizen engagement."

Source: *Schiavo, et al (2014) Communicating risk and promoting disease mitigation measures in epidemics and emerging disease settings*

A systematic review of the available evidence on communication during outbreaks in 2009 (albeit in medium to high income countries) suggested that communication strategies should **focus on specific demographic groups** and on **raising levels of perceived threat and susceptibility** as well as **perceived effectiveness of protective measures.**

Higher levels of trust in the authorities, was also seen to be associated with an increased practice of protective behaviours. The study also found that women and older people were more likely to adopt the protective behaviours.

The authors underlined the importance of: '***Identifying spokespeople who can give legitimacy to communications.'***

Source: *Cattaneo et al (2009) Systematic review of studies addressing population behaviours during infectious outbreaks and review of outbreak communication in 2009 pandemic*

Implementation

- Mobilisation of groups and communities can be achieved through discussion at the community or household level
- Consider the needs of different groups and also what might motivate or deter different participant groups
- Hygiene promotion efforts should also support community organisation to take responsibility for the facilities provided.

The following will usually be the priority actions in an acute situation:

Table 2: Key Activities in the Emergency Phase

	Key HP Activities	Means
a.	**Find out what women, men, children, older people and people with disabilities (as a minimum) know, think, feel, want and do in relation to water, sanitation and hygiene and identify the priority hygiene risks**	▪ Key informant interviews (with community and other stakeholders) ▪ Focus group discussions ▪ Household Visits ▪ Exploratory walks
b.	**Find ways to support community organization and outreach in collaboration with key stakeholders (community members and leaders and other response actors)**	▪ Identify community leadership and power structures ▪ Establish degree to which they are respected and trusted in community ▪ Encourage groups to elect representatives if necessary ▪ Coordinate with other response sectors and actors ▪ Identify and train CBW (Community Based Workforce) in collaboration with health and nutrition actors and in discussions with community
c.	**Provide people with information about key risks and practical (doable) actions to reduce risks ensuring where possible that they have the opportunity to ask questions and clarify misunderstandings**	▪ Use available mass media if working and people trust them ▪ Emphasise interaction (rather than messages) as quickly as possible e.g. radio phone ins or discussion groups ▪ Train CBW in communication skills especially in listening skills and asking open ended questions
d.	**Enable better hygiene for different groups by ensuring access to appropriate WASH facilities and hygiene items**	▪ In coordination with others undertake a rapid market assessment or validate any pre crisis market assessment data ▪ Identify appropriate, key hygiene items that will be useful for different groups ▪ Organise access to (or distribution of) priority items in coordination with others ▪ Where markets are functioning and accessible use cash or vouchers (hygiene and WASH requirements could be included in a multi purpose grant MPG) ▪ Where required provide information on the use of key items - especially any that people may not be familiar with (such as HH water treatment) ▪ Monitor the use of hygiene items and/or cash and vouchers and seek feedback from specific groups ▪ Ensure that emergency facilities are designed/ improved following feedback from users ▪ Identify needs of different groups especially older people, children and those with disabilities and whether their specific needs have been met by the distribution, cash or voucher modality
e.	**Involve refugees in making decisions about the WASH response and seek their feedback on the intervention and how to improve it**	▪ Share programme information and invite refugee comments and feedback in community and group meetings ▪ Integrate open ended feedback into monitoring ▪ Carry out ***Rapid 60 HH survey*** every week and discuss results and subsequent action with community groups ▪ Pass on non WASH related concerns to others

Rumour Tracking

In the event of an outbreak especially, it is important to hold discussion groups, listening exercises or simply household visits and transect walks in the community for the express purpose of understanding refugee concerns and their understanding of the emergency and the response.

For example in the event of a cholera outbreak, communities have often been fearful of treatment centres or spraying teams and misinformation and rumours are common and will be counterproductive to the response.

Compiling a 'rumour bank' to share amongst all agencies working in the response can be useful to help identify potential barriers to people's participation and to ensure that there is consistency between different intervention actors.

Case Mapping

It may also be useful during an outbreak to map where people with the disease live e.g. cholera and to find out the geographical distribution of disease and if there are clusters of cases in particular areas. In this instance it would be sensible to direct WASH efforts in these areas.

Design of Facilities

Initially the provision of shower and toilet facilities may have to follow a standard design in order to meet the basic needs of large numbers of people. However, feedback on these should be sought once they are in use and adaptations should be made as soon as possible.

As time permits discussions should take place with different refugee groups (women, adolescent girls, children, older people, people with disabilities etc.) about the designs that best meet their different needs.

Cleaning and maintenance of toilets

Even in an acute emergency situation, it is important to bear in mind that refugees may be forced to remain in that situation for many years. It is vital to consider the issue of sustainability right from the start by involving men and women as much as possible in the design, siting and management of WASH facilities. It may also be useful to suggest that communities select WASH Committees to oversee construction work and the operation and management of facilities. However, such committees are not compulsory and communities can determine what structure works best for them.

It is unrealistic to expect that public latrines (that anyone can use) - in health centres, markets and other public places - will be kept clean without employing cleaners. Similarly public latrines in a camp situation will usually not be kept clean if used by large numbers of people and it will often be necessary to pay toilet attendants who will need training, cleaning equipment and supervision.

The management of any cleaners should be the responsibility of either the health centre or the market committee or the agency responsible for managing community centres or other public spaces but could also be the responsibility of the hygiene promotion team in the case of public toilets in a camp.

Wherever possible, however, the users should take responsibility for cleaning community level toilets and this may be made more feasible by allocating specific toilets to specific families to share. This should be discussed with community groups and their leaders to identify the most appropriate, acceptable and effective system.

Where a large number of families are using the same communal facility or where there is little chance of encouraging a sense of ownership e.g. in a transit or reception centre, it will be necessary to pay for toilet attendants.

Selection, training and support for WASH committees

- WASH committees need to be representative of the community and ideally should be selected by community members through fair and transparent elections.
- Community meetings should be organized prior to elections to discuss the formation of the committees. Discussions should include considering the importance of involving women and ensuring the accountability of committee members to the community.
- Re-elections might be required after a certain time period or if committee members are not performing well
- Training cannot be undertaken in only a few days and WASH committees will usually require regular follow up and support from the implementing partner and/or government partners for some time.
- Involve any long-term WASH stakeholders such as government or faith-based organizations in the selection, training and support provided to committees, wherever possible.

Hygiene Related Non-Food Items

Evidence

There is limited evidence (both in terms of quality and quantity) on the impact of distributions of WASH NFIs and most studies focus on the provision of household water treatment (HWT).

There is also currently no evidence on the health impact of cash and voucher distributions or evidence that indicates that vouchers are more effective than cash in achieving public health outcomes.

However, a recent review identified that:

> "Prepositioned stock, quick release of funds and early triggers for rapid scale-up were important facets of a positive response, particularly with hygiene kit and HWT."

The same review went on to note that in relation to HWT:

> "The wide range of use is attributed to the availability and amount of hygiene promotion given to beneficiaries; this is consistent across all (HWT) interventions."

Source: Yates et al (2017) WASH interventions in disease outbreak response; Humanitarian Evidence Programme

Only one study has attempted to provide evidence on the effects of soap distribution on diarrheal outcomes. This study found reductions in risk for diarrheal diseases of 25%, or greater. No further studies on soap distribution have been documented since then.

Source: Peterson et al (1998) cited in Ramesh et al (2015) Evidence on the Effectiveness of Water, Sanitation, and Hygiene (WASH) Interventions on Health Outcomes in Humanitarian Crises: A Systematic Review.

If people have been forced to flee their homes, they may not have been able to bring necessary hygiene items with them such as water storage containers, soap and menstrual hygiene materials.

If markets are functioning and if a market assessment demonstrates that the market can respond easily to increased demand, the provision of multi purpose grants (MPG) or cash or vouchers will be preferable to in kind distributions and have the potential to both offer people greater choice and support the local economy.

In the initial phase of an emergency situation it may be necessary to distribute in kind and to make assumptions about what is required before being able to carry out a more detailed consultation with community members. Ideally, people should be familiar with such items e.g. soap and water collection and storage containers. If household water treatment products are distributed, it is vital that people are also given information on how to use them correctly. If people are not familiar with such items it may be preferable not to distribute them in an acute situation.

Any information given verbally in demonstrations etc. should be backed up with written or pictorial instructions (even where literacy rates are low, there may be people in the household who can read).

Distributions of any new and unfamiliar items must be rigorously monitored to ensure that people are able to follow the instructions provided.

The provision of underwear and sanitary material for women is often neglected in emergencies and can be a hotly debated topic when done badly. As far as possible women must be consulted on their choice of sanitary material and thought must be given to how and where it is distributed. See **A Toolkit for integrating MHM into Humanitarian Response** for useful information.

Where washable sanitary towels are provided then provision should be made for women to wash and dry these in private. The 100% provision of sanitary towels for women is one of the high commissioner's non-negotiable standards of assistance.

Where disposable towels are provided, thought will need to be given on how women are to be able to dispose of them hygienically.

The following hygiene items might be required:

Personal Hygiene

- Soap for laundry and personal hygiene (Sphere recommends 250 gm. bathing soap/person/month and 200 grams 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
- Washing basin for personal hygiene or washing underwear or washable sanitary towels
- Washing line and pegs
- 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.)[4]

However, the specific items that are provided will need to be discussed with affected men, women and children and this process is an important aspect of hygiene promotion. See **WASH Cluster Briefing Paper: Hygiene Related Non-Food Items**, for further information.

Promoting hand washing

The practice of handwashing can have a significant impact on reducing rates of diarrhoea. A meta-analysis of all the available studies by Curtis and Cairncross in 2003, showed that hand washing with soap and water after contact with faecal material can reduce diarrhoeal diseases by 42% or more. It has also been shown to reduce rates of respiratory tract infections.

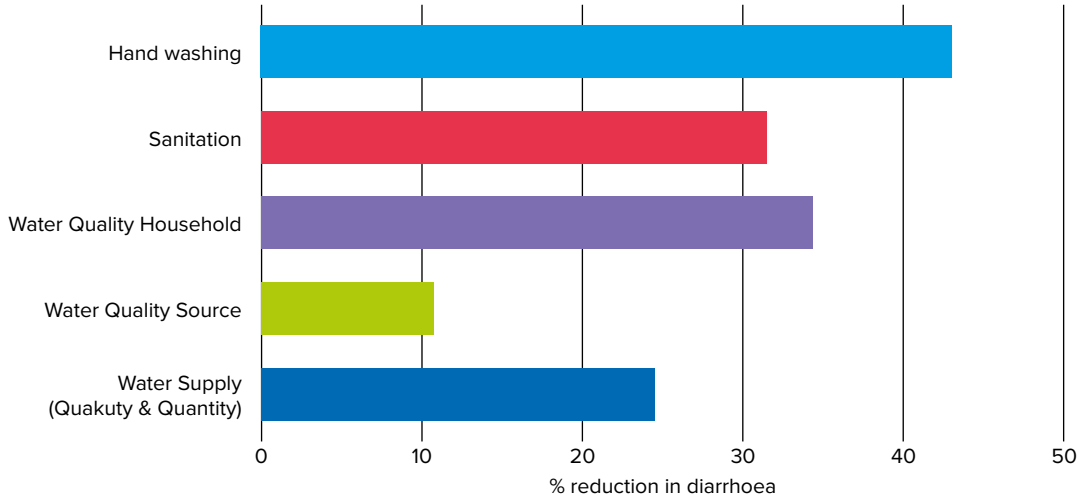
Ensuring that people wash their hands especially following defaecation or changing a baby's nappy and before eating or preparing food should be a key focus of communication for hygiene promotion.

Where communal toilets are constructed or rehabilitated, handwashing facilities should always also be provided but communication efforts must focus on how both toilet and handwashing facilities are managed. Unless there is piped water to the handwashing tank, this will need to be constantly refilled. Soap or an alternative (e.g. ash or sand) should also always be available. The use of liquid soap dissolved in water can sometimes help to deter theft.

It might be useful to train latrine attendants at public or communal toilets, to encourage handwashing – especially where the public health risks are high e.g. during a dysentery or cholera outbreak.

Household handwashing can also be encouraged by introducing low tech solutions that people can hang outside their latrines such as the 'tippy tap' (shown on the next page) or using a jerry can with a nail to produce a small flow of water.

Figure 5: Importance of handwashing in diarrhoeal prevention



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

4 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

A variety of different handwashing solutions:

Tippy tap in Ugandan refugee settlement

Photo: AAF/Ariku

Soap container in toilet in Yemen refugee camp

Photo: UNHCR/Ferron

Leaky tin Kenya refugee camp

Photo: CARE/Ouko

Communal handwashing facility

Photo: Jane Beesley

Working in host communities

Where people live with host communities, it may be necessary to undertake work that meets the needs of both refugees and those who are hosting them. WASH committees, community groups or outreach workers may need to be incorporated into the existing host community structures and have both refugee and host community representatives.

In an urban area a WASH committee could provide oversight for the repair or construction of a public water point or to help promote more equitable use and/or conservation of water.

Where refugees are living with host communities, improvements to water and sanitation may focus primarily on small-scale plumbing in homes to repair household water and sanitation to make it more efficient or to provide more storage.

It is important to provide as much autonomy as possible to the families that are involved – giving them the opportunity to make decisions about the way the service is provided - much as they would do if living in their own homes.

Hygiene promotion teams in conjunction with WASH engineers need to ensure that families are able to provide feedback on the work done (both positive and negative) as well as to complain if necessary.

If contractors are employed to do this work then they will need to be trained to communicate effectively with community members and the latter should be involved in monitoring their work. Contractors will also need to be familiar with codes of conduct and relevant standards.

Accountable actions in the emergency phase

The following actions should be feasible in the emergency phase:

- Consult with men, women, and children on design of facilities, hygiene items, and outreach system
- Identify and respond to vulnerability e.g. older people or those with disabilities
- Support and collaborate with existing community organisations, organisers, and communicators
- Ensure transparency, respect and open communication with affected communities on intervention plans
- Explain who you are and your approach and invite feedback whenever possible on WASH interventions.

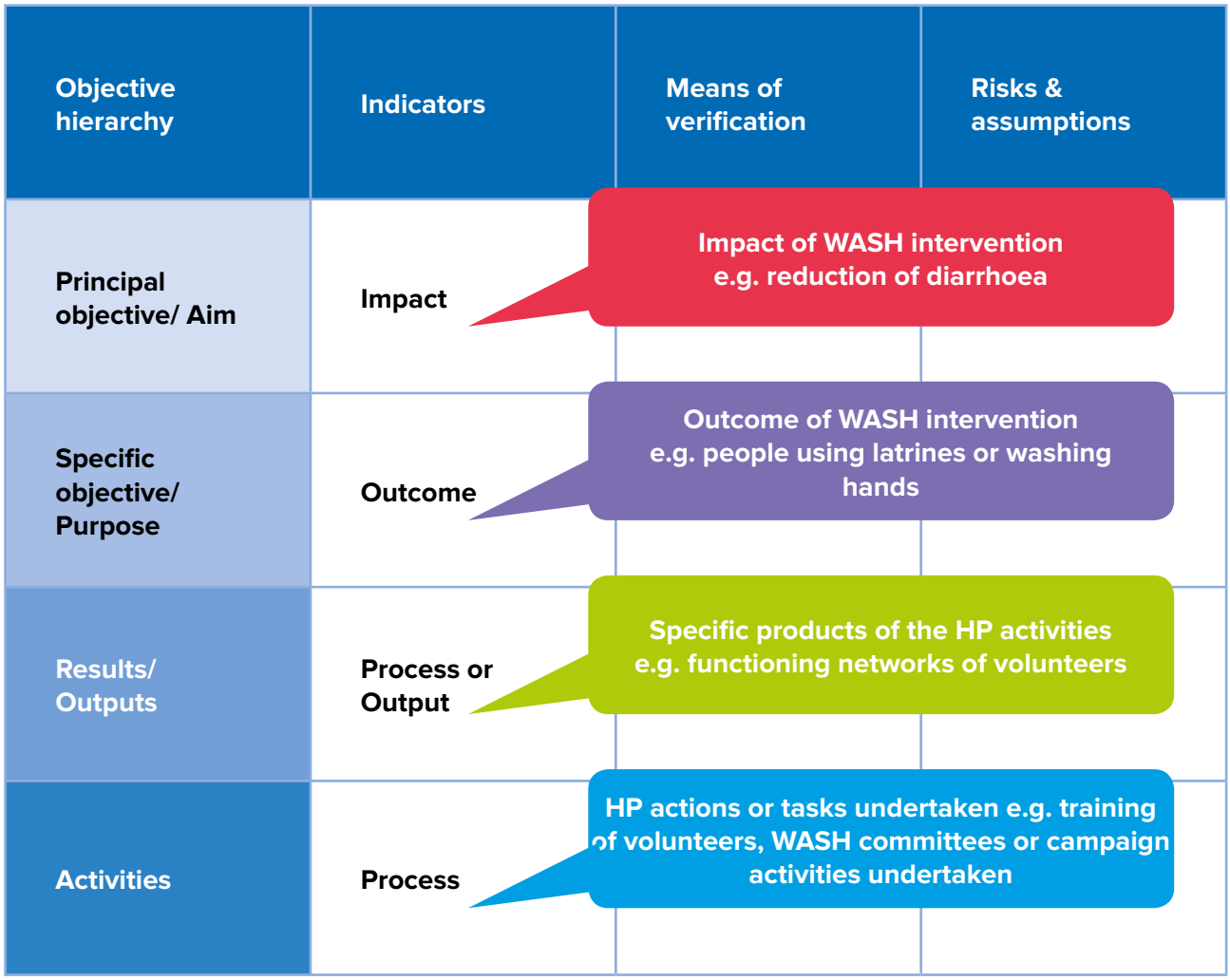
Monitoring

Information about monitoring the overall WASH response can be found in **the UNHCR WASH Manual**. Hygiene Promoters (including Community Mobilisers) will often be involved in monitoring different aspects of the WASH response e.g. monitoring drinking water quality by measuring free residual chlorine (FRC) at tap stands or sometimes in households.

Community members can also be involved in monitoring activities to ensure that it meets their and their neighbour's needs.

Indicators for monitoring should be defined in the planning stage of project cycle and the use of a logical framework will help you to define whether the indicator is at the **process, outcome** or **impact** level as shown on the next page:

Figure 6: Logical Framework with different levels of indicators



Key Hygiene Promotion Indicators

In addition to the proposed key WASH indicators (see **UNHCR WASH standards and indicators**), the hygiene promotion teams should select the most appropriate indicators from the list below and investigate and monitor these as appropriate. Both qualitative and quantitative methods should be used in monitoring.

The rapid HH survey should be undertaken each week but will only provide limited quantitative information. It will also be necessary to examine other qualitative data to understand better the obstacles that community members may face in ensuring adequate hygiene and health. The table below provides a list of possible indicators, how they can be tracked and whether they form part of the list of indicators in the UNHCR Standardized KAP survey (http://wash.unhcr.org/wash-monitoring-system).

Table 3: Key HP Indicators and means of verification

	Indicator	Means of Verification	Included in UNHCR Standardized KAP?
a.	Use of facilities by *different sections* of the affected community	HH monitoring forms Observation Discussion groups Exploratory walks **Discuss with women and men, girls and boys, people with disabilities, older people etc.**	No KAP and 60 HH rapid survey do not disaggregate data for latrine use
b.	Number of people per toilet	60 HH rapid survey	Yes
c.	Disposal of babies' and young children's excreta	As above **Discuss with mothers with babies and young children**	There is a question: "Where do children under 5 defecate?" but no specific question for babies and no detail of obstacles or enabling factors.
d.	Use of and satisfaction with hygiene items	PDM forms/surveys (usually agency specific) FGDs	No
e.	Hand washing with soap at key times	HH and latrine monitoring forms Observation of hand washing following use of latrine Presence of hand washing facilities with soap at HH	Yes but self-reported measures of hand washing are often unreliable so need for triangulation of data
f.	Average litres of water per person per day HH storage capacity	60 HH rapid survey	Yes
g.	Safe storage and treatment of drinking water	Observation at HH level FGDs FRC at tap stands **Conduct discussions to identify user's viewpoints and problems**	Yes but limited information on obstacles and enablers
h.	Other actions taken to address public health risks such as disposal of solid waste or digging of drainage around shelters	HH monitoring forms Observation	Solid waste Cleanliness of courtyard Covering food But no details on obstacles and enablers
i.	Use of ORS and management of diarrhoea (especially in young children)	HH monitoring forms Discussion groups **Discuss with mothers of young children**	No

j.	User satisfaction with WASH facilities, interventions and staff conduct	HH monitoring forms Listening and feedback exercises **Complaints mechanisms should be in operation for serious complaints but CBW should invite verbal feedback on performance also**	No Only one question about privacy of toilets and one about acceptability of MHM materials
k.	Participation of the affected community (considering different groups)	Listening and feedback exercises with different groups	No

It is also important to track WASH related disease data to ensure that the overall response is having the desired impact. This can be done through regular contact with health staff responsible for data analysis. A question on the incidence of diarrhoea within the last two weeks is included in the **UNHCR Standardized KAP survey.**

Data Collection Methods and Tools

Data can be collected in various ways through mini surveys, focus group discussions, household visits and observation. Photographs, films and mapping exercises are also useful monitoring tools.

In the emergency phase, a **Rapid HH Survey of 60 households** should be carried out every week to ensure a regular check on progress and to identify any problems (see forthcoming **Briefing note on Rapid HH Surveys** – wash.unhcr.org).

In addition Community Mobilisers should seek regular feedback from community members about the response and whether they feel that it is meeting their different needs. There may also be a need for rumour tracking in the case of disease outbreak particularly (see page 25).

Remember

that there may be many different refugee groups in any location. A camp or settlement wide household questionnaire survey may mask the specific differences (knowledge levels, understanding, cultural beliefs etc.) between these different refugee groups.

Transition Phase (6 months up to 2 years)

As refugees become more accustomed to their new environment, and as WASH and other service provision improves, the situation will usually stabilize although public health risks will remain and there may be outbreaks of disease.

WASH service provision will transition from emergency life-saving activities to long term and more sustainable solutions. In this phase there will be a movement towards increased household ownership rather than communal facilities and improved integration with existing National WASH service provision structures.

However it is likely that there will be some degree of intra household inequality where specific groups such as those with disabilities or pregnant women may still find access difficult – even if they have a household toilet.

In the medium and longer-term the hygiene promotion response should become more strategic – planning ahead rather than reacting to specific events as they happen.

There will be time for more in depth assessment and analysis of the issues and of the many factors influencing hygiene practices. This is often known as formative research. If there has not been time to carry out a formal baseline – or to compile assessment data in the first phase then this will be a priority for the transition phase.

Remember

in the transition phase there may still be many new arrivals. It may be necessary to run both emergency phase and transition phase activities in parallel – depending on the context, numbers of new arrivals and the public health risks they face.

Assessment

If it has not been possible to carry out a Coverage (or KAP) Household Survey in the emergency phase of the response then this should be carried out as soon as possible as this will provide important quantitative data for the purpose of monitoring and evaluating the intervention.

However it is also useful in this phase – if not more useful in terms of shaping the programme - to carry out more in depth formative research to understand about what people are doing in relation to WASH, how change can be brought about if needed and where the specific gaps are in access and use.

There are various formative assessment tools that can be useful in this stage. There may be more time to use interactive tools such as those drawing on Participatory Rural Assessment/Participatory Learning and Action (PRA/PLA). The aim of these tools is to enable communities to analyse their own situation and to define community led solutions. An adaptation of some of these PLA tools forms the basis of CLTS.

Other tools draw on anthropological methods such as video ethnography or scripting (see page 70).

Super Amma Formative Research

Staff spent three weeks in rural Indian villages collecting data on existing and potential behavioural practices and related psychological environmental factors, using the following methods:

- Video ethnographies of women with children under five, ensuring that all daily activities were filmed
- Household inventories of water, sanitation and hygiene facilities including all types of soap and its uses
- Behavioural trials in which informant HH members were urged to wash their hands with soap at relevant times of the day, and then visited several days later to see how well they had fared
- Key informant semi structured interviews to conduct the 'Motives Mapping', attribute ranking and other projective exercises

Taken from: Aunger, R. and Curtis, V. (2015), A Guide to Behaviour Centred Design

Doer/non-doer surveys seek to identify those who do and do not practice a particular behaviour and to understand how they differ in terms of motivation and other determinants of health. The discrepancy between the two groups can then be used to inform communication campaigns targeted at the non-doers. For example, both doers and non-doers may believe that latrines offer privacy but only the doers consider latrines to also offer convenience. In this case the campaign would focus on how convenient latrines are rather than the fact that they offer privacy.

This technique is employed by many social marketing campaigns. The RANAS framework and approach also draws on this survey technique. See page 101 for more information on RANAS. A Practical Guide to Conducting a Barrier Analysis (Kittle 2013) also provides more information on carrying out a 'Doer, Non Doer' Survey.

A variety of other frameworks and approaches also recommend more in depth formative research as a vital step in designing an effective hygiene promotion programme. Some example in depth assessment questions are provided in the appendix on page 83.

However it should be borne in mind that not all successful promotional programmes draw on detailed formative research carried out before the intervention. CLTS, for example, has been very effective in mobilising communities to construct latrines but does not rely on an in depth assessment by outside researchers. The aim in CLTS is to facilitate each community through a relatively short process of learning and discovery.

However even in community led programmes such as CLTS, formative research can help to identify specific gaps in the programme and help to uncover community perspectives and answer questions such as:

- Is the programme meeting equity and inclusion goals?
- What health and behaviour determinants is the programme not addressing?
- What is preventing change from occurring?
- How can the programme be made more effective?

Planning and Design

It is useful in the transition phase to compile a more detailed *Theory of Change* that articulates not only what changes are expected but also how change is expected to happen and the evidence and assumptions that this is based on.

An example overall theory of change for hygiene promotion is illustrated on the following page. However, it is preferable if this is made context specific and incorporates the specific changes that are expected and the assumptions that hold at the time of implementation.

It is also crucial to develop (or refine if previously developed) a joint hygiene promotion strategy in conjunction with all agencies working in HP - that aligns closely with the planning for WASH infrastructure.

The potential for involving community members in shaping plans for WASH will also increase as time goes on. It is important to listen carefully to what people say they need and want and to ensure that any decisions about new water systems or plans for improving sanitation involve discussions with communities.

It will often not be possible to fulfil all of the expressed needs of refugees but it is vital to discuss what limitations there are, to involve people in identifying potential solutions and to ensure they are on board with any future plans.

Evidence

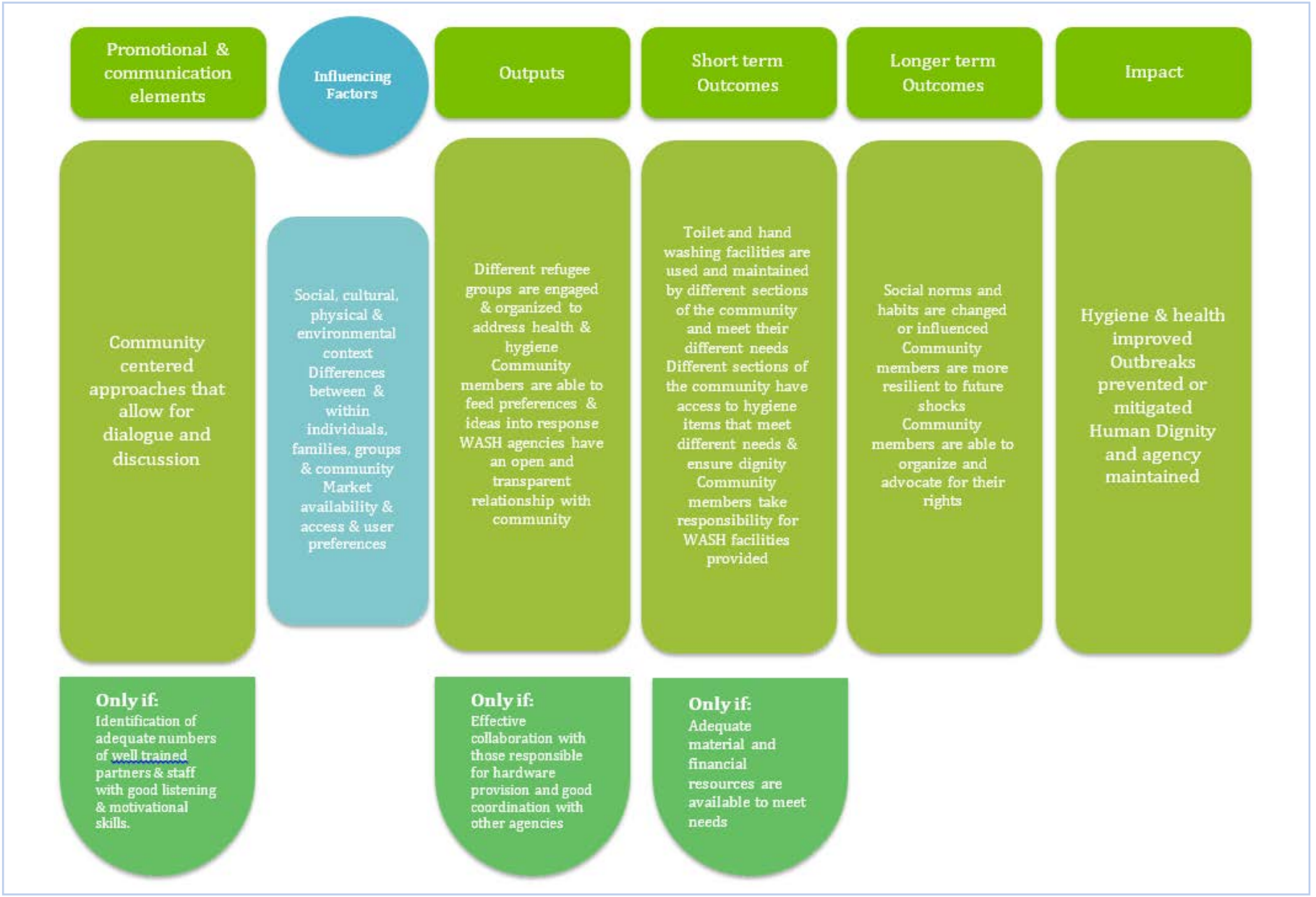
A systematic review carried out in 2015 examined the sustainability of WASH interventions. It found that interpersonal communication was associated with longer-term behaviour change and was widely represented across the studies examined.

The authors went on to say that,

> *"Evidence from this review suggests that the most influential programme factors associated with sustainability include frequent, personal contact with a health promoter and accountability over a period of time. Personal follow-up in conjunction with other measures like mass media advertisements or group meetings may further increase sustained adoption."*

Source: *Hulland et al (2015). What factors affect sustained adoption of safe water, hygiene and sanitation technologies?*

Figure 7: Hygiene Promotion Overall Theory of Change



Implementation

The following table outlines some of the potential key activities in the transition phase:

Table 4: Key Activities in the Transition Phase

	Key HP Activities	Means
a.	**Ensure comprehensive household coverage survey is carried out if not undertaken in emergency phase**	▪ Collaborate with other organisations where possible ▪ Identify staff member to co-ordinate and lead ▪ Train survey team ▪ Analyse and share results – including with community
b.	**Deepen knowledge about what women, men, children, older people and people with disabilities know, think, feel, want and do in relation to water, sanitation and hygiene by carrying out formative research into motivations and obstacles to change**	▪ Carry out learning review ▪ Explore introduction of new approaches based on detailed formative research using e.g.[i]: - Focus group discussions - Doer, non doer surveys - Behaviour trials - Participant observation - Video ethnography - Scripting
c.	**Develop joint HP strategy with other organisations and ensure that this is developed in conjunction with the water and sanitation strategy**	▪ Coordinate with other HP actors and health and nutrition actors ▪ Coordinate and work closely with WASH engineers / Government WASH departments ▪ Share lessons learnt ▪ Focus on needs of groups who might be excluded
d.	**Develop and improve HP IEC materials where required based on formative research**	▪ Coordinate with other actors to avoid duplication ▪ Ensure materials emphasise and support two way communication
e.	**Review community based workforce numbers but continue to support, train and motivate them**	▪ In collaboration with health, nutrition and community services actors and in discussions with community
f.	**Ensure that where necessary people have access to necessary hygiene items and consumables – using cash/ vouchers where possible**	▪ Where markets are functioning and accessible use vouchers or other cash based means ▪ Ensure the needs of different groups especially older people, children and those with disabilities are not forgotten
f.	**Involve refugees in making decisions about the WASH response and seek their feedback on the intervention and how to improve it**	▪ Identify ways to involve refugees in programme e.g. support/ training for committees, initiate community peer groups /clubs, community monitoring ▪ Share programme information and invite refugee comments and feedback in community and group meetings ▪ Continue to seek regular feedback through 'listening exercises' ▪ Pass on non WASH related concerns to others

i See HP methods section for more information

Management of WASH Facilities

In the transition phase there should be the opportunity to provide more support for strengthening community management systems and ensuring that they have the training and support to operate effectively.

Promoting a sense of ownership and responsibility for WASH facilities should help to improve sustainability. In some situations vandalism of facilities can be a problem

In the past community management has often been promoted to the exclusion of government involvement but sustainability is unlikely unless the government is included in this process.

The available research shows that on-going institutional support is required for sustainable rural water supply services. Governments are in the best position to take on this role. There may also be other organizations (such as long term local NGOs or faith based organizations) and the private sector that are also able to take on some of the responsibility.

Community management: encouraging ownership and sustainability

- ✔ Is there a functioning WASH committee? What support and training is being offered?
- ✔ Are there regular community meetings to discuss WASH issues such as management of facilities, diarrhoea prevention or other issues identified by community members?
- ✔ Are water, sanitation and hygiene facilities provided at public places such as youth centres, religious institutions, community centres and places of worship?
- ✔ Is there a system in place for the operation and maintenance of all WASH public facilities?

Various WASH projects in Kenya have been using photographs in training to discuss the potential problems that committees might face and hence improve capacity for communities to address these.

Practice Example 1: Use of photographs to improve WASH Committee problem solving

The pictures below (adapted to the context) can be used to initiate discussions about what are perceived to be good and bad practices and how to address some of the problems that the WASH Committee might encounter.

Photo 10-11

- Bad practice
- Shared animal/human access
- No controlled access for animals

Photo 12

- Bad practice
- Masonry water tank leaking
- No effort to undertake necessary repairs

Photo 13-14

- Bad practice
- Drinking contaminated water. Often remains a common practice after water systems have been constructed either because people can't afford access or because pump breaks/no fuel, spares etc. Poor management

Photo 15

- Bad practice
- Major public health risk and mosquito breeding site.
- Illustrates a total failure of management.

Photo 16

- Good situation
- Newly installed handpump considerably improved water access and reduced the time spent collecting water.
- Will it have a long term impact though?

Photo 17

- Bad situation
- Handpump broken one year earlier.
- Committee has done nothing to resolve the situation and had been waiting for someone to come & support them.

Photo 18-19

- Bad situation
- Illustrates poor design as it is difficult to use by children.
- Children are also likely to damage the pump by playing on it.
- No caretaker to monitor use/abuse.

Photo 20

- Good practice
- Framework within which WUA makes decisions. This is a recognised water service provider.
- Do water users know about these rules and are they enforced?

Photo 21

- Good practice
- Mechanism to control and monitor water usage.
- However in practice is it really used?

Source: McSorley B. (2009) Toolkit for training water management committees in Kenya, Oxfam

Hygiene Related Non-Food Items

In the transition phase it is important to ensure that people still have access to NFIs that will enable better hygiene. Various consumables such as soap and sanitary towels may need to be replenished and the use of cash or vouchers may become easier in the transition phase as businesses recover.

However as time goes on, the level of public health risk will determine whether it is necessary to target provision to those who are most vulnerable only. It is likely that some form of targeting of resources will be necessary in this phase.

Working in host communities

Communicating effectively with refugees living in host communities can be difficult, as they will often be spread throughout the country in various locations. Using the mass media allows you to communicate with larger numbers of people but often at the expense of the interaction and personal contact that leads to effective behaviour change.

However, the mass media can be useful to convey important information and can also be made more interactive through the use of e.g. radio phone ins or enabling people to ask questions using mobile phones or by using social media as a key communication platform.

As with the emergency phase, hygiene promotion should focus on involving people in improvements or repairs to WASH infrastructure ensuring that people are able to provide feedback on the work undertaken.

Monitoring

It is useful to review the monitoring system in the transition phase as it may be collecting too much information that is not used to inform adaptations to the programme. The quality of the data collected may also not be adequate and staff may need more training or data collection forms may need to be modified.

It should now be possible to carry out a more detailed household survey (often known as a KAP -Knowledge, Attitudes and Practices survey) to serve as a *quantitative* baseline for future monitoring and evaluation.

The household survey provides quantitative information on changes in access and use of facilities but it will not explain why people are not using the facilities or how things could be improved. KAP surveys are often merely household 'coverage' surveys (rather than surveys that examine attitudes and practices in depth) and are very blunt instruments for understanding people's motivations and the barriers to change.

The sample size of the survey may also not be large enough to make any generalisations about the situation for specific groups such as babies or people with disabilities. There is therefore a need to also collect and analyse *qualitative* information such as that obtained from focus group discussions or other interactive exercises.

When working in widespread urban areas, it may be difficult to visit every family but phones or social media can be used to support monitoring and accountability.

Most of the generic key indicators listed in the emergency phase will also be applicable to the transition phase but will need to be tailored to the specific context.

In addition there should be more time to monitor process indicators.

Process Monitoring

Process monitoring concerns how the programme is carried out and not just the outcomes or impact.

It is important for the purpose of evaluation to keep a record of staff recruitment and training, materials development and the communication content of any activities such as campaigns, home visits or radio broadcasts.

It may also be useful to occasionally review the methods that are used for hygiene communication against a variety of criteria as shown in the table below.

Table 5: Example monitoring of hygiene communication methods[5]

	Poster	Group Training	Radio
Visibility	The poster was placed in the church and many people noticed it	The session was organised when women were working in the fields and many couldn't attend	The programme was broadcast in the afternoon when parents were collecting their children from school
Interest	Several people thought the poster was not very good as it was produced in black and white	The trainer just lectured those who attended and told them what they mustn't do.	A soap opera format was used depicting local stories of interest to the local community
Understanding	People thought that the poster showed a recently deceased person under a net.	The trainer used the local language and words that were familiar to the participants	The radio presenter who introduced the show used long words that people didn't understand but they could relate to the programme.
Acceptance	People use nets to keep flies off dead people before they are buried.	People thought the trainer was patronising them and didn't really understand the constraints they faced	Some well-known celebrities appeared on the show and people trusted what they had to say.
Action/practice change	No practice change resulted	No action resulted and people felt very resentful towards the trainer who seemed to be expecting too much from people	Women wanted to build a latrine like the family in the show and some did but others said they hadn't enough money
Improvement in health	No improvement in health	No improvement in health	Clinic data showed that the rate of diarrhoea had not decreased.

5 Adapted from ACF Hygiene Promotion Self Training (draft 2007)

	Poster	Group Training	Radio
Remedial Action	Conduct more detailed formative research to understand people's understanding of malaria and perception of bed nets. Ensure other interactive means to promote the use of nets prior to using posters. Pre –test all posters prior to use. Use more colour to attract people.	Conduct more detailed formative research to understand people's perception of hygiene, what channels of communication people use and trust and if suitable when they might be available to attend meetings/ training sessions. Train facilitators in adult learning and promoting hygiene	Examine in greater detail the constraints to latrine provision. Mobilise social resources to push for change. Ensure the use of other interactive methods of hygiene communication that complement the radio programmes.

The monitoring frequency will need to be determined in each situation but it is important that any data that is collected is used to inform decisions about programming. If data is collected too frequently it may not be collated and used so a balance will need to be struck according to programme needs and available resources.

Accountability

In the transition phase there will be more time to focus on improving accountability and identifying ways to involve the population in the response.

Accountable actions in the Transition phase

- Involve refugees in consultation on plans for future infrastructure such as new water networks
- Involve refugees in monitoring the work of contractors or rating their satisfaction with facilities
- Invite regular and systematic feedback on the work of the WASH sector
- Examine ways to share project information with refugee groups including field level budgets

Practice Example 2: Sharing budget information

Transparency and participation

In discussing the available budget with a refugee community in a camp in Sierra Leone, UNHCR staff used a coloured pie chart showing what proportion of the available budget was spent on each sector, such as health, water and education. The pie chart was then used to discuss the community's priorities and to determine how UNHCR should divide up the budget the following year.

Source: UNHCR A Community Based Approach

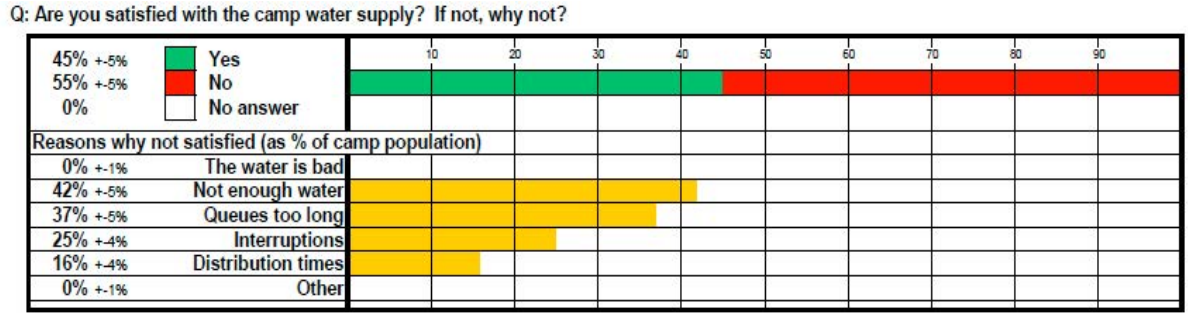
Practice Example 3: Measuring user satisfaction

Measuring User Satisfaction

In My Ayni camp in Ethiopia, IRC decided to try and obtain feedback from the community on the water, sanitation and hygiene programme in a variety of ways.

In their annual questionnaire survey they included a question on satisfaction with water supply and camp cleanliness. The results for water supply are shown below:

This led to further discussions with the community on how to address the problems.



Source: IRC KPC report

Post emergency and protracted (2 years to 26 years +)

In protracted crises or chronic situations, it may be very difficult to maintain the enthusiasm of individuals and communities and even of staff when working on social programmes.

Hygiene Promotion interventions may start to be carried out in a very mechanistic fashion in this phase and may seem to be just repeating the same information to people over and over again. Such interventions stand little chance of succeeding and can therefore lead staff to feel even more disheartened and de-motivated. The weary repetition of the mantra 'behaviour change takes a long time' can often be heard as the basis for continuing interventions despite limited success.

This may be the time to commission a review of the work or to introduce a new approach and it may be necessary to call on outside support to be able to do this effectively. A 'fresh pair of eyes' may help implementing partners to see how the programme can be improved

Maintaining motivation of staff

Funding will often be limited in the post emergency phase and the lack of incentives for voluntary staff such as mobilisers can make them feel demoralised.

The numbers of community-based workers will also need to be rationalized and as far as possible incorporated into existing government systems. It is likely that these workers will focus on several different public health issues and not just WASH. See the forthcoming publications **Community Based Workforce Operational Guidelines** and **Key Roles of Community Workers** for more information.

Maintaining the motivation of the community-based workforce can partly be managed by ensuring on going supervision, support, recognition and training. Ensuring that their work continues to achieve meaningful results will also help to ensure that they remain motivated. It may be possible to try out new methods and approaches to promoting public health such as motivational interviewing.

On-going training and support for staff will also be vital – especially where they have limited skills in facilitating groups or little experience of working in participatory ways.

Appreciative enquiry approaches[6] can help to support staff in questioning what they do and making changes in the way they work. Mentors or coaches can help to ensure that staff members have support to develop their skills.

Assessment

In the post emergency phase refugees will have adapted to new living conditions and identified strategies to ensure that water, sanitation and hygiene needs are met. However there may still be people who need support such as people with disabilities, those who are chronically sick and their carers and there may still be unequal access to water and sanitation facilities.

Household toilet facilities are more likely to be used and maintained but there may still be some problematic communal facilities in public areas such as markets, schools and community centres and ways to manage and maintain these effectively will need to be identified. Assessment in this phase needs to concentrate on identifying these and other gaps in provision.

It will also be important to situate the assessment of refugee public health into the broader assessment of the public health of the host community and identify the similar and separate issues. The use of advocacy as a promotion strategy should also not be forgotten and lobbying of government and others in positions of power may become increasingly important.

Risks to public health will remain and these will need to be identified and responses to them prioritized. For example work may be needed on cholera or disaster preparedness or on responding to outbreaks of disease.

Implementation

Another key to addressing a lack of motivation in staff is to ensure that interventions remain responsive to communities and work in partnership with them. Involving communities in searching for answers both to health and hygiene issues as well as to successful strategies for the programme can help to revive flagging programmes.

6 'Appreciative enquiry' is an approach that aims to identify what people do well and what their strengths are and play to these – making them feel good about themselves and giving them the impetus to engage in creative and positive life choices. It can be used with both staff and communities to motivate change.

It may be possible to incorporate skills training and income generation, such as soap making or sewing menstrual hygiene materials, into programme plans.

Environmental issues such as the importance of water conservation and recycling may become priority issues that require input by the hygiene promotion teams. The focus of work will often become broader than just WASH and may incorporate other public health issues.

The table below outlines some of the key activities in the post emergency phase:

Table 6: Key Activities in the Protracted Phase

	Key HP Activities	Means
a.	**Carry out a review of programme drawing on recent monitoring and evaluation data to identify gaps in response**	▪ Collaborate with government stakeholders and other organisations ▪ Promote staff learning through on the job and workshop based discussion ▪ Identify who has been excluded, bottlenecks, training needs ▪ Analyse and share results – including with community
b.	**Consider alternative or new HP approaches (as funding allows) but ensure that community involvement and decision making is at the forefront of this**	▪ Select approaches to address findings of the review ▪ Further formative research may be necessary
c.	**Revise HP strategy including advocacy plan and encourage government stakeholders to take the lead**	▪ Coordinate and work closely with Government WASH and health departments ▪ Coordinate with other WASH actors and involve health and nutrition actors ▪ Examine how strategy can be aligned with government country strategy
d.	**Review community based workforce numbers but continue to support, train and motivate them**	▪ In collaboration with government, health, nutrition and community services actors and in discussions with community
e.	**Identify HP research gaps**	▪ Collaborate with other stakeholders ▪ Develop links with national and international research institutions ▪ Support joint funding applications
f.	**Involve refugees in making decisions about the WASH response and seek their feedback on the intervention and how to improve it**	▪ Share programme information and invite refugee comments and feedback in community and group meetings ▪ Continue to seek regular feedback through regular ‘listening exercises’ ▪ Pass on non WASH related concerns to others

Practice Example 4: Model Family Approach

Model Family Approach

The model family approach is based on the assumption that through training and accreditation, model families will be able to set an example and encourage communities to embrace healthy lifestyles. In 2014, ARRA started implementing the approach in all five Dollo Ado refugee camps in Ethiopia. Families who were influential and who actively participated in immunization, nutrition and family planning programmes were key criteria for the selection of the model families as well as latrine use and positive hygiene practices. It was also ensured that there was an equal distribution of families across the camp blocks.

Selected families received three months training on the 16 health extension packages with daily coaching and monitoring by trained outreach workers. At the end of the three months' training course, each family undertook practical tests (observation and oral tests) to qualify for graduation. Post graduation follow up sessions led by outreach workers also ensure the continued support for the exemplary practices of the model families. Over almost 3 years, 8253 families have graduated and the plan is to have 20% model family coverage - 1 in 5 families – in line with the Ethiopian Government system.

Adapted from: UNHCR Model Families Approach Brief

Monitoring

Where monitoring shows that interventions are not having any effect, it is paramount that changes are made or that new approaches are introduced.

In this phase attempts should be made to incorporate monitoring into existing government systems. A review of the indicators to determine how useful and feasible they are is useful and changes to the timing of data collection will also need to be determined. The important thing to bear in mind is that only data that will be used should be collected routinely.

It may also be possible to conduct specific 'learning exercises' or reviews on specific areas of concern such as School WASH and hygiene promotion or menstrual hygiene management.

Accountability in Protracted phase

Promoting accountability to affected populations will continue to be important in the protracted phase. Involving refugees in future programme planning, looking for ways to be more transparent with project information and seeking feedback from refugees are still important components of any WASH intervention. In this phase there may be more opportunities to provide funding to support and/or train other stakeholders, including government officials on e.g. accountability to refugees and the use of standards. However, the greater availability of time will probably coincide with less available funding and difficult decisions will often have to be made. Advocating for increased funding for important issues such as promoting accountability may be required.

Practice Example 5: Soap Making in Nakivale Camp

Soap making in Nakivale camp in Uganda

One of UNHCR's partners in Nakivale refugee settlement is a Ugandan organization called Nsamizi who are working both on sanitation and livelihoods.

In July 2010 a soap making group was formed called 'Umucho' which means 'friendship'. The 42 members are a mixture of refugees from DRC, Rwanda and Burundi and they formed the group in response to the lack of affordable soap in the refugee settlement.

Nsamizi provided training on modern techniques of soap making and quality control as well as on business development and leadership. The group has started making soap that is now sold in the settlement area and has been market tested on various consumer groups in the settlements and Kampala. The Government of Uganda has now certified the product.

Users feedback on the soap included the following comments:

1. It is comparable in quality as that of the existing competitors.
2. It is cheaper and more affordable for the refugees.
3. It is available within the refugee settlement.
4. The raw materials are also purchased from within the settlement providing an income to other refugees e.g. the supply of lemon.

Photos: Nsamizi /Cang

Source: Nsamizi training institute for social development

Hygiene Promotion in urban areas

There is a limited amount of information available on working in HP in urban areas. However the principles of listening to refugees and persons of concern and involving them closely in the response remain the same.

Specific hygiene promotion interventions will be largely dependent on whatever water and sanitation response is thought to be appropriate and integration between those involved in the hardware provision and those responsible for the software will as always be vital. People may be living in collective centres, in rented accommodation or with host families.

Hygiene Promotion should focus on how to give refugees (and their hosts) a say in planning WASH interventions. For example if small scale household plumbing is required, it will be important to give people

a say in how this is done and in approving the work – just as they would do in their own homes. Some families may have the skills necessary to do such work themselves but may simply need materials – whilst others may need to have the work done for them by contractors. Such contractors will need to be trained to respond to people's specific needs and to work in an accountable way whilst refugees will need to be aware that they do have a voice in this process.

There may be tensions between the host community and refugees and so hygiene promotion interventions should also focus on trying to bring people together. In Jordan, during the Syria Response, Oxfam set up integrated peer groups of both refugee and host community women and provided information and advice services tailored to both their needs.

Practice Example 6: Using vouchers in urban areas

Hygiene Promotion in Host Communities

In August 2013, Oxfam conducted an emergency assessment of the water market in its programme areas in Jordan. This revealed that refugees were often purchasing directly from private water companies / vendors if they had enough money to supplement the piped water supply.

So Oxfam decided to distribute water vouchers to support both refugees and vulnerable families in the host community. Each beneficiary family received a booklet of 15 water vouchers valid for six weeks. Pamphlets were also distributed, providing information on the use of the water vouchers, their validity and the phone numbers of the water vendor and Oxfam's accountability hotline number.

Post-Distribution Monitoring aimed to assess beneficiaries' use of the vouchers as well as their satisfaction with the service provided. Every two weeks, the Oxfam team conducted random household spot checks to crosscheck the supply list of the vendor versus the actual delivery.

Taken from: Oxfam Briefing Paper 2014 Water Vouchers – a way to increase access to drinking water in Jordan's host communities

Coordination in urban areas

In urban areas, coordination and collaboration may become even more of a challenge because of the number of stakeholders. Private companies and contractors may be engaged to complete some of the WASH hardware or there may be numerous different government ministries involved in the intervention. It may be useful in such instances to sign Memoranda of understanding between the different parties. These MoU's should also detail what is expected in terms of community involvement and participation. Guidance should be provided to support all parties to understand the practical actions they can take to ensure accountability to affected communities e.g. being open to positive and negative feedback and ensuring that a complaints mechanism is in place.

Practice Example 7: Hygiene Promotion in Iraq

Hygiene Promotion in Iraq

In Erbil Governorate in Iraq, the majority of refugees and IDPs live with host communities in urban areas. Hygiene Promotion is linked closely to the provision of clean water.

To increase water access UNHCR is drilling 8 new boreholes, replacing old damaged booster pumps, installing new main water tanks and extending pipelines in various areas in the governorate.

Hygiene promotion with the community focuses on trying to prevent water wastage – especially during the summer months. Advocacy with the local authorities is also important to address some of the causal factors.

Some of the factors that contribute to the wastage of water are:

- Most water services are provided free of charge or at low cost and in most cases there are no meters.
- An inadequate reporting system for leaks so repairs are not done in a timely fashion
- Poor operation and maintenance of water supply facilities e.g. roof tanks without float valves and leaking taps also contribute to the wastage of water

Concerted efforts have been directed at advocating with the town mayor, relevant authorities and the directorate of water to start charging for water and to improve the reporting system.

Source: UNHCR WASH Officer in Iraq

Table 7: Overview of Hygiene Promotion in different phases and context

	Assessment	Coordination and Planning	Implementation	Monitoring	Other
Emergency	Rapid assessment to determine key risks, main obstacles to change, enabling factors and practical actions. Identify key cultural factors that will affect design and use of facilities. Identify requirements for sanitary pads and other hygiene items and mode of access (e.g. distribution, vouchers etc.) Begin process of identifying different groups and their respective WASH needs e.g. children, older people and people with disabilities etc.	Set up HP working group as part of broader WASH coordination In coordination with others develop initial HP strategy to cover immediate response – priority actions, who will do what, where and how. Update strategy as situation evolves Collaborate with others to ensure that WASH protection needs are met	Use mass media to ensure access to essential WASH information Identify, train and support community based workers Involve refugees in design of facilities as far as possible Seek feedback and suggestions on use, accessibility, and safety of existing facilities Ensure handwashing facilities are in place and in use Identify ways to support the management and maintenance of facilities with refugees. Ensure access to hygiene items and replenishment where necessary Track rumours/ misconceptions (especially in the case of outbreak response)	Obtain feedback on facilities and refugee satisfaction with these as well as suggestions for improvements Conduct rapid HH survey weekly Post distribution monitoring of distribution process, use and satisfaction and to identify any people left out Use communal latrine and handwashing monitoring checklists	Develop refugees trust by being as transparent as possible with information and seeking refugees input – don't pretend to know things that you don't know and encourage a sense of people needing to work together Work with other sectors to ensure refugees can begin to organize themselves and identify spokespersons and leaders – both women and men Ensure that protection concerns are referred on appropriately

	Assessment	Coordination and Planning	Implementation	Monitoring	Other
Transition	Coverage survey /KAP survey (who is being missed out and why) In depth qualitative study of hygiene practices to determine key motivations and barriers to action and ways to address these. Where appropriate conduct a comprehensive market analysis to understand the potential for WASH cash based interventions	Develop HP strategy to consider longer time frames, possible outbreak response and more comprehensive approach covering different groups and different methods depending on key issues e.g. schools, out of school children, women's and men's groups, youth etc. Review numbers and remuneration of community based workers	Continue to involve refugees in the design of the next phase of WASH facilities to encourage a sense of ownership and responsibility Strengthen existing systems for the management of any communal WASH facilities e.g. water points Training should focus on building refugee leadership capacity to identify and mitigate public health problems in collaboration with others Use a variety of HP approaches -experimenting with new approaches where old ones are not working (e.g. CLTS, sanitation marketing, motivational interviewing) Emphasize the use of participatory and interactive approaches rather than approaches that simply provide information Community workers and staff will continue to need support and refresher training to remain motivated (see HP guidelines)	Coverage surveys should be carried out every 6 months to 1 year. Keep the monitoring system manageable and only collect information that will be used Continue to seek qualitative feedback on the WASH response and keep track of how this has informed changes in the response Encourage refugee led monitoring wherever possible	Share project plans and community level budgets where possible – inviting refugee input

	Assessment	Coordination and Planning	Implementation	Monitoring	Other
Post Emergency/ Protracted	Ensure that assessment of refugee specific needs is situated within assessment of overall public health needs of host community	Integrate HP strategy into national WASH or Public Health policy and strategy Ensure that an outbreak response plan exists and that WASH is included in this Integrate outreach workers into existing government outreach systems (1:1000 or according to Government Standards)	Work closely with government WASH/ health, social welfare and education structures to integrate hygiene into on going work. Advocate on behalf of specific WASH needs of refugees and/or host communities Training should focus on self-reliance and sustainability	Review indicators and ensure that only those that are useful are being used. Ensure that monitoring data is used to influence and adapt the response. Identify ways to merge monitoring system with government systems	Share project plans and community level budgets where possible – inviting refugee and host community input
Urban Areas	Divide area into more manageable zones and assess specific WASH needs of different groups e.g. those living in rented accommodation, with host families, in collective centres etc. Identify refugee priorities and how WASH can fit within this. Ensure that the assessment takes account of host community issues and needs also.	HP strategy needs to be fully integrated into overall WASH strategy – however there may be a need to collaborate with other sectors also to ensure that the felt needs of the community are met (e.g. working with protection actors to ensure that refugees know how to access health, education etc.) Important to understand impact on host community and mitigate negative impacts by bringing people together to help each other.	Work closely with engineers to ensure involvement of community in any household /community level WASH improvements Identify different interest groups and include WASH discussions alongside other issues of interest such as health, education, sport, IT etc. Where possible respond to host community WASH needs and involve them in the response. Advocate on behalf of specific WASH needs of refugees and/or host communities	Where possible integrate monitoring into existing government systems. Ensure that monitoring tries to identify any negative impacts and seeks the views of both refugees and host communities.	Emphasise transparency and share project plans and community level budgets where possible – inviting refugee and host community input

Relevant Standards

Sphere Standards

The Sphere standards reflect the minimum requirements for a humanitarian response and the standards, indicators and guidance information outlined in the Sphere handbook provide useful guidance for all WASH programmes.

Whilst the minimum standards required for development should be much higher, it could be argued that Sphere is also relevant and useful in many long-term situations and at the very least provides a useful format for developing standards applicable to the long term.

The current 2010 edition of Sphere identifies one overarching WASH standard and 2 Hygiene Promotion Standards. In addition, all of the other standards on water and sanitation incorporate hygiene promotion issues, so that the 'hardware' and 'software' work together. The standards will be updated in 2018.

WASH Standard 1: WASH programme design and implementation:

All facilities and resources provided take account of the vulnerabilities, needs and preferences of the affected population. Users are involved in the management and maintenance of WASH facilities where appropriate

Hygiene Promotion Standard 1: Hygiene promotion implementation

Affected men, women and children of all ages are made aware of key public health risks and are mobilized to adopt measures to prevent the deterioration in hygiene conditions and to use and maintain the facilities provided.

Hygiene Promotion Standard 2: Identification, distribution and use of hygiene items

Disaster affected households have access to and are involved in identifying and promoting the use of hygiene items to ensure personal hygiene, health, dignity and wellbeing

Core Humanitarian Standard (CHS)

The CHS was developed in 2015 and will take the place of the existing Sphere Core Standards in the next edition of Sphere. They are designed to be used in conjunction with the WASH sector standards and are focused on ensuring greater accountability to affected populations and comprises nine commitments to them. It concerns ways of working that are applicable to all sectors including water, sanitation and hygiene promotion

UNHCR WASH Standards and Indicators

UNHCR has outlined specific quantitative standards that should be met in all WASH programmes.

These standards, along with the accompanying indicators, should inform every emergency WASH response.

3: Human Resources

Introduction

It is important to make sure that your programme is adequately resourced with appropriately qualified and experienced full time staff members who can ensure that hygiene promotion efforts are carried out in a planned and systematic way.

Hygiene Promoters on staff contracts should have a professional qualification in community development and/or public health and ideally be familiar with community development techniques and approaches.

It will usually be necessary to have one key person managing the hygiene promotion and software aspects of a WASH response as this ensures adequate focus and time is given to this important part of the programme. Additional staffing requirements will depend on the size and phase of the response and additional hygiene promotion officers or team leaders and hygiene promotion assistants may be required.

Key considerations will be ensuring the recruitment of staff at different levels. Team leaders and hygiene promoters will need to have the skills to interact effectively in interagency coordination meetings, develop strategic plans, provide capacity building to the hygiene promotion team and will also need to have the confidence to incorporate Gender, Protection and Accountability concerns into the programme. Hygiene Promotion Assistants will need to be able to directly manage and support the community-based workforce on a day-to-day basis as well as deliver training, undertake monitoring and report writing.

In an acute situation however, it can be difficult to recruit enough staff with the key skills required to undertake hygiene promotion and it may be necessary to recruit people who seem to have at least good communication skills, empathy and enthusiasm for the work and to provide additional training in other required skills.

Selection of Community Mobilisers

Outreach Workers or Community Mobilisers are usually identified from within the refugee population. In an acute emergency, where there is a very large influx of refugees or a significant outbreak of disease it may be warranted to pay financial incentives as mobilisers will be expected to work longer and more consistent hours. However, ideally community members are expected to volunteer their time (a few hours a week) for the good of their immediate community. Incentives can be provided but should be ‘in kind’ such as training opportunities, a bicycle or soap etc.

It is not necessary to have a medical or health background to do hygiene promotion – in fact those with a medical background will have to learn new skills in order to know how to use a community based approach. Social workers or community organisers can make very effective hygiene promoters because they have usually been trained how to communicate with individuals and communities and how to motivate them to take action.

These staff can take on roles as team leaders or hygiene promotion assistants but they will need to be well managed and supported - especially if they have little experience of working in humanitarian situations or on water and sanitation programmes.

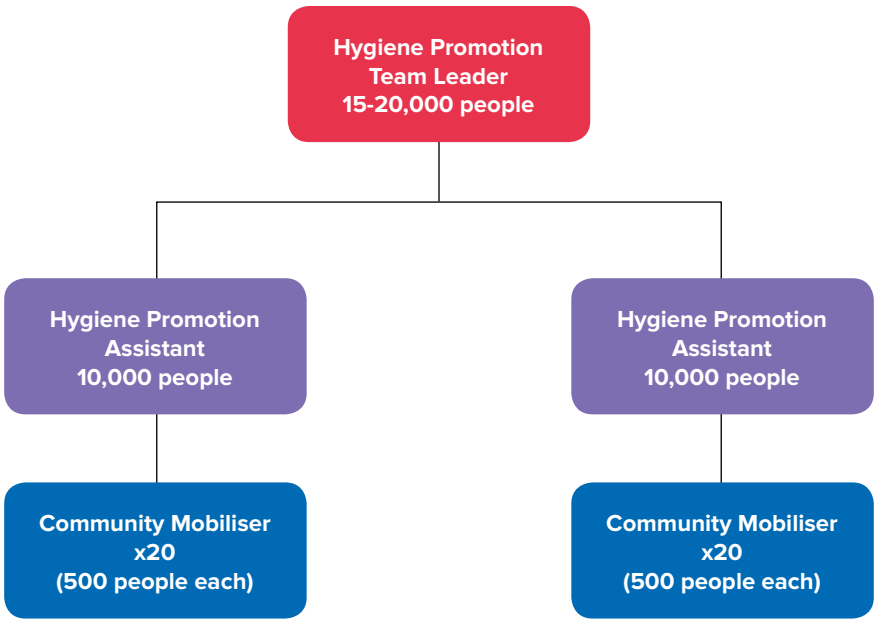
Motivation

In order to keep staff motivated they will need both training and on-going support. The Community Based Workforce as a whole (which will include other outreach workers from other sectors) will need to be co-ordinated closely to ensure there is no duplication of training or tasks.

Staffing Levels

Staffing levels for hygiene promotion will depend on the context and the phase of the response. In an acute situation where public health risks are high, there will be a need for higher rations of staff to population but this will normally decrease over time. The distance that needs to be covered by staff to allow them to carry out activities in the field or to conduct home visits also needs to be considered when identifying staffing needs.

Figure 8: Suggested staffing structure for Emergency Phase



Acute versus chronic situations

The above organogram is suggested for the *Emergency Phase* and over time this coverage will be reduced, combined with other sectors and eventually will be incorporated into existing government systems.

However, in many of the contexts that UNHCR works in there may be on-going influxes of asylum seekers and those who have recently arrived will often be more vulnerable than the longer term caseload. It is important that priority is given to working with these groups – especially when there are large-scale influxes and when public health risks are high such as during a disease outbreak.

In such situations the hygiene promotion component of the response may need to scale up and recruit more staff to meet the increasing demands as quickly as possible.

Importance of Co-ordination

Communication and coordination with the health and nutrition sectors, on the roles and training of all community level outreach staff is vital throughout the response. As the response progresses staffing will need to be rationalised and may be combined with community based workers from the health and nutrition sectors.

Job/task descriptions

Example job descriptions prepared by the WASH Cluster HP project are available here: http://pakresponse.info/LinkClick.aspx?fileticket=ZLR9x4WAI3M%3D&tabid=92&mid=639

Hygiene Promotion Coordinator

This person should have significant experience of working on hygiene promotion in the context of a WASH programme. They should have a professional qualification in public health and ideally have community development experience. They are primarily responsible for ensuring hygiene promotion outcomes and will manage a team of hygiene promotion officers carrying out activities at field level. They should be responsible for ensuring coordination and collaboration with other members of the WASH team, other agencies and other sectors such as community development, health, nutrition, education etc.

Hygiene Promotion Team Leader

This person should have a formal qualification or proven competencies in community development and/or community based public health and should have several years' work experience with communities. They must also have experience of facilitation and the use of participatory methodologies. **Team Leaders** (TL) are primarily responsible for managing the day-to-day hygiene promotion activities, with each **TL** managing several hygiene promotion assistants (depending on the population size, area covered etc.) in a specific location or sector of the camp or settlement. They work by identifying and/or initiating community structures or groups and mobilizing them to become involved in the WASH response. They will also have local responsibilities for co-ordination and collaboration with other stakeholders.

Hygiene Promotion Assistant

Hygiene promotion assistants should have proven competencies in working with communities and in the use of participatory methods. The hygiene promotion assistant will support the hygiene promotion team leader in carrying out the day-to-day hygiene promotion activities of the WASH response at community level. They work by establishing a relationship with community members that allows them to be an important interface between the refugee community and the agency. They will directly manage and support community mobilisers.

Table 8: Overview of key staffing responsibilities

	HP Team Leader	HP Assistant	Community Mobiliser
1. Coordination and collaboration	▪ Active participation in HP coordination meetings ▪ Advocacy with other stakeholders on issues identified by community	▪ Supports work of WASH team leaders – local coordination responsibilities	▪ Works supportively with community members listening to concerns
2. Individual and Community action	▪ Determines HP strategy ▪ Organises staff recruitment ▪ Trains HP Assistants and supports training of community mobilisers	▪ Trains and manages community mobilisers ▪ Organises community meetings as necessary	▪ Conducts household visits to identify WASH issues, discuss refugee WASH concerns and provide key information on the response. ▪ Organises community meetings
3. Use & maintenance of facilities	▪ Ensures coordination and communication with staff responsible for hardware and construction	▪ Seeks refugee input into the design of facilities ▪ Identifies obstacles to effective and acceptable use for different groups	▪ Encourages participation and feedback from refugees ▪ Mobilises households to maintain infrastructure
4. Identification and use of hygiene items	▪ Identifies needs and plans type of response e.g. cash, distribution, vouchers etc.	▪ Helps to organise and monitor cash or distribution	▪ Carries out NFI distribution with support
5. Participation & accountability	▪ Overall management of HP response ▪ Ensures gender, protection & accountability are incorporated	▪ Identifies community members at risk of exclusion ▪ Seeks feedback from refugees on satisfaction with the response and proposed modifications	▪ Helps to identify those at risk of exclusion ▪ Seeks feedback from refugees on satisfaction with the response and proposed modifications
6. Assessment & Monitoring	▪ Determines HP assessment and monitoring plan	▪ Supports formative assessments as required ▪ Conducts rapid HH survey and KAP survey ▪ Ensures HH monitoring is carried out effectively by mobilisers	▪ Carries out key HH and community level monitoring tasks Identifies rumours and misinformation and responds with support from HPA and Team Leader

Training and support

Training is a key component of hygiene promotion and will be needed at various levels of the intervention – both for staff and for community members. All training should incorporate adult learning principles and should be interactive and participatory. Training should focus on what is essential to know and on practical skills rather than just knowledge.

It will be useful for both incoming managers as well as advisors and evaluators to compile a training plan so that a record can be kept of what training has been undertaken and where the gaps are for the different levels.

Training materials for different levels of hygiene promoters were developed in 2007 by the Global WASH Cluster and are available from here: http://washcluster.net/?s=Hygiene+promotion+training

Compensation and incentives for community mobilisers

The issue of whether or not to provide financial incentives for community volunteers is often highly contentious – especially in emergency contexts. Government ministries will often have their own policy on this and discussions on the provision of incentives must involve the local authorities. Generally, it is not advisable to provide financial incentives as often there will not be the means to sustain them but incentives in kind (e.g. soap, t-shirts, recognition, bicycles etc.) are often necessary.

Compensation will depend on existing legislation and the number of hours that mobilisers are expected to work. The latter will be dependent on the level of public health risk. For example, if there is a cholera outbreak, then it will be important to intensify the number of home visits and efforts to ensure that people know how to protect themselves.

It must be made clear to all mobilisers or volunteers what compensation is available to them before they are selected and start work. The issue of compensation will probably be brought up by the mobilisers themselves regularly but should be discussed with them in an open and transparent way.

See the forthcoming publications **Community Based Workforce Operational Guidelines** and **Key Roles of Community Workers** for more information.

4: HP Approaches and Methods

Introduction

There are an often bewildering, array of different approaches and methods used in health and hygiene promotion and people often ask which is the most effective approach to use. The limited research has so far failed to identify definitively which approaches are more effective than others but community based approaches seem promising and can also contribute to other humanitarian objectives such as improving accountability to refugee populations and meeting psychosocial needs.

Key Hygiene Promotion Approaches

Only a few approaches are outlined here – they represent the most common approaches that are in use as well as some of the more innovative approaches that have recently been introduced. A table of all the approaches used and when they are used can be found on page 88 in the appendix.

Three approaches (Behaviour Centred Design (BCD), COMBI and RANAS) are covered separately in the WASH Frameworks section on page 100, along with details on their theoretical framework and how to apply this in practice.

Evidence

A very recent systematic review examining the effectiveness of a variety of HP approaches came to the conclusion that on the available evidence no one approach was preferable to the others. They did however find that working in a community based way and involving the community were effective in terms of sanitation and handwashing outcomes and approaches using interpersonal communication and interactive elements were also important.

The use of marketing mainly showed an effect in sanitation programmes and was less uniformly effective. Educational programmes (predominantly in Schools) seemed to have an effect but mainly in the short term. The study also noted that the use of theory-based promotional approaches (e.g. BCD or RANAS) 'seemed promising and warranted further research'.

Source: De Buck et al (2017 forthcoming) *Approaches to promote handwashing and sanitation behaviour change in low- and middle-income countries: a mixed method systematic review.*

Recent Innovations in Theory and Practice

Easy, Attractive, Social and Timely (EAST)[7]

The behavioural insights team, working for the British Government, to promote the use of findings from behavioural research in policy and practice, coined the term EAST as a simplified way to remember some of the insights into behaviour change that have been identified in recent years. Some of the approaches such as 'nudging' discussed later, also make reference to these behavioural insights. EAST stands for Easy, Attractive, Social and Timely.

1. **Make it Easy:** reducing the effort required to perform a behaviour can make it more attractive. Breaking down complex goals into simpler, easier actions can also be more effective.

   WASH Application: emphasise convenience of using toilets and ensure handwashing facilities are easily available. Consider what people will find easy to do rather than the ideal behaviour (see Small Doable Actions –SDA).

2. **Make it Attractive:** find ways to attract attention through personalisation, use of colour and images. Consider rewards and sanctions. Financial rewards, competitions and lotteries can be highly effective. Focussing on scarcity or an offer only being available for a certain length of time can also be effective. Competitions and games do not necessarily have to have a financial reward.

   WASH Application: Use colourful cues such as footsteps leading from the latrine to the handwashing station or mirrors at the handwashing station. Employ competitions, games and financial and non-financial rewards.

3. **Make it Social:** convey the idea that most people perform the desired behaviour - this encourages others. However, beware of inadvertently reinforcing a problematic behaviour by highlighting its high prevalence. Use the power of networks to provide support and mobilise collective action.

   WASH Application: Find out about social norms governing hygiene practices. Identify what people perceive others will think of them if they engage in the practice and try to change this perception if required. Encourage people to make public commitments to use toilets, wash hands or support others in building latrines. Focus on groups and communities not just on individuals.

4. **Make it Timely:** Prompt people when they are likely to be most receptive. Behaviour is generally easier to change when it has been disrupted such as around major life events such as childbirth. We are most influenced by costs and benefits that take effect immediately rather than those delivered later. There is a significant gap between intentions and behaviour. Help people to identify barriers to action and develop a plan to address them.

   WASH Application: Presenting attractive and motivational reminders to wash hands immediately after people have left the toilet (e.g. posters) may be more effective than providing this information at other locations. Enable people to identify possible barriers to the action before they occur and to think of strategies to overcome them – for example using dig and bury for disposing of faeces when not at home.

The paper makes the important point that context is everything and that such behavioural insights should always be trialled before use.

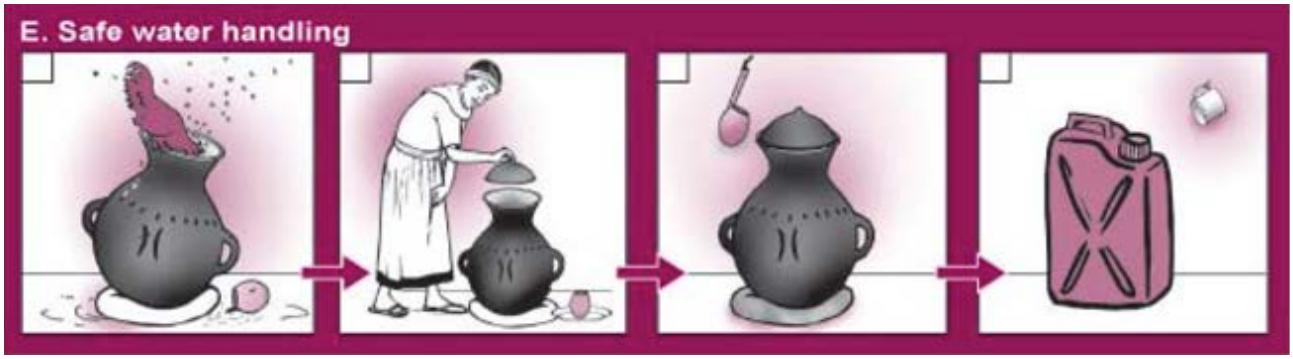
7 Adapted from: Service, O. et al (Behavioral Insights Team) (2014) EAST Four simple ways to apply behavioral insights in partnership with Cabinet Office, Nesta.

Small (Immediate) Doable Actions (SIDA)

Hygiene Promotion often focuses on trying to achieve 'an ideal behaviour' e.g. every member of the household using an improved toilet all of the time. The emphasis on small doable actions recognises that the ideal practice can often be difficult to achieve all at once and there is a need for negotiation on what is possible for each household or community.

The action should be not only feasible from the point of view of the household but also effective. So where it is not possible to use a latrine – perhaps when someone is away from home or working in the fields, then an effective and practical action might be to dig and bury faeces.

Below is a discussion aid that illustrates the possible progression of small doable actions with a specific context in Ethiopia.



The community mobiliser will need to be trained to identify potential issues for change and then negotiate with the household on what changes can be made. The mobiliser can ask questions such as:

- What makes this action hard to do?
- What would make it easier?
- Who will support you to do it?
- What problems might you face if you do it?
- Who will approve/disapprove of you if you do it?

In this way the mobiliser aims to obtain a commitment from the individual to try out the action for a length of time and then should visit again and discuss how it went.

Habit formation and the use of cues and nudges

Habit is a learned behaviour that has become automatic because it has been practised numerous times often in the same context, such as cleaning teeth before going to bed, wearing a seat belt or handwashing with soap after using the toilet. It is usually triggered unconsciously by familiar cues in the environment and behaviours can be triggered, disrupted or changed by using such behavioural cues.

Current research suggests that there is often not enough focus on habit formation in behaviour change programmes but rather they focus on changing conscious knowledge and attitudes for the most part (Neal et al 2013 and 2015).

A variety of cues have been used in research into habit formation in water, sanitation and hygiene. Banners, bunting and other dangling objects can be hung around the handwashing station to draw attention to it. Coloured footsteps leading from the latrine to the handwashing station or simply coloured latrine doors have helped to encourage use.

More information can be found here: http://www.washplus.org/sites/default/files/resource_files/habits-neal2015.pdf

CLTS /SLTS /CATS

Community led Total Sanitation (CLTS) and variants such as Community Approaches to Total Sanitation (CATS) facilitate communities to analyse their current sanitation practices to motivate change. School Led Total Sanitation (SLTS) as its name suggests applies the CLTS process to a school setting to trigger children to engage in sanitation.

The process aims to 'trigger' a sense of shame and disgust at current poor hygiene practice such as open defaecation that is strong enough to motivate sweeping changes in practice that are in effect driven by peer pressure and led by the community itself. The triggering leads to an 'ah ha' moment of self-discovery as people understand that they may unwittingly be 'eating shit' and they are then facilitated to come up with an action plan to address this.

The provision of subsidies is seen to undermine people's motivation to take immediate action – although this rigid stance is being questioned particularly as it relates to long-term sustainability and meeting the needs of the poorest.

It is important that handwashing motivation is incorporated into any CLTS intervention and specific triggering tools for motivating handwashing have been developed. 'CLTS Plus' variously aims to ensure that handwashing elements, sanitation marketing, solutions for difficult conditions or inclusive programming (including those who may be disadvantaged) or other additional programme elements are incorporated into the intervention. For more information see: http://www.communityledtotalsanitation.org/

PHAST /CHAST

PHAST (Participatory Hygiene and Sanitation Transformation) provides a step-by-step hygiene and sanitation promotion field guide aimed at community level field workers. The methodology focuses on participatory learning and aims to encourage the uptake of hygiene and sanitation through regular contact with community groups over a period of time. The groups are guided through a systematic series of interactive activities that encourage community assessment and analysis of the hygiene and sanitation problems that people are facing. Through discussion and debate, a community-defined response to these problems is encouraged. The methods used are similar to many PLA (participatory learning and action) methods but the process is less open-ended and guides people towards solving sanitation and hygiene issues.

The process involves seven steps that roughly follow the programme cycle of assessment, analysis, planning, implementation, monitoring and evaluation. Each step has accompanying tools (picture sets etc.) or activities that support the process and allow people to conceptualise and think through the issues. The steps should be followed in order as each step equips participants with the capacity to move to the next step, enabling people to overcome the previous constraints to change. The participatory approach aims to build people's self-esteem and confidence to work together to make changes.

However, the participatory process requires a certain amount of skill by the facilitator and demands an attitude of respect for people's knowledge and potential. In many situations the PHAST process is used in a very mechanistic way without adequate support to develop the facilitators' skills. The preparation of the toolkit and training of facilitators can take some time and it may be very difficult to introduce PHAST in an acute emergency context. However, the individual tools can provide useful ways to get groups talking and thinking about what they can do together to address sanitation and hygiene problems.

Various agencies including IFRC and Oxfam have sought to adapt PHAST for the emergency context. This has become known as FASTER PHAST and it shortens the process to three or four steps instead of seven.

CHAST adapts the PHAST tools and approaches for use with children.

For more details and a copy of the PHAST manual see: http://www.who.int/water_sanitation_health/hygiene/envsan/EOS96-11a.pdf

Child to Child

Child-to-Child is an approach that recognises that children can be a force for change in both influencing their peers and other members of their family and community. In many situations children are responsible for taking care of their younger siblings and are thus in a position to encourage them to wash their hands, safely dispose of faeces, use mosquito nets and practice positive health and hygiene.

The child-to-child approach can be introduced in schools during after school clubs or as part of a strategy for a 'health promoting school'. Activity sheets provide teachers with ideas for structured lessons that focus on a variety of health issues. See the section on Implementation for more information on how to include child to child in the hygiene communication response. More information can also be found at: http://www.child-to-child.org/resources/onlinepublications.htm

Social Marketing

Social marketing involves the use of marketing techniques to influence people to adopt changes or use/buy a product that has some social value such as mosquito nets, condoms, household water treatment or the practice of handwashing. It involves a significant period of formative research to understand what will motivate people to buy or 'buy into' the product. The 'customer' or 'user' is at the heart of the design of subsequent response strategies.

In order to reach large populations, significant use is made of the mass media but interactive methods are not ruled out. PSI (Population Services International) works in many countries on various social marketing strategies including many that are relevant to WASH such as promoting household water treatment technologies or the use of soap for handwashing.

Where social marketing campaigns have already been devised or where social marketing organisations are well established in country, it may be possible to adapt strategies and materials for use in an emergency but otherwise this approach will not be appropriate for an acute situation. However, the emphasis in social marketing on understanding the consumer perspective is an important lesson to apply to all hygiene communication initiatives. Techniques that are used in social marketing such as 'doer/non doer' analysis are very helpful in understanding what might motivate change.

A Public-Private Partnership (PPP) is a contractual agreement between a public agency (federal, state or local) and a private sector entity. The skills and assets of both the public and private agencies are maximised in delivering a service or facility for the use of the general public. Social Marketing programmes are often delivered in this way.

For more information see:

http://www.dh.socialmarketing-toolbox.com/content/what-social-marketing-1

Motivational Interviewing

Motivational Interviewing is an approach that can be used to develop an individual's motivation to change. It has been used in many countries as a counselling technique to encourage people to modify health behaviours or to treat addiction. To date there is limited documented use in the WASH sector although it has been used in Zambia to promote the use of water treatment methods and elsewhere to promote handwashing amongst hospital staff.

The facilitator or community mobiliser engages the individual in 'change talk' where the individual is supported to identify the reasons to change, what might prevent or aid this change and what the disadvantages of doing nothing might be.

A variety of tools can be used including visualisation and scaling. In the latter people are asked to rate on a scale of 1-10 how important the change is to them and how confident they feel about making the change (see below). According to their rating they are then asked how they could move up the scale and what would need to change to allow them to do so. The facilitator would then support them to develop a change plan by setting goals and brainstorming options.

For more information see: http://www.motivationalinterviewing.org and

Fuller, T & Taylor, P. (2011) A Toolkit of Motivational Skills, John Wiley and Sons, England

Sanitation Marketing

As with social marketing, sanitation marketing draws on marketing principles. Formative research should form the basis for an understanding of what people want and what they are willing and able to pay. It assumes that people both want and are able to change their sanitation practices.

A well-designed communication campaign is critical to the success of the approach. Sanitation Marketing will normally involve collaboration with microfinance institutions and community based micro enterprises.

Such an approach will not be feasible in the acute emergency phase of an emergency but may hold potential in longer term protracted situations.

For more information see the WSP sanitation toolkit:

https://wsp.org/toolkit/what-is-sanitation-marketing

Example Tools for Hygiene Promotion

There are a huge variety of hygiene (or health) communication methods that can generally grouped together as:

- Interpersonal communication (peer to peer, household visits, group discussions, committees, champions, natural leaders etc.)
- Traditional communication (theatre, puppets, songs, stories etc.)
- Mass media communication (radio, newspapers, leaflets, social media etc.)

Below are just some examples of useful tools that can be used to stimulate discussion during household visits or in group discussions.

Motivational Interviewing Tools

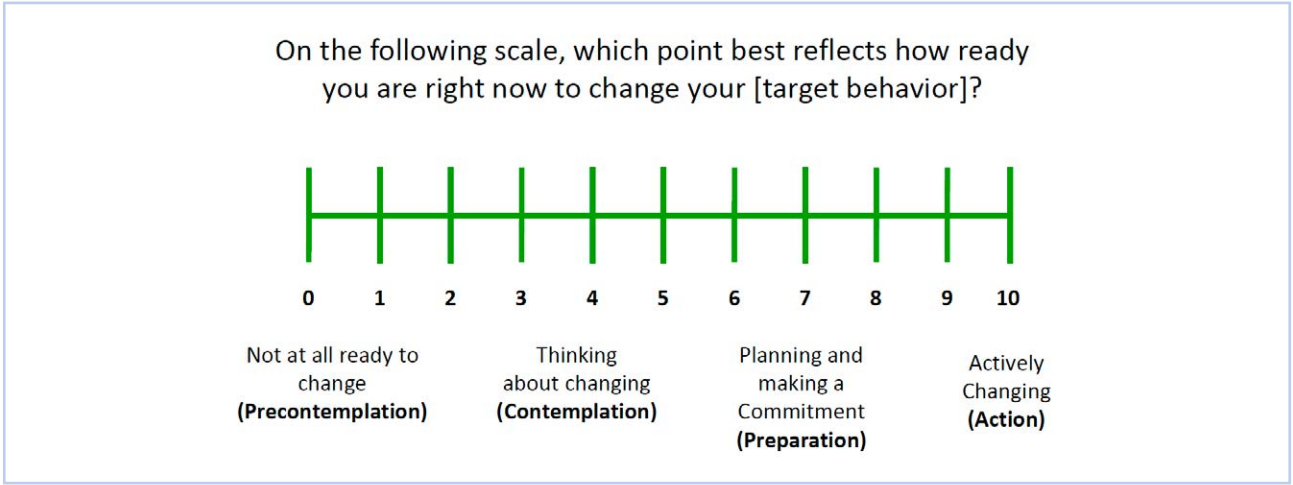
Motivational interviewing techniques and tools can be used during interpersonal communication. These can be used to try and elicit change talk. It is not necessary to use all of the tools and they can be adapted to suit the situation. The **OARS** tool in particular can simply enhance communication skills and ensure that the community mobiliser remains focussed on change but doesn't try and impose their own beliefs on the person they are working with.

1. Self-assessment scales and rulers:

For example the hygiene promoter could ask about sanitation practices or the use of household water treatment:

On a scale of 1-10 how ready are you to make this change?

Figure 9: Readiness Ruler. Source: Adept (2013) Motivational Interviewing Tools and Techniques



Scales could also be asked to find out about how important the change is and how confident someone feels to make the change.

On a scale of 1-10 how important is this change to you?

On a scale of 1-10 how confident do you feel to make the change?

Depending on the rating given, the interviewer can then ask why that rating was chosen and why not lower – thus usually establishing some positive pre-existing capacity to change. Asking how to reach the next level can help to identify possible actions and any perceived barriers to change.

2. Examining pros and cons

This can help the individual to weigh up the positive and negative aspects of their practice and can help to enhance motivation. Pros and cons can simply be discussed or can be listed as reasons to change and reasons to stay the same.

3. OARS

This stands for:

a) **O**pen ended questions:

Don't ask yes/ no questions but rather e.g.:

- Can you tell me about how you are managing to keep healthy in this situation?
- What sort of problems are you facing when you prepare food for your children?
- How do you collect and store your water?
- How do you normally manage your child's poo?
- Can you explain how these living conditions make you feel?
- What things would you like to change to improve the hygiene situation here?

b) **A**ffirmations

- It is difficult to manage when you live in a tent but you have made it very homely
- You are really thinking about how to keep your children healthy
- You are trying to ensure normality for your children

c) **R**eflections

Communicate back to the person that you have listened and cross check that they agree with your interpretation:

Mother; I don't have the resources to be able to dig a latrine and I don't have a husband to help me

Mobiliser: You feel that it is not possible to dig a latrine because you don't have the tools to do this – and maybe you also feel that you don't have the strength?

Mother: Well I might have the strength to dig a shallow pit but I don't know how to make a slab.

There are certain 'universal safe reflections' that can often be adapted to many situations such as:

- It sounds like you are feeling..
- It sounds like you are not happy
- It sounds like you are having trouble with...
- In other words you are saying...

d) **S**ummaries

The aim of this is to summarise what you have both discussed before leaving and to recap on what was decided and what actions can be taken before the next visit.

Practice Example 8: Motivational Interviewing

Using Motivational Interviewing to Promote Household Water Treatment and Safe Storage

In Zambia, CDC and PAHO promoted household water treatment (HWTSS) using locally produced chlorine solution combined with a 20 litres narrow-mouthed plastic storage vessel with a lid and spigot, and education in using the system. Motivational Interviewing (MI) was used to augment the educational component and to increase the adoption of the system at the household level.

Five neighbourhood health volunteers were trained in MI and made household visits to encourage the use of the new system. Rates of purchase of the disinfectant were much higher in the group using motivational interviewing than in a control group. Higher purchase rates in the MI group were sustained over 8 months of sales monitoring. Another study in a different community in Zambia coincided with a health education campaign of the safe water system. Eighteen neighbourhood health volunteers were trained in MI, which was delivered in visits every four weeks to households. Measurement of chlorine residuals in household water took place three months following the MI intervention. These follow up measurements revealed a 16-fold increase in chlorine residuals in the MI group (65%) compared to group that were exposed to the health education alone (4%).

Source: http://motivationalinterview.org/clinical/safewater.html

Tools combining assessment and Intervention

Behaviour trials

Behaviour trials involve asking people to try out specific behaviours for a limited period of time and then discuss how they found this. For example volunteer mothers can be asked to try out handwashing with soap at key times for one or two weeks. They will then be visited at home and asked questions such as:

- How easy did you find the practice?
- What did you find difficult about it?
- What specific problems did you have?
- How did you overcome them?
- What did you like/dislike about the practice?
- How easy was it to remember to carry out the practice? What would make is easier to remember?

You could even ask them if you could film them doing the practice and play it back to them to provide the basis for further discussion. Make sure that you ask permission to do this and delete any material once you have finished the discussion.

Video Ethnography

This involves videoing specific health and hygiene practices such as handwashing or infant feeding and then playing this back to the participants in order to elicit their understanding of why they do or do not behave in a particular way.

The aim is to try and carry out the recording unobtrusively so that the person being filmed forgets that this is being done. It is therefore preferable to train people living in the same context to do the filming.

The facilitator/researcher can then play back segments of the footage to the participants in order to discuss the practice under investigation in more detail.

Once again care must be taken to ensure that informed consent is sought and that privacy is respected.

Scripting

This is a technique taken from cognitive psychology and is similar to Daily Activity Charts or Activity Clocks used in PRA. The participant(s) are asked to identify the different practices they carry out within a certain time period and to put them in order. Pictures can be used to represent each activity.

Once the order has been sorted out then questions can be asked about specific activities of interest or even about activities that might have been left out (because they are perhaps embarrassing) such as going to the toilet.

A full list of different approaches and when they are applicable can be found in the appendices.

Working with Children

Hygiene Promotion efforts will need to be tailored to specific age groups and should involve both school children and those who do not go to school. It is important to collaborate with other agencies that may also be working with children and it is vital to ensure that child protection policies are adhered to.

The involvement of parents, teachers and the children themselves in planning any intervention is recommended.

Evidence

Proper disposal of children's stools (Yeager *et al.* 1999), is an important part of many hygiene promotion campaigns and likely to benefit children. A meta-analysis of observational studies of infants' faeces disposal practices found that unsafe disposal increased the risk of diarrhoea by 23%, highlighting the importance of the safe management of both adults' and infants' faeces

Source: *Mara et al. 2010 cited in DFID (2013) Water, Sanitation and Hygiene Evidence Paper*

The findings from an eleven country review into handwashing found that, 'on average, only 17% of child caretakers handwash with soap after the toilet' and that, 'handwash 'habits' were generally not inculcated at an early age' and explained that 'handwashing practices are often automated and habitual, and established during childhood'. The review went on to suggest that:

'While mothers may not make specific long-term plans to avoid disease, they do plan to teach the social arts to their children. Persuading mothers that a child that washes hands with soap is demonstrating good manners may be an effective means of getting habits established early.'

Source: *Curtis et al (2009) Planned, motivated and habitual hygiene behaviour: an eleven country review.'*

Figure 10: Example Qualitative methods for understanding hygiene in schools[8]

Physical Environment and Handwashing Behaviour	
Structured Observations	Watching what children do around toilets and handwashing to know exactly what is and isn't going on and to understand the environment within which handwashing should take place.
Behaviour Trials	A one-week 'experiment' where children in specific classes are enabled to wash their hands with soap because experiencing regular handwashing helps individuals learn the 'feel' of a specific behaviour so they can report on it in a more accurate and real way.
Children's Psychology and Media Influences	
Handwash Detectives	Children 'spy' on other children's unsafe hand washing practices and report back through drawings (younger) or photos (older). This uncovers additional insight on behaviour plus on what understanding children have of what is adequate/inadequate hand hygiene.
Motivator Pictures	A focus group in which children explore their motivations for handwashing to help understand the fundamental motivators around hygiene; it provides deep insight into what is likely to shift children's behaviour.
In-depth Diaries	Structured 24-hour diaries are given out to understand what the children do and what media and influences they are exposed to outside as well as inside school.
What's New	'Junior researchers' must discover how the latest trends and fashions – in language, games, music, jokes, stories, etc – filter into the classroom or playground, through informal as well as formal channels to see what becomes popular and how, and to identify the channels used by students to learn about the world outside school.
Policy Environment and School Culture	
Moments that Matter	A group discussion with school leavers, reflecting on what stands out from their time at school to discover where and when handwashing messages and activities can most effectively be fit into the school calendar.
Who's the Boss?	Workshops designed to determine the power structure within a school and how its operating procedures might affect children's behaviour, because what children do in school is a function of their incentives, and their incentives, in turn, depend on who can tell them what to do and reward them for doing it.
School 360°	Interviews designed to elicit the barriers, motivators or opportunities that might influence the running of a handwashing programme in a school.

8 Taken from: Getting Children to Handwash with Soap: A Guide for Conducting School-Based Handwashing Programmes, LSHTM/Hygiene Centre for Unilever PLC

Ideas for activities with children

"The Blue Hand Game

The blue hand game is a game used by WaterAid's hygiene educators in villages and towns in Africa and Asia. The game was developed to show children how easily germs are spread and get them thinking about what can be done to stop it as well as illustrating the importance of hand-washing. Put blue chalk on the children's hands and ask them to continue with another activity or cover a ball with blue chalk and ask them to play 'catch'. After five minutes the blue chalk is everywhere. Ask them to imagine the blue chalk represents germs so they can see how easily they are spread and how important hand washing is. This might be a good one for outdoors, but chalk is generally easy to clean off most surfaces.

Soap and Suds

The soaps and suds game teaches children the importance of washing their hands. For this activity, you will need: two washing bowls (at least!), one bar of soap and one jar of the spice turmeric. Cover all students' hands with the turmeric. Be careful to avoid their clothes. Divide the class into two groups. Each student has one minute to wash their hands. One group uses soap and water, the other just water. Each student should then dry their hands on a piece of kitchen towel. The ones who didn't use soap should leave a yellow dye on the kitchen towel. The turmeric represents germs and teaches students the importance of washing their hands with soap. This simple act can stop two in five people from suffering from water borne disease

Mosquito

This activity should be carried out in an area with lots of space for running, ideally the school hall or the playground. One child is 'Mosquito'. Mosquito will aim to catch other children as they try to run away. When a child is caught they are out of the game. This game warns schoolchildren of the dangers of malaria. This is a killer disease, carried by mosquitoes. A mosquito is an insect that lives off human and animal blood. As it takes the blood it can also transfer malaria from another sufferer. In this way the disease is spread very quickly. Mosquitoes often gather around pools of stagnant water. Children are taught not to leave wastewater to stagnate, and to cover buckets of water, left over water can be used to water kitchen gardens.

Fly

You will need one plate of biscuits or similar tempting treats! The students will need to form a protective circle around the plate of goodies. Their aim is to protect the plate of food. Meanwhile two other pupils, acting as the flies, will try and get into the circle and steal the food! This teaches students the importance of covering their food and water from flies. Flies are responsible for the transference of many nasty diseases such as Trachoma and dysentery.

Sanitation in my Neighbourhood

Children in Madagascar were given cameras to take pictures of what they thought was sanitation, both good and bad. Get the children to draw pictures of how they use water, sanitation and hygiene education in their day-to-day lives."

Source: WaterAid www.wateraid.org

The websites below also have useful material:
www.schoolsanitation.org
www.health.qld.gov.au/healthyschools/toolbox.asp
www.freshschools.org

Working with Women and Girls

Women and girls will also have specific needs and may have specific obstacles to ensuring hygiene. The safety and privacy of WASH facilities is crucial and women should be involved in the design and siting and their feedback on facilities must be sought.

The MHM in Emergencies Toolkit provides a wealth of information about responding to the specific needs of menstruating women and girls. See **A Toolkit for integrating MHM into Humanitarian Response.**

Consider the following:

- Have women and girls been involved in the design and siting of WASH facilities?
- Have you asked for feedback on:
  - Accessibility, safety and privacy of facilities?
  - Suitability of MHM products and facilities?
- Do women and girls have adequate means to manage their periods with dignity? (Sanitary pads, laundering or disposal facilities, information on MHM)
- Is there a need for separate discussion groups with women and girls or do age groups need to be separated?

Source: A Toolkit for integrating MHM into Humanitarian Response

Hygiene Promotion Troubleshooting

Every situation will be different and everyone working on a WASH programme will need to listen carefully to the particular issues that refugees and people of concern to UNHCR are saying about the constraints and problems they face.

Below are just some example suggestions for managing some of the problems that are commonly voiced by community members. It may be helpful to make a list of the problems you face in your situation and identify some additional suggestions for discussing these issues with communities.

Troubleshooting Tips[ii]	
What to do if:	**Suggestion**
People complain about the taste of chlorine	Verify that the amount of chlorine they are using is correct for the quantity and cloudiness of the water. Explain that the measure is temporary and discuss the importance of trying to prevent acute diarrhoeal disease and cholera especially in young children and babies even if adults refuse to drink the water.
People don't like the taste of boiled water	Suggest that they pour the water back and forth using 2 clean containers or shake the water well in a bottle. Adding a very small pinch of salt can also help to restore the taste.
People say there is no soap available	Suggest they keep a small pot of ash by the handwashing facilities and use this instead. Other possibilities for handwashing are sand, or 'lemon tree leaves'.
People complain of the smell of the latrines	Suggest they collect a large quantity of ash and pour this on top of the faeces. The use of vent pipes with fly mesh can also be used to reduce the smell.
Family members are not able to share the same latrine	Discuss the issue in small groups and ask participants to make some suggestions for addressing the problem e.g. 2 families sharing 2 latrines so that different members do not have to share.
People believe that witch-craft is the cause of cholera	A scientific understanding of disease is not always necessary for people to make changes. They may be motivated by something other than improving health such as a sense of disgust that they may 'eat' shit if they don't wash their hands (as in the CLTS methodology).
Children's faeces are safe	People may believe that children's faeces do not cause disease but they may still not want to 'eat' them! Pull a hair from your head (which represents the size of a fly's leg) – drag it over some children's faeces and dip the hair in a bottle of water. Ask if anyone wants to now drink this water!
People don't like to use soap for washing hands before eating because it makes the food taste dif-ferent	Suggest that they use a brand of soap without a strong scent and rinse their hands thoroughly when washing. Explain that not washing hands with soap could mean that they are eating someone else's 'shit' along with their tasty food.

ii Taken from Tanzania WASH Toolkit E –Hygiene Communication in Emergencies

5: Behaviour change models, theories and frameworks

Introduction

It is useful to have an understanding of the theory and concepts underpinning behaviour change although it must be borne in mind that no one theory has been shown to be preferable to another – rather they can all help us to understand some of the complexity of human behaviour and provide a systematic way to help shape an intervention and to devise a theory of change.

Several models focus on the individual whilst others place more emphasis on the individual within their immediate context. Others consider how collective behaviour change happens. The social ecology model provides a useful way of considering different levels of intervention.

The Behaviour Change models outlined below (and in the appendix) can be applied to diverse contexts but it is important to also incorporate an understanding of gender, age, ability and other socio-economic factors when planning an intervention.

Most theories have been adapted from the social and behavioural sciences and draw upon a variety of different disciplines including Psychology, Sociology, Anthropology and Marketing.

The use of more than one behaviour change model may be useful in informing the different elements of any hygiene promotion intervention.

Common Principles in Behaviour Change Theories and Models

- Knowledge does not equal behaviour change.
- People are at different stages of acquiring behaviour.
- Psychological beliefs and values matter.
- Rewarding experience fosters behaviour change.
- Social relationships and norms are important.
- Behaviour is not independent of the context.
- Research and evaluation should guide our efforts.

Source: Oxfam Briefing Paper Behaviour Change in Water, Sanitation and Hygiene Promotion TB (19) V1

Key Concepts

Several models make use of the concepts of attitudes, values and beliefs, self-efficacy and social norms. These are briefly explained below.

Self-efficacy

Self-efficacy relates to the person's perception of their ability to do something and create the desired effect and can play a major part in how one approaches goals, tasks and challenges. People with high self-efficacy often persist longer and make more of an effort than those with low self-efficacy. Numerous studies on health behaviour have measured self-efficacy to assess its influence on people's intention to change and their success in changing behaviour.

Why is self-efficacy relevant?

A family that has experienced traumatic incidents (such as different types of violence), and that is living in very deprived conditions, may find it difficult to change their hygiene practice (for example, cleaning the home environment in order to avoid being exposed to illness). Indeed, the effect of their past and present difficulties, in terms of self-esteem and self-perception of capacity may hinder their ability to change. In such a situation, some interventions may be insufficient or unrealistic for this family (for example, only providing information on hygiene practices). Other interventions aimed at providing support to increase their self-esteem and self-efficacy, may be more successful, e.g. regular home-based counselling, individual support or peer support groups.

Adapted from: ACF Assisting Behaviour Change

Social Norms

Social norms are the 'rules of behaviour' that are considered acceptable in a given context. People who do not follow the rules are often shunned or stigmatised and there is often significant pressure to conform. They can help to regulate conduct but will often differ from culture to culture. Norms can cover what we should do (prescriptive) and not do (proscriptive) or cover what happens (descriptive norms – what most people do) and what should happen (injunctive norms – what we think we should do).

Attitudes, values and beliefs

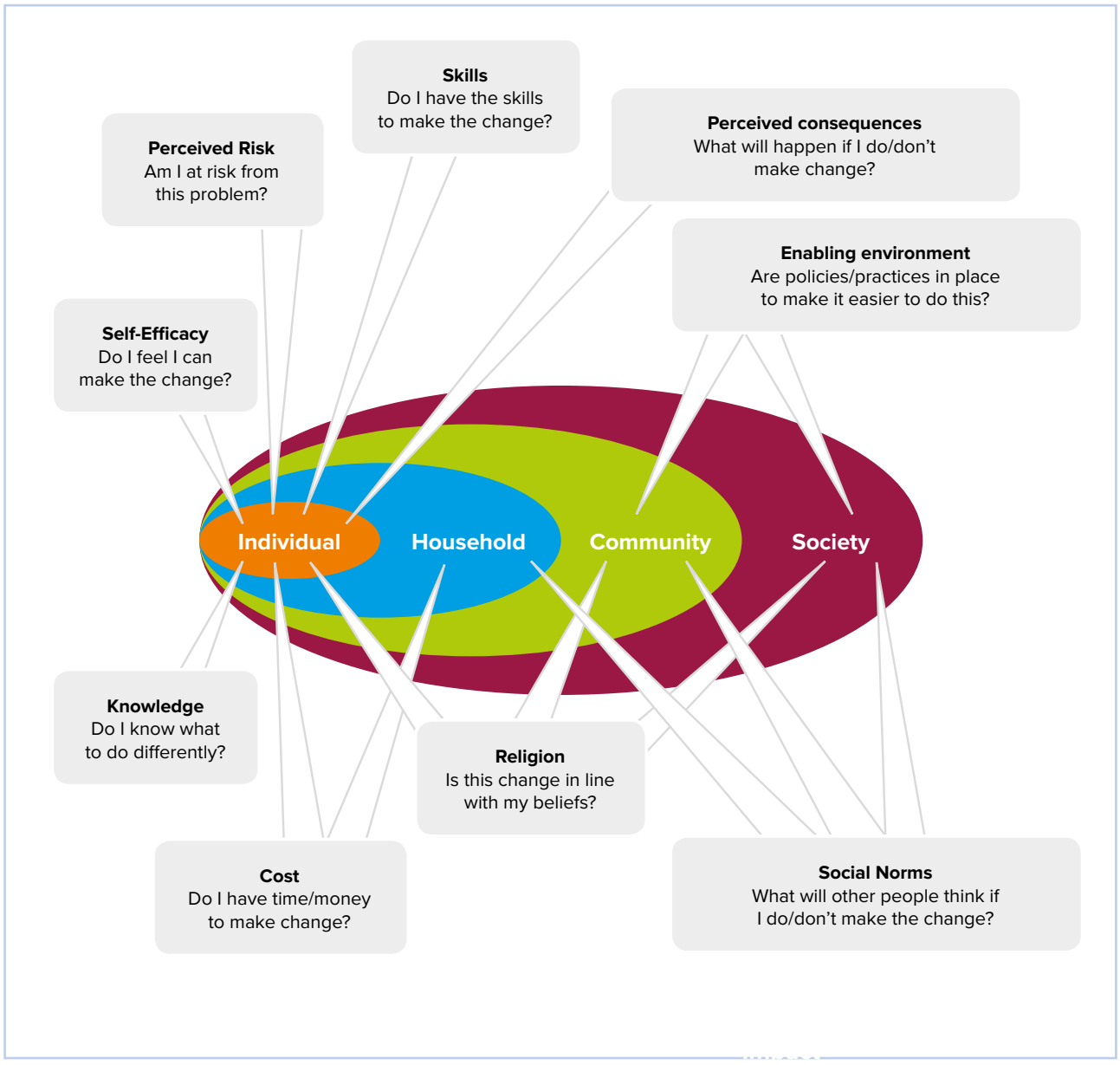
A value is the measure of the worth that someone attaches to something e.g. the importance of sanitation or handwashing. Beliefs represent what you think you know about something or someone and attitudes are how you express those beliefs and values. In some countries there is the belief that water should be free of charge and this would therefore make it difficult to convince people to pay for it. In some countries people might value a particular water source as they believe it has spiritual significance e.g. The Ganges in India.

How does change happen?[9]

When considering how change happens, it is useful to think of the individual living within their context and of the different levels of influence on his/her life. An individual may be influenced by their background, education, history and individual psychology as well as by social and cultural norms and values held by their family, community or society. Whilst not exhaustive, the diagram below gives some examples of these influences and how they work at different levels.

It is also important to consider what factors might motivate people to change. The promise of better health or of preventing ill health may not always be key motivating factors. Recent research has shown that disgust and shame (as is used in community led total sanitation), affiliation or the desire to nurture and do one's best for one's children and family, comfort and convenience and social acceptance can all be powerful influences for change.

Figure 11: Factors influencing behaviour change Source: Oxfam 2016

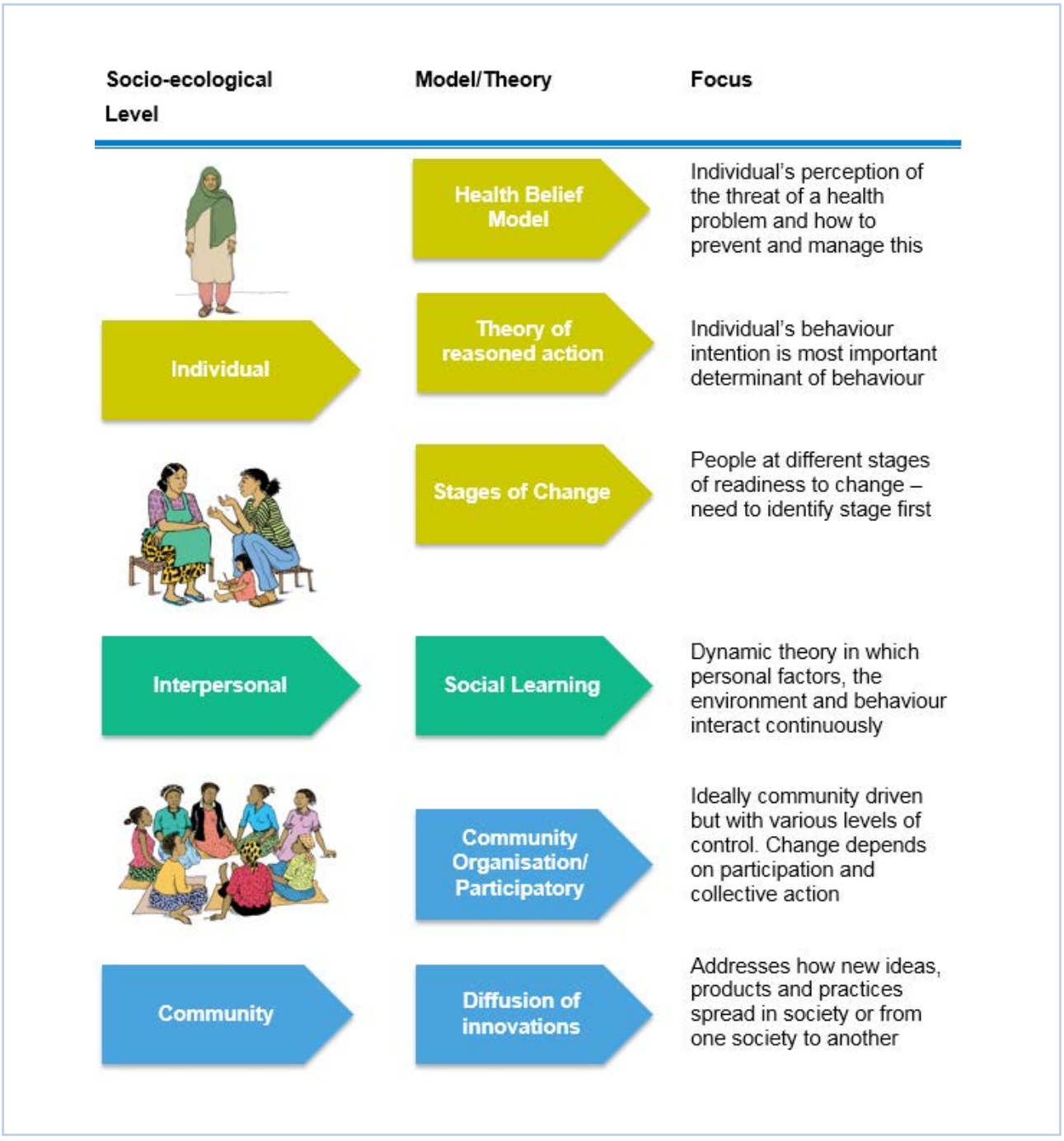


9 Taken from: OXFAM (2016) Draft Community Engagement Framework

Key Behaviour Change Models

Some key examples of behaviour change models are described in more detail in the appendix. They outline how change is believed to happen at either the individual, interpersonal or community and societal levels and all of them go some way in explaining the complexity of human behaviour. However, no one model can be said to be better than the others or even complete in its explanation of how behaviour changes. Figure 12 illustrates some of the key models and the 'socio-ecological level' at which they are expected to work.

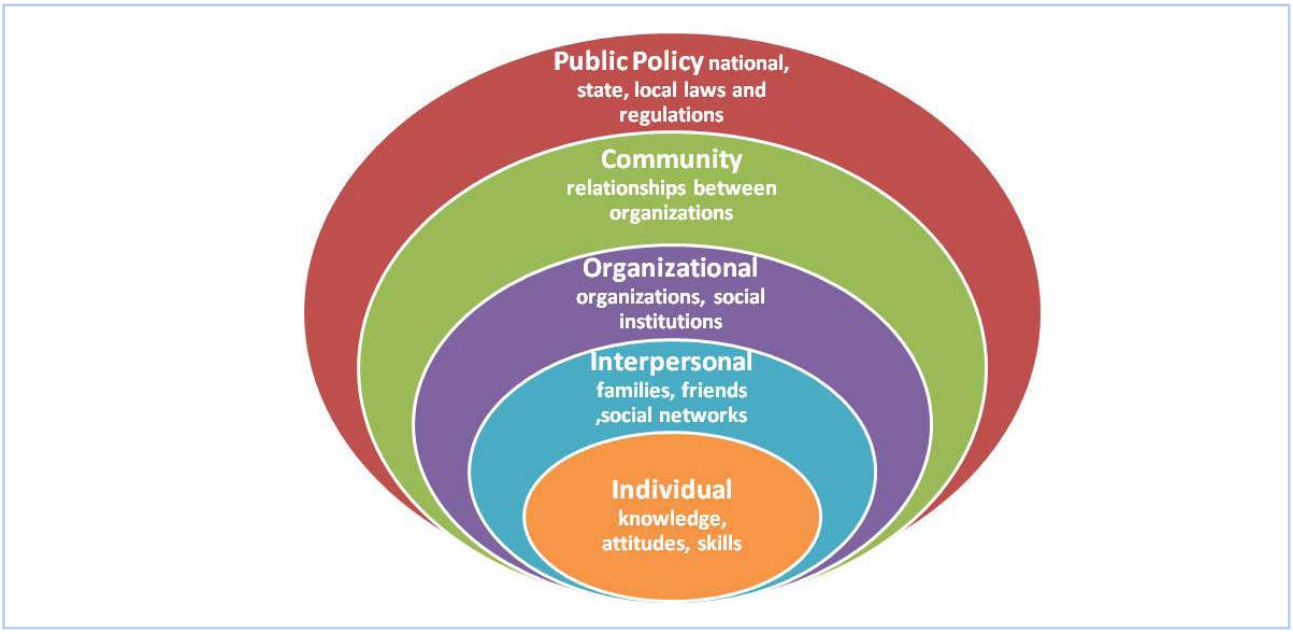
Figure 12: Overview of Key Behaviour Change Models and their focus Adapted from: The Health Communication Capacity Collaborative (HC3)



Social Ecology Model

The Social Ecology Model considers the complex interrelation between the individual, their family, community and society. The overlapping rings illustrate how factors at one level can influence the factors at another level. It can help us to understand the personal and environmental factors that influence behaviour and identify different possible levels of intervention for hygiene promotion and communication.

Figure 13: The Social Ecology Model



More information can be found of specific behaviour change models – including those specific to WASH in the appendix.

6: Appendix

Example Formative Assessment Questions

General	What are the most important issues for you and your family at the moment?
	What do you think about water, sanitation and hygiene in your village / camp /town?
Positive and Negative aspects	What would be the advantages of or the good things about hand washing / having a latrine etc?
	What might be the disadvantages or bad things about having a latrine?
Self efficacy	What makes it difficult to wash your hands /have a latrine / tippy tap / fuel-efficient stove / dish rack?
	Could you persuade your partner /family members to have a latrine?
	Do you think you can do something about the problems facing your community?
	Whose responsibility is it to ensure that you and your family are healthy?
Social Norms	Do your neighbours have a latrine?
	Would anyone disapprove or object to you having a latrine?
	Who (person or group) would approve if you had a latrine?
	Whose opinion (out of the previous groups) do you most value?
Illness and health seeking behaviour	When was the last time your child (ren) got sick?
	Why did your child (ren) get sick? What caused their sickness?
	What did you do about it?
	What happened next?
	What happens if your children are sick in the middle of the night?

Positive Deviance	What do you like about having a latrine? (tippy tap / fuel efficient stove /dish rack etc.)
	What did you have to do in order to get the latrine?
	Who cleans/looks after the latrine?
	How did you get your family to make use of it/clean it etc.?
	What does your family like about having a latrine?
	How would you motivate others to have a latrine? What would you say to them? Have you ever managed to persuade someone else to get a latrine?
	Do your neighbours have a latrine?
Channels of Communication	Where do you go to for advice if your children are sick?
	Do you listen to the radio /watch television? When and for how long?
	Do you notice the posters/ leaflets at the clinic?
	Do you like to have written information to take away with you from the clinic?
	Do you read a newspaper /magazine regularly?
	Do you trust what you hear /read on radio newspaper etc?
	Do you / people here attend religious services regularly?
	Where else do people meet together?
Perceived susceptibility, severity and action efficacy	Are you / your children at risk of getting diarrhoea?
	Do you think diarrhoea is a serious illness?
	What illnesses are most serious in your opinion?
	Will the behaviour e.g. hand washing help to overcome the illness?
Perception of divine will	Is this illness the result of god's will or divine spirits?
	Is it God's will that I prevent or overcome the problem?
Cues for Action	Do you know about hygiene practices (e.g. hand washing) but have difficulty in remembering to practice them?
	What would help you to remember?

Hygiene Promotion Review Checklist

Hygiene Promotion has 6 key components

1.	Use & maintenance of facilities
2.	Assessment and monitoring
3.	Participation & accountability
4.	Identification & use of hygiene kits
5.	Communication with WASH stakeholders
6.	Individual & community action (mobilisation)

General		Action required
1.	Is there an adequate number of HP staff (supervisors, hygiene promotion field workers, community volunteers)?	
2.	Have staff been given job descriptions/ task sheets that outline specific HP activities) and been trained in hygiene promotion (especially communication skills)?	
3.	Are there regular meetings between the hardware and software staff members?	
4.	Is the HP team aware of key techniques to mobilise communities?	
5.	Are visual aids being used appropriately and to maximum effect?	
Use and maintenance of facilities		
6.	Have representative WASH committees been identified and trained? Are they offered on-going support? Do they hold regular meetings to discuss 'software' and 'hardware' concerns?	
7.	Have all new designs for WASH facilities been discussed and approved by the WASH committee and other male and female community representatives	
8.	Have male and female representatives been involved in the siting of new communal WASH facilities?	
9.	Are toilets arranged by household or segregated by sex including in schools, clinics, community centres and other public places?	
10.	Are all communal toilets provided with handwashing facilities and soap or an alternative?	
11.	Has provision been made for ensuring safe excreta disposal for children and have child friendly WASH facilities been made available in schools?	
12.	Do men, women and children with disabilities have access to toilets, washrooms and other WASH facilities?	
13.	Are all sections of the population satisfied with the provision of the WASH facilities?	

Assessment and monitoring		
14.	Are the barriers to change and improving hygiene being identified and addressed in the different refugee groups?	
15.	Is there evidence of a qualitative and quantitative baseline?	
16.	Has an assessment been made of the key motivators for change in different groups?	
17.	Is there a WASH monitoring plan available that details each staff member's responsibility for monitoring?	
18.	Are simple monitoring forms in use that identify as a minimum; user satisfaction, improvements in handwashing and the key problems related to the use and maintenance of facilities?	
19.	Are the team using monitoring forms appropriately? (Is data being collated and acted upon?)	
Identification, distribution & use of hygiene kits		
20.	Do men and women have adequate hygiene items such as water storage containers, washbasins, soap or food covers?	
21.	Have washable or disposable sanitary towels been made available to women of menstruating age following discussions with them on preference and acceptability?	
22.	Are men and women using the hygiene items distributed?	
23.	Have innovative methods of distribution been considered? (E.g. cash, vouchers or lingerie fairs?)	
Participation & accountability		
24.	Do field workers understand the practical meaning of these terms? (E.g. Can you give me some practical examples of what you do to ensure participation and accountability)	
25.	Do community members know how to complain if there is a problem with the WASH work?	
26.	Has the WASH cluster accountability checklist been adapted and is it in use?	

Communication with WASH stakeholders		
27.	Does the current WASH co-ordination mechanism integrate HP into its proceedings?	
28.	Have government ministries been consulted about the WASH and hygiene communication interventions?	
29.	Have links been made with schools, health centres, community organisations and religious groups?	
30.	Is there evidence of co-ordination with other sector agencies especially education, health and community services?	
Individual & community mobilisation		
31.	Are participatory HP methods being used to encourage dialogue with community members?	
32.	Are community and mass media methods (e.g. street theatre, puppets, radio etc.) being used to communicate essential hygiene information?	
33.	Do hygiene promotion efforts focus on addressing the key public health problems?	
34.	Are participatory small group discussions or training sessions relevant to WASH issues held in a variety of locations and with a variety of target audiences e.g. in religious centres, clinics, community and vocational centres	
35.	Are community meetings held to discuss key WASH issues that are context specific e.g. the management of facilities, diarrhoea prevention, water conservation etc.?	
36.	Are WASH activities incorporated into the school curricula or in after school clubs?	
37.	Are school canteens and community kitchens provided with accessible handwashing facilities with soap (or an alternative) and are pupils and users are encouraged to WASH hands prior to eating?	

Matrix of Hygiene Promotion Methods and Approaches

Approach	Goal					Participant Group								Context				
	Information Provision	Behaviour change	Community Involvement	Community Mobilisation	Advocacy	Individual	Household	Community	Children	Youth	Schools	Leaders	Decision makers	Acute risk	Chronic risk	Rural	Urban	Peri-urban
Mass Media	①	②				○	○	○	⊘	⊘	⊘	⊘	⊘	○	○	○	○	○
Home visitors	①	②				○	○							○	○	○	○	○
PHAST		②		①				○						⊘	○	○	⊘	⊘
Social Marketing		①					○	○							⊘	○	○	○
Community led total sanitation		②		①				○							○	○	⊘	⊘
SLTS		②		①							○				○	○	○	○
Child to Child		①	②				○		○		○				○	○	○	○
WASH in schools		①	②						○	○	○				○	○	○	○
Community health clubs		①		②		○	○	○	○						○	○		
CHAST		①		②					○						○	○	○	○
Global Handwashing Campaign		②			①			○				○	○		○	○	○	○
Methods	**Goal**					**Participant Group**								**Context**				
	Information Provision	Behaviour change	Community Involvement	Community Mobilisation	Advocacy	Individual	Household	Community	Children	Youth	Schools	Leaders	Decision makers	Acute	Chronic	Rural	Urban	Peri-urban
PHAST /PRA methods			①	②				○	○	○	○	○		○	○	○	○	○
CLTS				①				○	○	○	○	○		⊘	○	○	⊘	⊘
Campaign methods	①	②			②	○	○	○	○	○	○	○	○	○	○	○	○	○
Marketing methods	②	①				○	○	○		○		○		⊘	○	○	○	○
Formative Research & assessment methods		①	②	②		○	○	○	○	○	○	○		⊘	○	○	○	○

Key:
Usual Primary goal: ① **Usually employed in this context or with this participant group:** ○
Usual Secondary goal: ② **Will need modification/justification to work in this context or for this target group:** ⊘

Adapted from: Water and Sanitation Collaborative Council (WSSCC) 2010; Hygiene and Sanitation Software. An Overview of Approaches; Geneva, Switzerland available from: http://www.wsscc.org/sites/default/files/publications/wsscc_hygiene_and_sanitation_software_2010.pdf accessed 28.04.11

Example Communication Analysis in Emergency Response

Target Groups	Communication Channels: People (Secondary Target group)	Communication Channels: Means	Communication Channels: Places	Example focus of communication
Mothers of young children	Community Mothers (volunteer outreach) TBAs School children Clinic staff Traditional healers Lady Health Visitors Women's leaders	Home visits Group meetings Demonstrations Drama and Songs Public Address System (mobile) Radio/phone ins	Home Community centre Crèche or nursery Clinic Feeding centres CBO's Private clinics Literacy classes Markets Post offices	Using and maintaining latrines and handwashing facilities Management of diarrhoea using ORS Household water treatment using chlorine tablets and safe storage Working collaboratively with WASH agencies (Feedback, managing facilities etc.) Entitlements to aid
Husbands/ Fathers	Religious leaders Teachers Farming co-operative heads Union representatives	Radio /phone ins Community meetings Public Address (mobile) Leaflets Mobile phone	Mosque (and other religious buildings) Coffee shops Schools Camel Markets Festivals	Using and maintaining latrines and handwashing facilities Protecting the family: use of health services Working collaboratively with WASH agencies (Feedback, managing facilities etc.) Entitlements to aid
Primary School Children	Teachers Parents Older children	Puppet Shows Street Theatre Drama, songs Games Competitions Leaflets/posters/ comics	School Community centres After school clubs	Hand washing Use of toilets Practical hygiene actions at home & school Preventing water wastage

Target Groups	Communication Channels: People (Secondary Target group)	Communication Channels: Means	Communication Channels: Places	Example focus of communication
Older children and youth	Media celebrities or sports personalities Teachers Youth leaders College students	Street Theatre Announcements/ leaflets at dance competitions, sports or entertainment events Peer groups Mobile phones	School Sports clubs Youth Clubs Concerts Festivals Newsletter	Keeping safe Handwashing is 'cool' Getting involved in the WASH response: Helping to monitor situation Care of facilities
Older women	Health staff Religious leaders Women leaders	Home visits Group meetings Magazines	Health facilities Community centres Mosques	Using and maintaining latrines and handwashing facilities Working collaboratively with WASH agencies (Feedback, managing facilities etc.) Entitlements to aid
Older men	Religious leaders Elders	Radio Newspapers Peer groups	Community centres Mosques Coffee shops	Using and maintaining latrines and handwashing facilities Working collaboratively with WASH agencies (Feedback, managing facilities etc.) Entitlements to aid
Staff in Community Kitchens	Supervisors Population using canteen	Training Demonstrations	Kitchens Canteen	Handwashing Food hygiene

Example Community Mobiliser Monitoring Form

CAMP_____BLOCK_____			MONITOR_____	
Tick the face that applies: RED : Bad YELLOW: OK GREEN: Good				**Proposed Action**
No observable excreta near (within 20 meters) of the shelters or water points				
Separate latrines are provided for men and women				
Women are satisfied with the latrines and use them				
Men are satisfied with the latrines and use them				
The stools of young children are disposed of in the latrine				
The latrines are clean				
Hand washing container is filled with water				
Soap or an alternative is available for handwashing at latrines				
Men, women and children are washing hands with soap or an alternative after using the latrine				
Tapstands are free from standing water				
Comments				

Example Hygiene Promotion Strategy

The hygiene promotion strategy should be based on the analysis of the hygiene promotion assessment so that it is clear:

- What the specific problem is
- What the Public Health Objectives are
- Who the specific audience groups are
- What the specific behavioural objectives are for each group
- What methods will be used to achieve the objectives
- Who will carry out the methods, how and what support is required
- How progress will be measured
- What measures will be taken to ensure the response is accountable to refugee populations

It should include the following elements:

- Situation Analyses
- Audience Segmentation
- Prioritizing Behaviours
- Behaviour Analyses
- Strategic Approach
- The Message Brief
- Communication Channels, Tools and Strategy
- Management Plan
- Monitoring and Evaluation
- Overall Recommendations

A useful example Hygiene Promotion Strategy for a longer-term WASH programme (WASHplus Behaviour Change Strategy: Hygiene Promotion Guidelines for Bangladesh) can be found here:

http://www.washplus.org/sites/default/files/bangladesh-behavior_change.pdf

A guide to designing a behaviour change communication strategy can be found here:

https://sbccimplementationkits.org/courses/designing-a-social-and-behavior-change-communication-strategy/

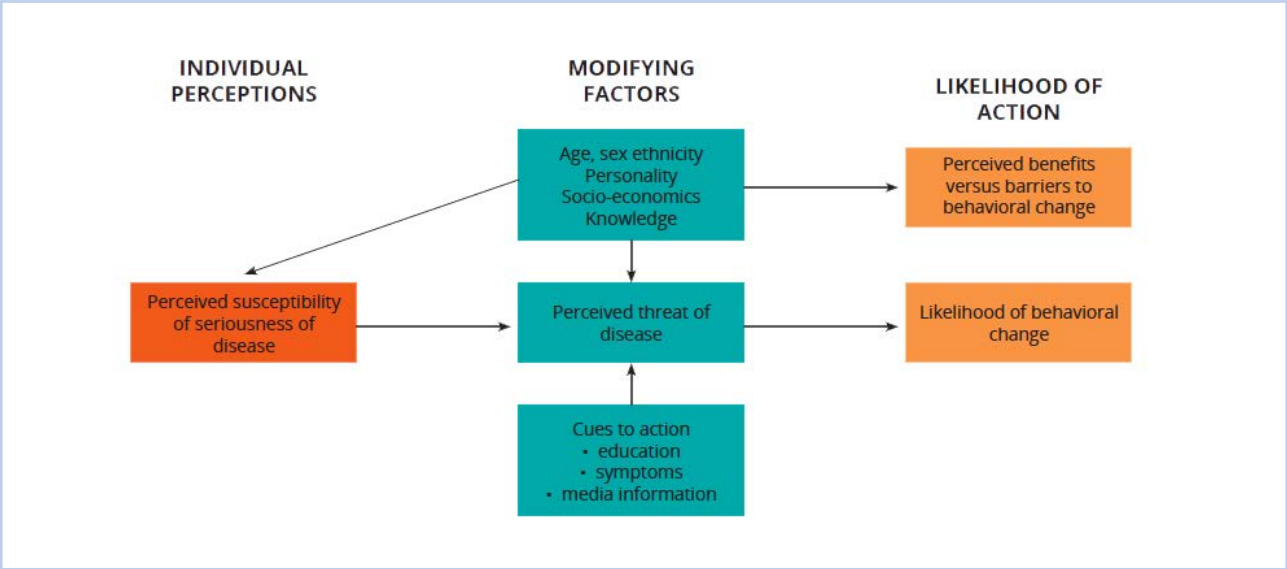
Example weekly work plan for hygiene promotion officer

	Monday		Tuesday		Wednesday		Thursday		Friday	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
WASH team meeting	8.30-9.00						8.30-9.30			
HP team meeting										14.00-16.00
Meeting with WASH committee in block 4 to arrange 2 day training	10.00-11.30									
Meeting with CHWs and public health nurse at health centre									12.00-13.00	
Meeting with head teacher of Magala School prior to PTA meeting: organise date for teacher's ToT		14.00-15.00								
Meeting with parent teacher association to discuss use of school latrines and hygiene education classes		15.00-16.00								
Community meeting in blocks 7 & 8 to feedback results of recent monitoring exercise			9.00-11.00							
WASH co-ordination meeting with NGOs and Government PH officers in Nerada camp			11.30-13.00							
Joint training for hygiene promotion assistants from all camps					8.30-13.00	14.00-17.00				
Exploratory walks in camp; monitoring of tap stands, communal latrines and HH visits				14.0-15.30					09.00-11.45	
Assessment of new arrivals' area	11.30-13.00									
Train tap stand attendants at proposed new tap stands							10.00-12.00			
Focus group discussion with secondary school girls on the use of school latrines				15.30-17.00						
Meet with mother's group for short hygiene orientation in vocational centre								14.00-15.30		

Individual Level Behaviour Change Models

Health Belief Model

Figure 14: Health Belief Model Source: The Health Communication Capacity Collaborative (HC3)



According to the health belief model, health behaviour is dependent on personal perceptions about disease. These perceptions are categorised into 4 constructs: perceived susceptibility and perceived seriousness (together these constitute the perceived threat), perceived benefits and perceived barriers. The different modifying factors will affect these perceptions and some of them can be modified to this end. For example reminders to perform handwashing (cues to action) can be in the form of mass media campaigns or home visits. Perceived barriers can include expense, inconvenience and discomfort. The benefits must outweigh the barriers for a person to want to take action.

Implications for Practice

We need to understand people's perceptions of disease, whether they feel it affects them and what they think are the benefits and barriers to doing things differently if we are to be able to influence their practices.

We should concentrate on highlighting both the benefits of action and how to overcome the barriers in our interventions.

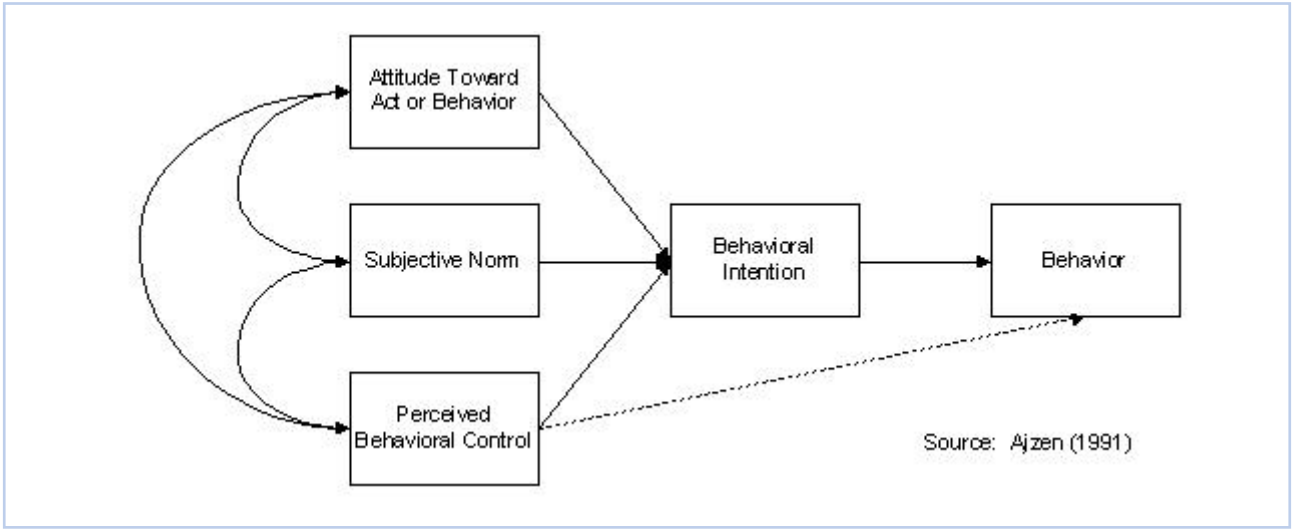
Theory of Reasoned Action

This theory is also sometimes known as the Theory of Planned Behaviour. According to this theory, behaviour is influenced by:

Attitude: That the behaviour will be beneficial to the individual. For example: people believe that using a toilet will be convenient and worth the costs in terms of construction and maintenance.

Subjective norms: The belief that other people think that the behaviour is acceptable. For example: Other people will think that using a toilet or handwashing are 'good' practices and will not think badly about you for practising these behaviours.

Perceived ability / behavioural control: The belief that one has the skills and capacity to practise the behaviour (self efficacy). For example: do people have the confidence and belief in their own abilities to construct their own toilet or make up and administer ORS to their child?



Implications for Practice

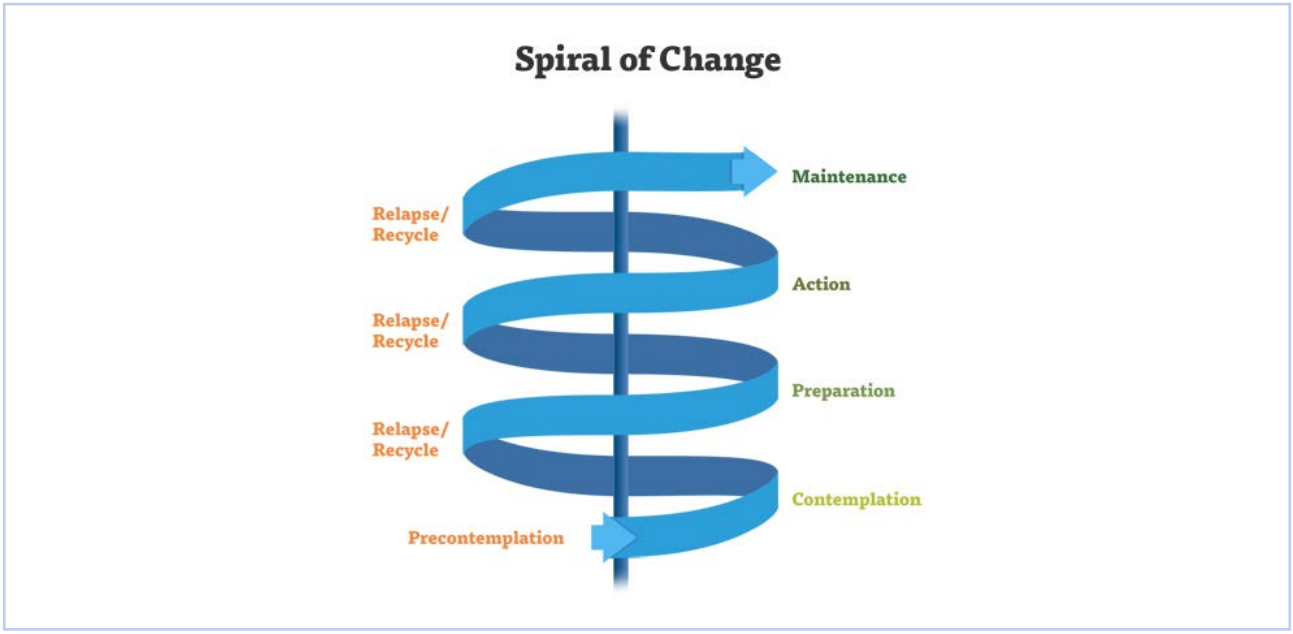
This model tells us that people's social networks (such as relatives and friends) need to be targeted to support the desired behaviour change. It is also important to highlight the short-term benefits of the behaviour change to promote action.

It also shows us that confidence in one's ability to do something or 'self efficacy' is important and that practical support to enhance this will be necessary. Providing clear 'how to' information and support for practising the behaviour such as simulations or behaviour trials may be helpful.

Stages of Change Model

This model suggests that behaviour change is a process not an event and that an individual will move through five different stages on their journey to change: *pre-contemplation*, *contemplation*, *preparation*, *action*, and *maintenance.* These stages are described in the diagram below.

Figure 15: Prochaska and Diclemente Stages of Change Model: source harmreduction.org



The Stages of Change model can be applied during one-to-one interactions, for example, during home visits. Knowing the specific stage that the individual is at can help the community mobiliser to select what information to share.

Implications for Practice

Before we can support people to change we need to know which stage they are at. We can then tailor our intervention to suit their specific needs.

For example at the pre-contemplation or contemplation stages the focus would be on providing information about the risks of the current behaviour and the benefits of changing behaviour.

At the preparation and action phases, it would focus more on practical opportunities for changing behaviour and how this might be possible e.g. how to construct a tippy tap.

It is also important to think about strategies for maintaining the practice in the later stages so that people try to imagine how they will overcome potential pitfalls such as running out of water or soap.

Interpersonal Level Behaviour Change Models

Social Learning Theory Model

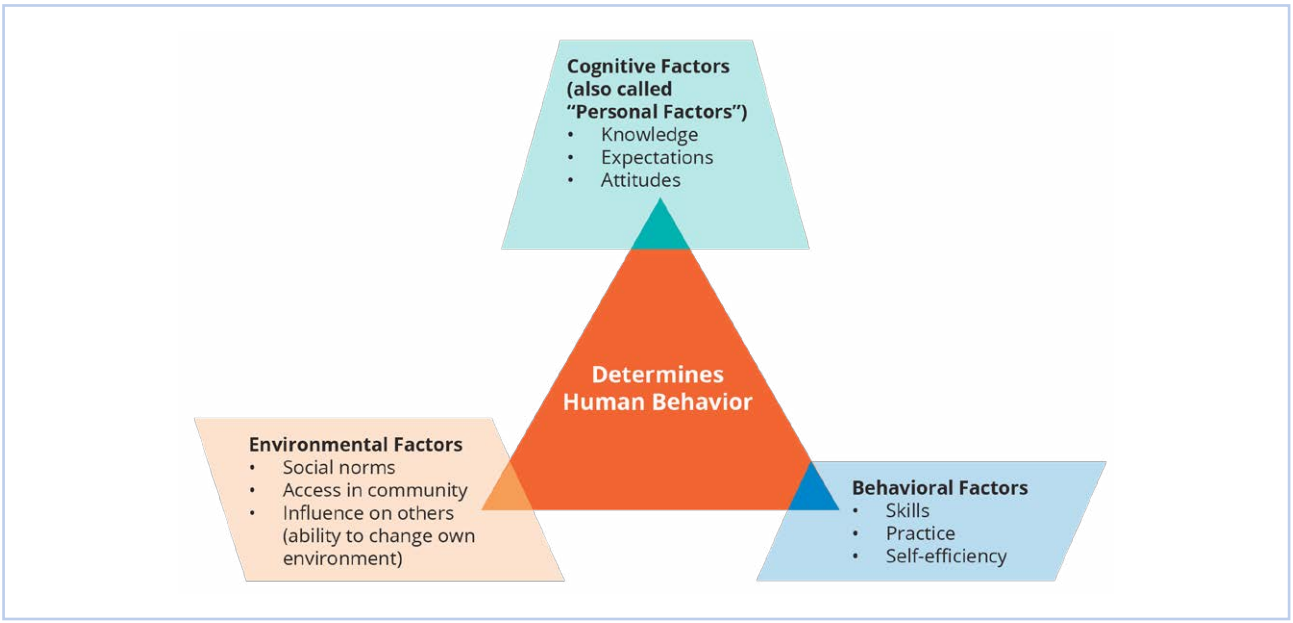
Considers the individual in their own environment and suggests that the way we learn is through observation of others (both their behaviour and the consequences of their behaviour) as well as through direct instruction.

Learning – as the basis for change- is a cognitive process (not just behavioural as is the case in conditioning) but the learner is not a passive recipient and rather there is an interaction between the learner and their environment or context that works both ways with one influencing the other and vice versa.

Modelling of the desired behaviour is considered as an important aspect of social learning – directly observed, via the media using real or imagined characters or through verbal instruction.

The concept of self-efficacy is central to this model also and the likelihood of someone performing a behaviour will depend on whether they have high or low self efficacy in relation to that behaviour.

Figure 16: Social Learning Model: Source: The Health Communication Capacity Collaborative (HC3)



Implications for Practice

People are influenced by what others do and by the social norms of their culture or group. Introducing something new such as using a latrine or handwashing before preparing food may not always conform to what the majority does and may be disapproved of by others.

The Social Learning Theory illustrates the importance of creating an enabling environment so that the desired change is made easier.

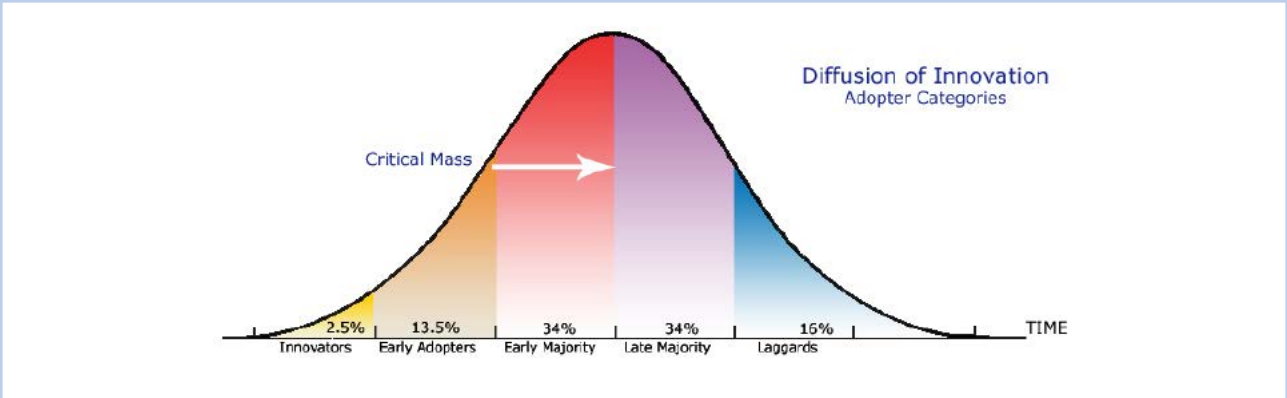
It also tells us that seeing the behaviour in practice can help influence others. This can be done by modelling the desired behaviour in pictures, theatre or films or by using simulations and role-play. Celebrities, sports people or others that people emulate can also help to model and endorse the desired behaviour.

Community Level Behaviour Change Models

Community models aim to explain how collective behaviour change can happen. The diffusion of innovations model considers how new ideas, products or practices spread in a community.

Diffusion of innovation Model

Figure 17: Diffusion of Innovation, source: The Health Communication Capacity Collaborative (HC3)



The Diffusion of Innovation model can be used to understand behaviours that are influenced by social norms and social trends. The theory tells us how to promote the desired behaviour by focusing on people with different attitudes towards change.

A focus on the early adopters of a new behaviour can be beneficial if they then promote it and encourage others to adopt it. Agents of change can be people working in the community or community members who have adopted the new behaviour and who can act as role models.

Implications for Practice

The Diffusions of Innovation model suggests that it may be useful to focus initially on so called ‘early adopters’ or opinion leaders and encourage them to influence others.

Targeting local leaders, influential individuals, peers and celebrities, can accelerate the adoption of a new behaviour.

Examining the divergence between those who adopt a particular behaviour and those that don’t (through a doer, non doer survey) can also help to define what variables might influence the late adopters.

Community Organisation /Participatory Models

There are numerous participatory and community organisation models that fall under this category but they tend to share some common elements.

Community organising is seen as a process through which communities or community groups are supported to identify their own problems, develop action plans and mobilize resources to reach collective goals.

Ideally the process is community driven but various levels of control and influence are possible. The concept of ‘Empowerment’ where people gain knowledge, skills and confidence is usually important in these

participatory models, as is the idea that community members are 'experts' of their own situation and the likelihood of change will depend on their full participation and action.

CLTS, SARAR and PHAST are useful examples of approaches that emphasise community action in WASH and draw on participatory models of change.

Information about all of the above approaches can be found in the references section.

WASH Models and Frameworks

There are also numerous WASH specific models and frameworks that have incorporated some of the above theoretical models or developed new theoretical models.

There are so many models that it is often difficult to know which one is best. The available research cannot yet provide definitive answers and much more research is needed to answer this question.

The models and frameworks presented here, however, can help you to identify the different determinants that can affect WASH behaviour and also suggest a variety of techniques and tools that can be used to assess these.

IBM WASH

The IBM WASH model (2013) provides an overarching framework from which to consider WASH responses and is a result of a systematic review looking at all the existing models that were in use in the sector at the time of the review. These were all found to have some limitations – many focused on individual level factors, none gave adequate importance to technology related factors and they largely ignored the role of the physical and natural environment.

Table 9: The integrated behavioural model for water, sanitation and hygiene (IBM-WASH)
Source: Dreibelbis et al (2013)

Levels	Contextual Factors	Psychosocial Factors	Technology Factors
Societal / Structural	Policy and regulations, climate and geography	Leadership / advocacy, cultural identity	Manufacturing, financing and distribution of the product, current and past national policies and promotion of products
Community	Access to markets, access to resources, built and physical environment	Shared values, collective efficacy, social integration, stigma	Location, access, availability, individual versus collective ownership/access and maintenance of the product
Interpersonal / Household	Roles and responsibilities, household structure, division of labour, available space	Injunctive norms, descriptive norms, aspirations, shame, nurture	Sharing of access to product, modelling/ demonstration of use of product
Individual	Wealth, age, education, gender, livelihoods / employment	Self-efficacy, knowledge, disgust, perceived threat	Perceived cost, value, convenience and other strengths and weaknesses of the product
Habitual	Favourable environment for habit formation, opportunity for and barriers to repetition of behaviour	Existing water and sanitation habits, outcome expectations	Ease/effectiveness of routine use of product

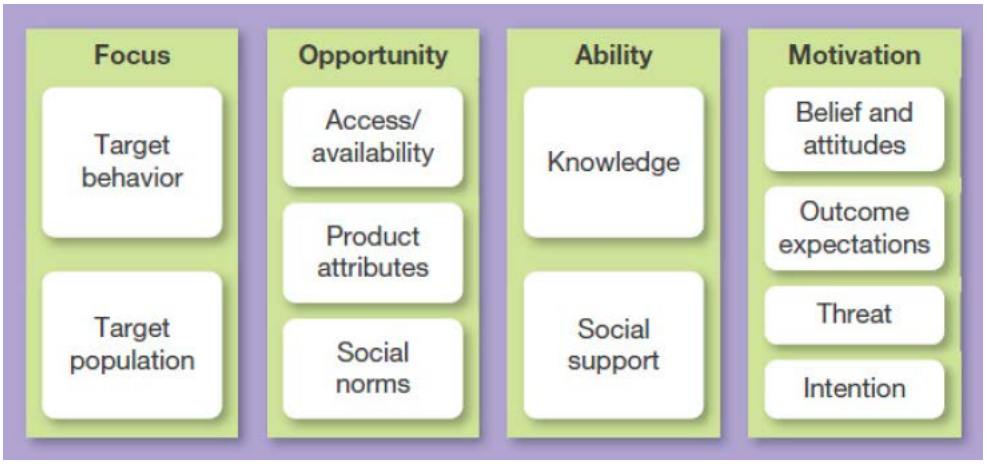
However, four other WASH frameworks are briefly explained below in order to provide more detail about how these different behavioural determinants listed in the IBM model can be investigated and how they can then shape programmes.

SANIFOAM and FOAM

Both FOAM (for handwashing), and SANIFOAM (for sanitation), were developed by the World Bank's Water and Sanitation Programme (WSP).

Behavioural determinants are organised into three domains covering 'opportunity', 'ability' and 'motivation'. In addition the target population and specific objectives must be defined by a 'focus' on these specific areas.

- **F** ocus: Who is the target population? What specific changes do you want to see?
- **O** pportunity: What is the likelihood of change? What might prevent or enable the change? Product attributes such as comfort, convenience and smell are included in this category.
- **A** bility: Is the individual able to perform the desired behaviour?
- **M** otivation: Does the individual want to perform the desired behaviour?



RANAS

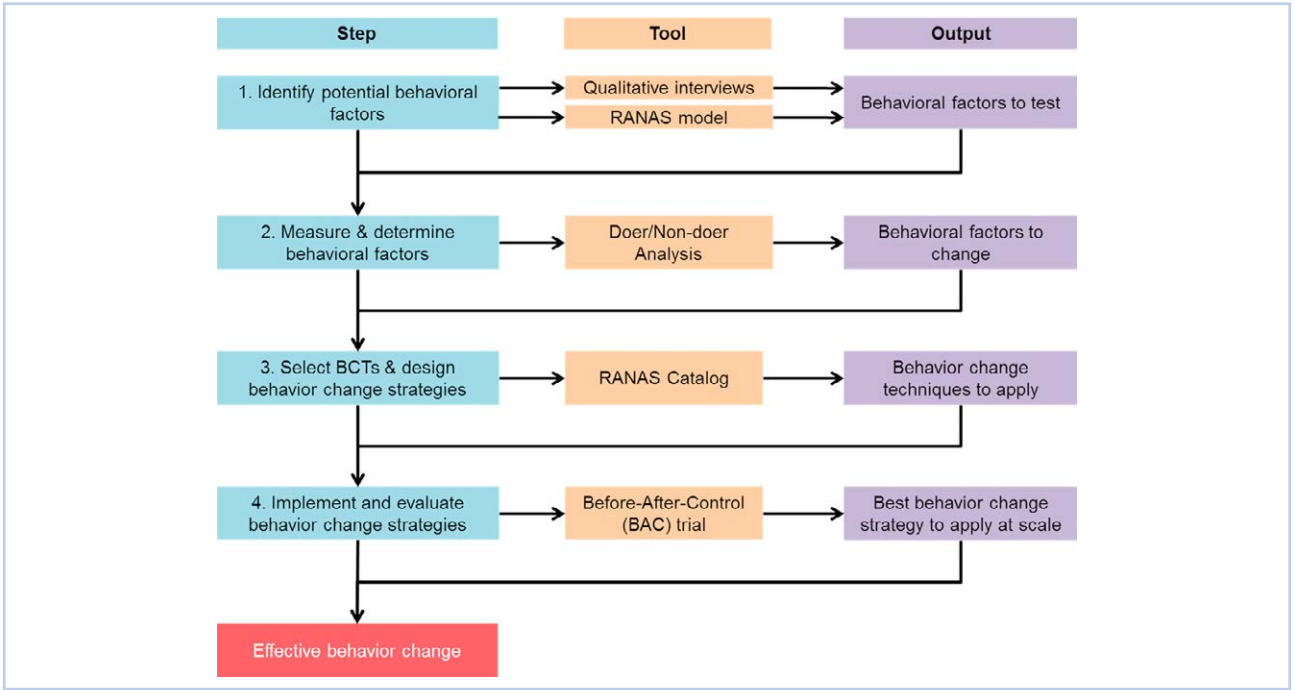
The RANAS framework describes a model and approach for designing behaviour change interventions and incorporates many of the well-known behaviour change models described above. RANAS stands for:

- **Risks** – the person's understanding and awareness of the health risk (includes health knowledge and perceived severity and vulnerability)
- **Attitudes** – a person's positive or negative stance about a behaviour (includes perceived costs and benefits as well as emotions)
- **Norms** – the perceived social pressure to practice (or not) a behaviour (includes other's behaviour, approval or disapproval)
- **Abilities** – the person's confidence and ability to practice a behaviour (includes knowledge about how to do something and self-efficacy)
- **Self Regulation** – the person's attempts to plan, self monitor and manage conflicting goals or distracting cues.

A doer/non-doer survey is carried out using focused questions illustrated in the example below that cover each behavioural factor:

Severity	Imagine you contracted diarrhea, how severe would be the impact on your daily life?	0 = Not severe; 1 = A little severe; 2 = Severe; 3 = Quite severe; 4 = Very severe
Beliefs about costs and benefits (effort)	How effortful do you think is it to chlorinate all your drinking water?	0 = Not effortful; 1 = A little effortful; 2 = Effortful; 3 = Quite effortful; 4 = Very effortful

The people that practice the behaviour in that specific context (doer) are compared to the people that don't (non doer) and the mean scores for both are calculated. The areas of greatest divergence between the two groups are seen as the most critical. For example if both the doers and the non-doers believe that the impact of having diarrhoea is severe there is no need to focus on making people aware of this. However if the doers believe that there are few costs and many benefits to the behaviour but the non-doers believe there are few benefits and it is very costly, then the issues of cost and benefits should form a key focus of your hygiene promotion intervention.



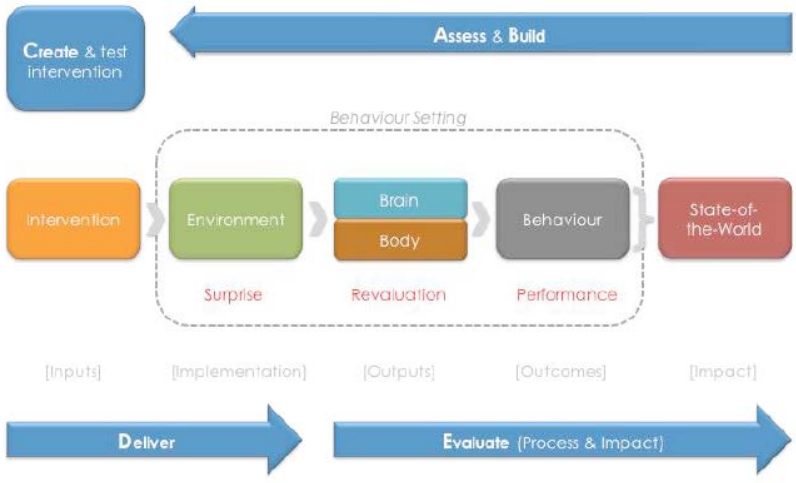
Risk Factors	Informational BCTs
Factual knowledge Vulnerability Severity	Presentation of facts/knowledge transfer Personal risk information Showing scenarios Fear arousal
Attitudinal Factors	**Persuasion BCTs**
Instrumental beliefs	Persuasive arguments Persuasive means Talking to others
Affective beliefs	Affective persuasion
Normative Factors	**Normative BCTs**
Descriptive norm Injunctive norm Personal Norm	Highlighting norms Informing about others' approval/disapproval Public commitment Anticipated regret
Ability Factors	**Infrastructural, Skill & Ability BCTs**
Action knowledge (skills)	Provide instruction
Self-efficacy	Guided practice Facilitating resources (financing) Social help Modelling Reattribution of past successes and failures
Maintenance (Coping) self-efficacy	Coping with barriers
Recovery self-efficacy	Coping with relapse
Self-Regulation Factors	**Planning & Relapse Prevention BCTs**
Action control Coping planning Remembering Commitment	Daily routine planning Outcome feedback Stimulus control Forming implementation intentions Prompts

Taken from Mosler 2012

BCD Behaviour Determination Model

Behaviour Centred Design is an approach to changing behaviour that incorporates new findings about how people learn and how brains work. The proponents of this approach suggest that behaviour change programmes, "need to focus on behaviour rather than cognition or communication" (Aunger 2015). As with the other models described above accompanying guidance also provides a variety of tools to help design the programme.

Figure 18: The Behaviour Determination Process, source: Aunger 2015



The approach follows five steps: 1. Assess, 2. Build, 3. Create, 4. Deliver, 5. Evaluate. The Build step involves formative research to explore hypotheses about the likely drivers of change and uses a variety of innovative methods for doing this such as motivational mapping, product attribute ranking, scripting and video ethnography (the last two methods are described in the HP methods section on page 70). The 'Create' step involves the use of a creative team in designing the intervention with the aim of making materials innovative, engaging and motivating. The intervention package is then delivered through various communication channels using both mass media and interpersonal methods.

Behaviour Settings

"In a good hygiene intervention in Nepal, groups of neighbours came together for 'kitchen makeovers' where the kitchen space was repainted and decorated as a safe food zone, food preparation gadgets were distributed and new behavioural scripts were suggested – all of which succeeded in creating new, safer food preparation routines amongst mothers in the intervention villages."

Source: Gautam cited in (Aunger 2015) Guide to Behaviour Centred Design

The approach uses the concepts of behavioural settings, motives and habits as a means to understand what influences people's behaviour. Behavioural settings are simply times when we enter into an agreed role and routine such as at meal times, using the toilet or attending a class. The authors argue that changing settings can provide a powerful way to change behaviour.

Motives, and particularly drives such as comfort, hunger, fear and disgust, and emotions such as nurture, love and affiliation are also important in influencing behaviour and can also be incorporated into interventions.

A habit is a routine behaviour that becomes automatic and that you perform almost without thinking. Repetition of an action in association with specific cues can lead to the action becoming habitual in the presence of those cues. Habits will persist long after conscious motivation is absent and is important if behaviour change is to be sustainable (see page 64 for more information).

The Behaviour Centred Design approach also elaborates on the importance of 'producing a surprising stimulus' to grab people's attention and force them to re-evaluate their current behaviour through the use of motives and rewards. Using reminders for the intended behaviour (such as stepping stones or arrows leading to the toilet or handwashing facility) can also help to promote change.

COMBI

Communication for Behavioural Impact (COMBI) provides a planning and implementation framework to guide health communication interventions in both chronic and acute situations. It's origins lie in social marketing and behaviour change communication. It replaces the 4 P's of social marketing with the 4 C's of:

- **C**onsumer's needs, wants and desires
- **C**ost - not only price but the effort that is needed to perform a particular behaviour
- **C**onvenience – the accessibility of both the behaviour and the things that enable the behaviour
- **C**ommunication – consisting of a mix of interventions that appeals to needs and emphasises value and ensures convenience

As with the previous frameworks, the emphasis is placed on 'formative research' known as a 'situational market analysis' in the COMBI approach. Listening to the 'consumer' is critical during this investigation phase

and allows the identification of socio cultural beliefs and practices that might be obstacles to adoption of the desired behaviour. The communication plan should engage people at all levels of society using a variety of methods in a variety of settings, as shown in the communication action areas below.

Figure 19: COMBI 5 communication action areas: source: WHO (2012)

In the COMBI approach, specific behavioural objectives should be identified that explain who the target audience is, what specific behaviour or action is expected, where it should be performed, when and how often.

A difference is made between behavioural objectives and communication objectives. The former being what we expect people to do and the latter being the beliefs and skills needed to promote the behaviour.

Example Behavioural Objective:

To ensure that the 20 000 refugees living in XXX:

- Treat all drinking water with xyz
- Wash hands frequently with soap after using the toilet and before eating
- Seek immediate (within 24 h) care from their nearest health centre if they have acute diarrhoea.
- Report any deaths from acute diarrhoea
- Take precautions during funeral rites (specify for context)

Example Communication Objectives to ensure behavioural objectives are met

- To raise awareness of the seriousness of cholera, how it is transmitted and ways to prevent it
- To communicate priority risks to population and what can be done to reduce them
- To hold discussions about the risks during funeral rites and identify appropriate protective measures
- Mobilise key informants e.g. religious and community leaders, frontline health staff and outreach workers etc. to communicate with population
- Mobilise mass media to report accurately on the outbreak

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- **Implementation Kits:**

  https://healthcommcapacity.org/i-kits-sbccimplementationkits/

- **Social and Behaviour change models**

  https://sbccimplementationkits.org/urban-youth/urban-youth/part-1-context-and-justification/social-and-behavior-change-communication-and-theory/

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