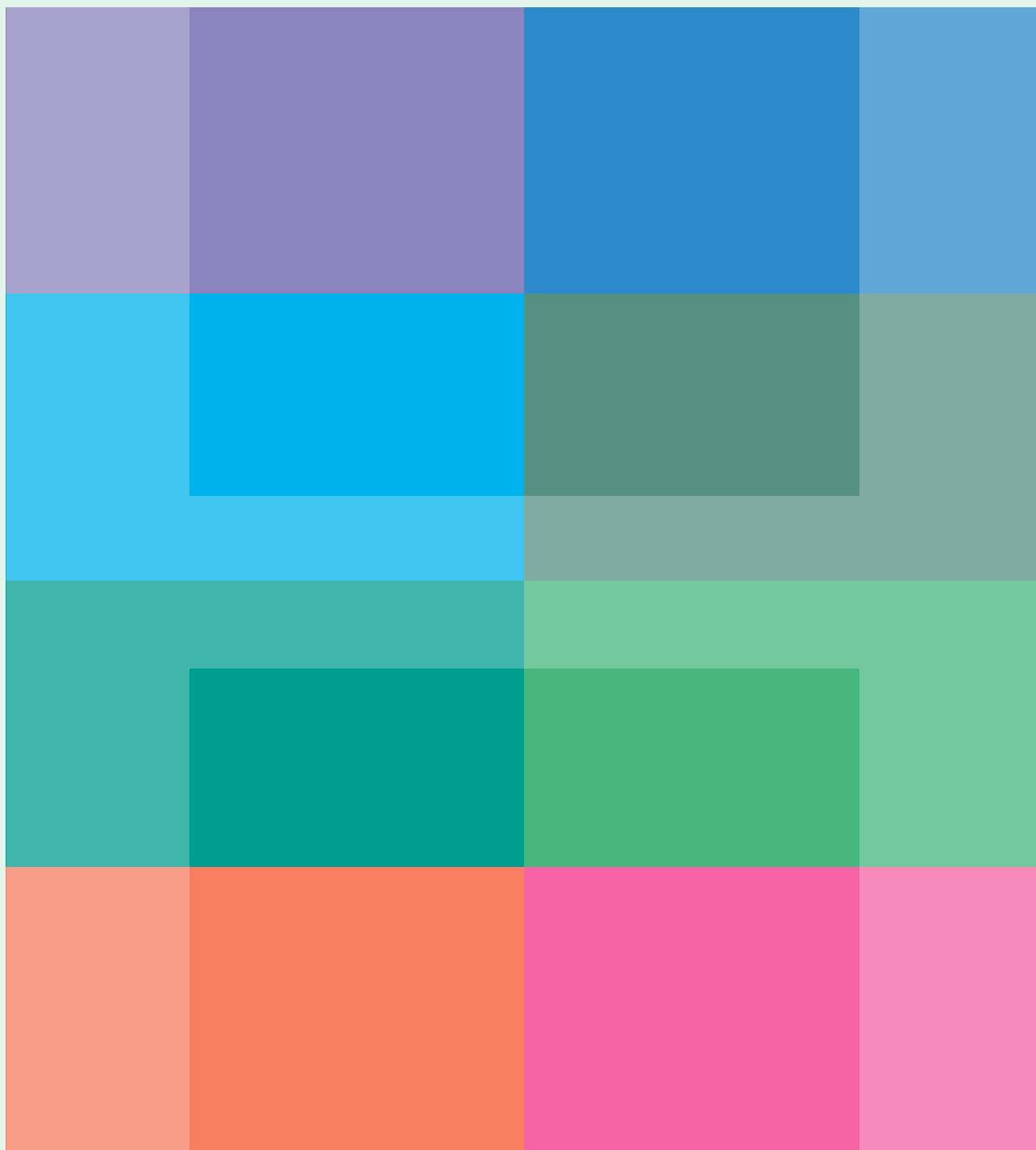


Compendium of Hygiene Promotion in Emergencies

1st Edition



Compendium Overview and Structure

HYGIENE PROMOTION COMPONENTS		
<div>P</div> <div>Preconditions and Enabling Factors</div> <div> <div>P.1</div> <div>Key Concepts and Good Practice</div> </div> <div> <div>P.2</div> <div>Access to Handwashing Facilities</div> </div> <div> <div>P.3</div> <div>Access to Water Supply Facilities</div> </div> <div> <div>P.4</div> <div>Access to Sanitation Facilities</div> </div> <div> <div>P.5</div> <div>Access to SWM, HCWM and Vector Control</div> </div> <div> <div>P.6</div> <div>Access to Hygiene Items</div> </div> <div> <div>P.7</div> <div>Menstrual Health and Hygiene (MHH)</div> </div> <div> <div>P.8</div> <div>Market-Based Programming (MBP)</div> </div> <div> <div>P.9</div> <div>Coordination and Collaboration with Other WASH Stakeholders and Sectors</div> </div> <div> <div>P.10</div> <div>Advocacy for WASH and Community Priorities</div> </div>	<div>E</div> <div>Community Engagement and Participation</div> <div> <div>E.1</div> <div>Key Concepts and Good Practice</div> </div> <div> <div>E.2</div> <div>Levels of Engagement and Participation</div> </div> <div> <div>E.3</div> <div>Gender Issues</div> </div> <div> <div>E.4</div> <div>Working with Babies, Children and Young People</div> </div> <div> <div>E.5</div> <div>Working with People with Disabilities and Older People</div> </div> <div> <div>E.6</div> <div>Hygiene Promotion in Schools</div> </div> <div> <div>E.7</div> <div>Ownership and Management of Facilities</div> </div> <div> <div>E.8</div> <div>Hygiene Promotion in Institutions and Other Settings</div> </div> <div> <div>E.9</div> <div>Community Capacity Strengthening</div> </div> <div> <div>E.10</div> <div>Community Engagement at a Distance</div> </div>	<div>A</div> <div>Assessment, Analysis and Planning</div> <div> <div>A.1</div> <div>Key Concepts and Good Practice</div> </div> <div> <div>A.2</div> <div>Risks and Influences Affecting Health and Hygiene</div> </div> <div> <div>A.3</div> <div>Assessment Process and Planning</div> </div> <div> <div>A.4</div> <div>Data Collection Methods and Analysis</div> </div> <div> <div>A.5</div> <div>Assessment Content and Scope</div> </div> <div> <div>A.6</div> <div>Existing Capacity</div> </div> <div> <div>A.7</div> <div>Community Profile</div> </div> <div> <div>A.8</div> <div>Conducting Quantitative Surveys</div> </div> <div> <div>A.9</div> <div>Planning</div> </div>
<div>C</div> <div>Communication</div> <div> <div>C.1</div> <div>Key Concepts and Good Practice</div> </div> <div> <div>C.2</div> <div>Communication Skills</div> </div> <div> <div>C.3</div> <div>Audience Profile and Inclusive Communication</div> </div> <div> <div>C.4</div> <div>Participatory Communication</div> </div> <div> <div>C.5</div> <div>Mass Communication</div> </div> <div> <div>C.6</div> <div>Community Perspectives and Rumours</div> </div> <div> <div>C.7</div> <div>Language and Cultural Considerations</div> </div> <div> <div>C.8</div> <div>Remote Communication</div> </div> <div> <div>C.9</div> <div>Risk Communication and Community Engagement (RCCE)</div> </div> <div> <div>C.10</div> <div>Communication Plan</div> </div>	<div>B</div> <div>Social and Behaviour Change</div> <div> <div>B.1</div> <div>Key Concepts and Good Practice</div> </div> <div> <div>B.2</div> <div>Behaviour Change Models and Theories</div> </div> <div> <div>B.3</div> <div>Motivators and Barriers: Knowledge</div> </div> <div> <div>B.4</div> <div>Motivators and Barriers: Ability and Self Efficacy</div> </div> <div> <div>B.5</div> <div>Motivators and Barriers: Motivation, Attitudes and Beliefs</div> </div> <div> <div>B.6</div> <div>Motivators and Barriers: Social Influence, Norms and Group Affiliation</div> </div> <div> <div>B.7</div> <div>Motivators and Barriers: Cues and Habit Formation</div> </div> <div> <div>B.8</div> <div>Overview of Behaviour Change Approaches</div> </div>	<div>M</div> <div>Monitoring, Evaluation, Accountability and Learning</div> <div> <div>M.1</div> <div>Key Concepts and Good Practice</div> </div> <div> <div>M.2</div> <div>Monitoring</div> </div> <div> <div>M.3</div> <div>Evaluation</div> </div> <div> <div>M.4</div> <div>Accountability</div> </div> <div> <div>M.5</div> <div>Participatory Monitoring, Evaluation, Accountability and Learning (MEAL)</div> </div> <div> <div>M.6</div> <div>Learning: Process and Key Elements</div> </div> <div> <div>M.7</div> <div>Learning: Research and Evidence</div> </div> <div> <div>M.8</div> <div>Learning: Knowledge Management</div> </div>

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T.2	Assessment Checklist	T.30	Photo Voice and Participatory Video	F.1	Community Health Club (CHC)
T.3	Barrier and Motivator Analysis	T.31	Pocket Chart Voting	F.2	Community-Led Total Sanitation (CLTS)
T.4	Beautification	T.32	Positive Deviancy and Doer / Non-Doer Analysis	F.3	Emergency Community Health Club (eCHC)
T.5	Care Groups	T.33	Print Media	F.4	IFRC's 8 Steps for Hygiene Promotion in Emergencies
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T.7	Community Mapping	T.35	Protection Mainstreaming	F.6	Participatory Hygiene and Sanitation Transformation (PHAST)
T.8	Competition	T.36	Public Announcement	F.7	Sani Tweaks
T.9	Cues and Nudges	T.37	Public Commitment	Approaches Mainly Targeting Children and Schools	
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T.11	Events	T.39	Ranking	F.9	Children's Hygiene and Sanitation Training (CHAST)
T.12	Exchange Visit	T.40	Rewards and Incentives	F.10	Fit for School (FIT)
T.13	Feedback Mechanism	T.41	Role Play	F.11	Three Star Approach (TSA)
T.14	Focus Group Discussion (FGD)	T.42	Routine Planning and Self-Regulation	F.12	Toilets Making the Grade (TMG)
T.15	Games and Toys	T.43	Seasonal Calendar	Approaches Mainly Targeting Women and Girls	
T.16	Gender Analysis	T.44	Social Media and Text Messaging	F.13	Baby WASH
T.17	Health Surveillance Data	T.45	Social Norms and the Use of Shame and Disgust	F.14	IFRC's 8 Steps for Menstrual Hygiene Management (MHM) Action
T.18	Household Visit	T.46	Social Support	F.15	WASH Social Architecture
T.19	Information, Education and Communication (IEC)	T.47	Songs and Stories	Approaches Based on Behavioural Science	
T.20	Institutional Checklist	T.48	Spidergram	F.16	Approach Focused on Behavioural Determinants (ABCD)
T.21	Integrated Behavioural Model (IBM) for WASH	T.49	Stakeholder Mapping	F.17	Behaviour Centred Design (BCD)
T.22	Involvement of Local Champions	T.50	Supervised Handwashing	F.18	Communication for Behavioural Impact (COMBI)
T.23	Key Informant Interview	T.51	Three-Pile Sorting	F.19	FOAM and SaniFOAM
T.24	Knowledge, Attitude and Practice (KAP) Survey	T.52	Transect Walk	F.20	Risks, Attitudes, Norms, Ability and Self-Regulation (RANAS)
T.25	Logical Framework Analysis and Problem Tree	T.53	Transmission Routes and Barriers (F-Diagram)	F.21	Sanitation and Social Marketing
T.26	Most Significant Change (MSC)	T.54	Venn Diagram	F.22	Wash'Em
T.27	Motivational Interviewing	T.55	WASH Committee	Approaches Targeting Participation and Accountability	
T.28	Observation			F.23	Accountability to Affected Population (AAP)
				F.24	Community Perception Tracking (CPT)

Compendium of Hygiene Promotion in Emergencies

1st Edition

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We would like to thank the following individuals for their invaluable contributions to this publication:

Yasmine Zaki Abdelaziz, Alberto Acquistapace, Bisi Agberemi, Syed Yasir Ahmad, Nadja Ahmed, Syed Hasnain Ali Abbas, Irene Amongin, Gemma Arthurson, Bob Aunger, Raissa Azzalini, Christopher Bachtrog, Niva Bajracharya, Nancy Balfour, Abie Bangura, Julie Bara, Janita Bartell, Claire Beck, John Brogan, Brenda Brouwer, Pierre Cerdan, Mariangela D'Adamo, Adrian Dongus, Jamilee Doueihy, Robert Dreibelbis, Mugur Dumitrache, Kit Dyer, Eva Erlach, Julien Eyrard, Michelle Farrington, Declan Galbraith, Chelsea Giles-Hansen, Pierre Marie Goimard, Emmanuela Gore, Jill Hass, Helen Hawkings, Tom Heath, Lasantha Herath, Alexandra Höhne, Everold Hosein, Sarah House, Aya Housheimi, Riaz Hussain, Ina Jurga, Martine Kayser, Emmett Kearney, Svenja Ksoll, Antonia Kühmichel, Jenny Lamb, Kirstin Lange, Lucie Leclert, Elli Leontsini, Priya Marwah, Samuel Mazingue, Beth Megnassan, Fenja Meinecke, Bella Monse, Jamie Myers, Eva Niederberger, Todd Nitkin, Alexander Oeze, Mary Omondi, Marion O'Reilly, Paul O'Sullivan, Silvie Palacios, Thilo Panzerbieter, Maryna Peter, Arabella Philipona, Nadja Pletsch, Jérôme Regnier, Bram Riems, Greg Rose, Johannes Rück, Sonya Sagan, Farah Salem, Isaac Samunete, Peta Sandison, Emilie Sanmartin, Minala Betty Santo, Stephanie Schramm, Lily-Madeleine Séguin, Franziska Stendebach, Georg Tertsch, Suliane Tillon, Iulia Andreea Toma, Megan Tucker, Rolando Walusche Saul, Pamela Wamalwa, Juliet Waterkeyn, Nicole Weber, Sian White, Michael Wicker, Peter Winch, Masumi Yamashina

Coming from the following organisations, institutions or networks:

Anthrologica, Arche noVa, Action Contre la Faim (ACF), Africa AHEAD, Austrian Red Cross, blueTap consult, Bremen Overseas Research and Development Association (BORDA), British Red Cross, Care Australia, Caritas Switzerland, Catholic Relief Service (CRS), Centre for Affordable Water and Sanitation Technologies (CAWST), Christian Blind Mission (CBM), COMBI Institute, COVID-19 Hygiene Hub, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Eawag/Sandec, German Toilet Organization (GTO), Helvetas, Global WASH Cluster (GWC), Global WASH Cluster Technical Working Group on Hygiene Promotion (GWC HP TWiG), Institute of Development Studies (IDS), International Centre for Diarrhoeal Disease Research Bangladesh (icddr,b), International Federation of Red Cross and Red Crescent Societies (IFRC), International Medical Corps, Menstrual Hygiene Management in Emergencies Working Group (MHMiE WG), International Organization for Migration (IOM), Johanniter International Assistance, Johns Hopkins University, Lebanese Red Cross (LRC), London School of Hygiene and Tropical Medicine (LSHTM), Malteser International, Mercy Corps, Norwegian Refugee Council (NRC), Oxfam, Ranas, Sanitation Learning Hub, Save the Children, Solidarités International, Swiss Agency for Development and Cooperation (SDC), Swiss Water and Sanitation Consortium, Technische Universität Berlin (TU Berlin), UNHCR, UNICEF, United Nations Populations Fund (UNFPA), University of Applied Science and Arts Northwestern Switzerland (FHNW), WASH United, World Vision International

**Our special thanks for hosting the
online platform go to:**

The Global WASH Cluster
The Sustainable Sanitation Alliance and
its Secretariat hosted by GIZ

**We would like to acknowledge
support from:**

The German Federal Foreign Office
The Swiss Agency for Development and
Cooperation (SDC)



sustainable
sanitation
alliance



Quotes



"The Hygiene Promotion in Emergencies Compendium shows how effective coordination between +100 sector experts can provide a state-of-the-art compilation of hygiene promotion approaches in the sector. It complements well, the two first compendiums on emergency water and sanitation and offers a unique set of tools for hygiene programming and behaviour change in humanitarian settings. The Global WASH Cluster fully supports the uptake of this new compendium by national humanitarian WASH coordination platforms and practitioners throughout the world. We will continue to be dedicated advocates and promoters of the compendium, as hygiene should be at the center of any public health and WASH responses for populations most affected by crisis."

Monica Ramos

UNICEF, Global WASH Cluster Coordinator



"Hygiene promotion is the key building block for successful WASH and is essential for building healthy and resilient communities. This compendium promotes many examples from our National Red Cross and Red Crescent Societies, highlighting the value of hygiene promotion in communicating and advocating people's WASH needs, in strengthening accountability, and in enabling behaviour change. As an IFRC network of local responders, we act on local knowledge and community feedback, and ensure that communities – including the most vulnerable – are involved in decision making for WASH."

Jagan Chapagain

International Federation of Red Cross and
Red Crescent Societies, Secretary General



"WASH is crucial in the fight against the spread of infectious diseases. The Covid-19 pandemic has once again made that very clear to us. It therefore remains one of the major priorities of our German engagement both in humanitarian aid and development to realise the human right to water and sanitation – including the closely related improvement of hygiene conditions – and with particular emphasis on the affected people in emergency situations. I will continue to strongly advocate for this and the Compendium of Hygiene Promotion in Emergencies can make an important contribution to this."

Luise Amtsberg

German Federal Foreign Office, Federal Government
Commissioner for Human Rights Policy and
Humanitarian Assistance



"In recent years the humanitarian sector has started to recognise the need to strengthen hygiene programming in emergencies. However, this desire for change has been difficult to realise because of the challenges of navigating the diverse array of guidance documents and tools. This Compendium will allow humanitarians to develop a common language about hygiene promotion in crisis-affected settings, to rapidly learn about effective approaches, and to compare and contrast the merits of these tools so that hygiene programming is increasingly evidence-based and contextualised."

Sian White

London School of Hygiene and Tropical Medicine,
COVID-19 Hygiene Hub



“Hygiene is to public health what nutrition is to food: the most important factor, but also the most neglected... May this compendium help all of us to live in a safer environment!”

Marc-André Bünzli

Swiss Agency for Development and Cooperation,
WASH Advisor and Co-Chair of the WASH Road Map 2025



“At our program in Juba, South Sudan, we promote good hygiene practices in underserved areas through the Community-Led Total Sanitation approach, which aims at hygiene behaviour change based on self-realisation of high-risk hygiene practices like open defecation. The Emergency Hygiene Compendium is a useful tool for field practitioners to get access to a comprehensive overview of hygiene promotion tools, approaches and methods that we can use in our WASH interventions with the underserved communities in South Sudan.”

Minala Betty Santo

Malteser International, South Sudan



“I’m pleased to see the Hygiene Promotion Compendium available for use by all WASH practitioners. This Compendium has been a feat of collaboration, bringing together Hygiene Promotion, Public Health, Community Engagement and WASH specialists from across the sector to compile a wealth of hygiene promotion approaches and resources into one easily navigable space. I hope this resource supports the further promotion of hygiene as an essential and central component of quality WASH responses.”

Michelle Farrington

Oxfam, Global Humanitarian Team,
Lead of the GWC Hygiene Promotion Technical Working Group



“As hygiene promoters, we complement the provision of water and sanitation facilities by engaging and mobilising affected communities. Through household visits and community consultations, we are able to gain first-hand knowledge on their needs, challenges and preferences. This new Hygiene Promotion Compendium will support us in discovering new approaches and methods to better engage with communities.”

**Thun Chanthy,
Chen Sarith,
Pum Kanha,
Som Et**

Red Cross Hygiene Promotion Volunteers in Tuol Sdey District,
Cambodia Red Cross

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Introduction

Background and Target Audience

The Compendium of Hygiene Promotion in Emergencies is a comprehensive and systematic compilation of the most relevant sector-reviewed components, tools, methods and approaches to design and implement successful hygiene promotion (HP) and behaviour change interventions. It is applicable to all critical hygiene behaviours across all response phases. It is not intended to be a 'How To' guide but to provide a single source of the available guidance and to summarise key concepts and good practice.

The target audience includes humanitarian staff, local first responders, engineers, planners, hygiene promoters, communications and community engagement professionals, government representatives, academic institutions, capacity strengthening agencies and other WASH professionals involved in humanitarian response, preparedness, stabilisation and recovery activities.

Humanitarian WASH interventions primarily focus on immediate life-saving measures and public health protection. However, the humanitarian community is increasingly confronted with longer-term protracted crises that stretch beyond an emergency response. Humanitarian WASH professionals may work in both urban settings and displacement camp contexts. They need to address the WASH needs of refugees, internally displaced people and host communities. The Compendium of Hygiene Promotion in Emergencies (referred to hereon as the Compendium) addresses this complex reality by including HP components, tools, methods and approaches that can be adapted for use in a variety of scenarios, contributing to complementarity between the humanitarian and development realms.

The Compendium is part of a series of WASH in Emergencies compendia. The first two focused mainly on sanitation and water supply technologies in emergencies (hardware). This Compendium addresses the third pillar of the WASH triad – hygiene promotion (software). Using a similar approach, it describes a widely sector-agreed categorisation and structure for all the different elements of HP. The Compendium draws on the latest initiatives, materials and evidence, disaggregating HP into its functional components, clarifying terminology and providing guidance on the most appropriate solutions in a given context.

The Compendium is primarily a capacity strengthening tool and a reference book. It also supports planning, implementation and decision making for specific HP interventions. It provides a systematic starting point to access relevant summarised information on HP with details and links to additional practical guidance and information as well as publications, case studies, videos and training materials where available.

Structure and Use of the Compendium

The Compendium is divided into four major sections:

Introduction

The introductory chapter describes the structure and use of the Compendium and defines key hygiene behaviours. It also provides contextual information about different emergency scenarios and response phases (including their implications for HP interventions) and outlines the relevant principles and standards related to HP. Compendium users are particularly encouraged to review the sections 'What is Hygiene Promotion' (**page 11**), 'Key Hygiene Behaviours' (**page 11**) and 'Implementation Guidance' (**page 22**). These sections familiarise users with the main terms and scope of hygiene behaviours. Users will also appreciate the importance of a systematic approach needed to successfully implement HP. The foldable coverpage includes a general overview of all the HP components, tools, methods, frameworks and approaches presented in this Compendium.

Part 1: Hygiene Promotion Components

This section is the core of the publication and provides a detailed description of the six key HP components. These are **P**reconditions and Enabling Factors, **E** Community Engagement and Participation, **A** Assessment, Analysis and Planning, **C** Communication, **B** Social and Behaviour Change and **M** Monitoring, Evaluation, Accountability and Learning.

Different elements of each component are described in a series of short sub-chapters outlining the essential aspects to be considered. The sub-chapters describe the component's main purpose, an overview and a practical process and good practice section. There are links to key resources and publications and to the key HP tools, methods and approaches described in **Part 2** and **Part 3** of the Compendium.

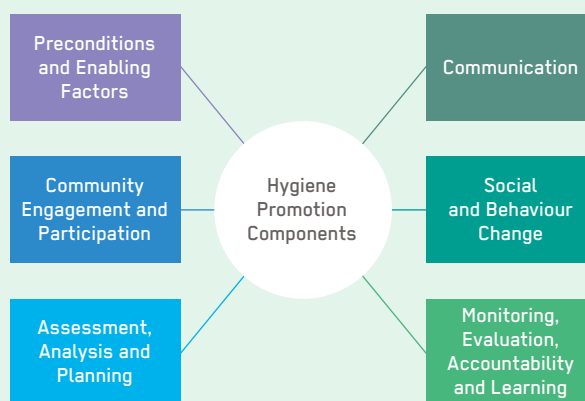


Figure 1:
Hygiene Promotion
Components

Part 2: Hygiene Promotion Tools and Methods

Tools and Methods is a compilation of all the relevant HP tools and methods that are commonly used in emergencies. Each is summarised in a concise one-page information sheet outlining its main features and basic working principles. The information sheets identify when, where and with whom the tools and methods can be used. They describe the main requirements and investments needed, practical do's and don'ts and a brief case study that provides a practical example. The purpose of these sheets is to enable users to compare tools and approaches and select those most suitable for their circumstances. They are intended as a platform for additional resources, not as standalone implementation guides. Each tool or method provides links to key resources and publications with practical and in-depth information.

Part 3: Hygiene Promotion Frameworks and Approaches

The final section of the publication is a compilation of existing HP frameworks and approaches. They may use several of the tools and methods described in **Part 2**. Each of the frameworks and approaches is described in a two-page information sheet outlining its main features and working principles and where and when they are applicable. The sheets include a list of all the tools and methods used as part of the approach (linked to the respective tools and methods in **Part 2** above), the main requirements and investments needed and any existing evidence of effectiveness. They also include practical advice on do's and don'ts, a representative case study and links to key resources and publications for each framework and approach.

What is Hygiene Promotion?

Hygiene (deriving from the Greek word 'hygieinos' which means healthful or relating to health) is a general term referring to conditions and practices of individuals and communities that help to maintain health and prevent the spread of diseases. Hygiene includes the preservation, promotion and strengthening of health and is interrelated with concepts of dignity, wellbeing, self-care, religion/spirituality and social participation, all of which play an important role in programming (e.g. to understand social norms about hygiene).

Hygiene Promotion (HP) in Emergencies is a planned, systematic approach that enables people to take action and encourages behaviours or conditions that prevent or mitigate WASH-related diseases. Hygiene promotion aims to support the dignity and wellbeing of emergency affected populations and no WASH intervention should be undertaken without including it. According to the Sphere

Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, HP is intertwined with community engagement and 'is fundamental to a successful WASH response'. Community engagement connects the community and other stakeholders so that people affected by the crisis have more control over the response and its impact on them. It should be supported by all involved in the response including government, local or international agencies and non-governmental organisations (NGOs). In recent years HP has also played a key role in outbreak response, addressing not only WASH-related diseases but, in line with the original Greek concept of 'hygieinos', focusing on maintaining health and preventing disease more broadly, for example in responding to Ebola and COVID-19.

With the adoption of the 2030 Agenda for Sustainable Development the 'leave no one behind' principle has been widely adopted in the WASH sector to ensure that the most vulnerable populations have access to basic services and is therefore an important part of hygiene initiatives. Hygiene promotion recognises the differences within any population and the necessity to respond in various ways to the different WASH needs of women and men, girls and boys of different ages from different backgrounds, with different cultural and social norms, beliefs, religions, abilities, gender identities or levels of self-confidence and self-efficacy.

Hygiene promotion's emphasis on the importance of listening to affected communities and its use of dialogue and discussion provide a practical way of facilitating participation and accountability. It gives people a voice and involves them in making decisions about the way the programme is delivered (e.g. about the design, siting, operation and management of WASH facilities).

Hygiene promotion should aim to understand the enablers and barriers to behaviour change so that programmes do not just focus on the provision of information and increasing knowledge but on working supportively with communities to understand how change can best be achieved. Hygiene promotion may therefore also consider other determinants of health and hygiene such as socio-economic, environmental and psychological barriers and enablers.

Key Hygiene Behaviours

This section describes the behaviours that a WASH programme can address. It is not intended as a list of topics to cover in HP programming – a context-specific assessment and the involvement of community members in designing the response is always necessary.

Hand Hygiene is a general term referring to any action of cleaning one's hands with soap and water (or equivalent materials such as alcohol-based hand sanitiser) to remove pathogens like viruses, bacteria and other micro-organisms as well as dirt, grease or harmful and unwanted substances which are stuck to the hands. Handwashing with soap is regarded as one of the simplest and most effective ways to prevent the spread of diseases and respiratory infections. The key critical times for handwashing with soap should always be promoted: after using the toilet or cleaning a child's bottom and before preparing food, eating and feeding a child.

In health care settings, hand hygiene should be promoted at five points: **(1)** before touching a patient and **(2)** before performing cleaning procedures and after contact with **(3)** the patient, **(4)** body fluids (or risk of contact) and **(5)** their surroundings. In the case of COVID-19, patients are also expected to wash hands with soap at the point of entry to the health care facility (with handwashing facilities provided at all points of entry).

There are other times when handwashing with soap is highly recommended (e.g. after touching animals, garbage or blowing the nose), but it is important to avoid promoting too many actions at once. The focus should be on the most critical hand hygiene behaviours with the biggest health impact first.

Handwashing technique is also very important. It includes wetting the hands with clean water, lathering the hands (including thumb, back of the hands, wrist, between the fingers and under the nails) by rubbing them with soap, scrubbing hands for at least 20 seconds, rinsing the hands under clean water and drying them either with a clean towel, on clean clothes or by air drying.

Handwashing frequency is important too, as evidence indicates that washing hands more frequently, even if for shorter durations, may be more effective and may have an influence on HP interventions (e.g. making handwashing as easy and convenient as possible).

Even though handwashing is a simple activity, its promotion faces substantial challenges as regular handwashing is difficult to maintain for many users. This is especially so in contexts where running water, soap and/or handwashing facilities are not available or easily accessible.

Behaviours Related to Sanitation (where the term 'sanitation' mainly describes human excreta management) refer to access to adequate and inclusive sanitation facilities and a set of behaviours associated with safe excreta management. It includes the use, by all, of sanitation facilities at all times. It also refers to the routine operation and maintenance (OSM) of toilets which include all activities needed to run a sanitation scheme to increase efficiency, effectiveness and sustainability. It requires the assignment of clear roles and responsibilities (e.g. for cleaning, the replacement of consumables, small repairs or occasional checking of pits and fill up rates). Sanitation-related behaviour also includes the correct use of culturally

appropriate anal cleansing materials, the safe collection, management, treatment and disposal of faeces (**see also Compendium of Sanitation Technologies in Emergencies**), the safe disposal of baby and child faeces, the use of items like potties or diapers if used (including effective cleaning or disposal), the use of incontinence materials and facilities and toilet training for children. It may also include the prevention of indiscriminate/open defecation and the potential clean-up of an already contaminated environment e.g. in the acute phase of an emergency if no toilets are available. It always implies handwashing after toilet use and after contact with children's excreta (**see also hand hygiene above**). When sanitation technologies are introduced that are new to the affected population, sanitation-related behaviours may need to change.

Water-Related Behaviours refer to access to adequate and inclusive water supply facilities, safe water management and all behaviours needed to ensure that the clean water provided at the point of supply (e.g. a communal borehole) remains uncontaminated until the point of use. It starts with the protection of the water source (such as keeping the area around the water source clean and fencing the source to prevent animals from entering) drainage of wastewater around taps and wells, maintenance of the installation and avoiding indiscriminate defecation around (and particularly upstream of) the water source. Water-related behaviours also include the safe transport of the water in clean, closed containers (e.g. jerricans) and the regular cleaning of the water containers. If further treatment at the household level is needed (**see also Compendium of Water Supply Technologies in Emergencies**), it may require the establishment (or reinvigoration) of habits and behaviours to ensure the correct use and maintenance of household water treatment options (e.g. household sedimentation, filtration or disinfection technologies such as ceramic filters, point of use chlorination, solar disinfection, or boiling of water). In addition, safe water storage at the household level must be ensured. That includes keeping water safe from (re-) contamination while it is being stored by protecting it from contact with hands, cups/dippers, animals, dirt and pathogens in the environment. It also includes the use of water storage devices with a fixed and lockable cover and a tap or a narrow neck that stands securely and is easy to handle. It may also require (community-led) water quality monitoring at regular intervals.

Menstrual Health and Hygiene Related Behaviours refer to inclusive access to facilities that support Menstrual Hygiene Management (MHM), the use of appropriate menstrual products and MHM awareness and education. It includes access to and use of clean and culturally-appropriate menstrual management materials for women and adolescent girls to absorb or collect menstrual blood and access to underwear. It also refers to a privacy requirement for changing materials as often as necessary

for the duration of a menstrual period and to wash as needed. Access to safe and convenient facilities to dispose of used menstrual materials and to launder and dry them is essential; the disposal of menstrual waste must be managed effectively (e.g. using incinerators). Awareness and education about MHM are necessary to counter related beliefs, restrictions, taboos and misinformation and the access to basic information about the menstrual cycle (both for women and girls and men and boys) is important. Menstrual hygiene related behaviours may also include pain management through exercise, nutrition, comfort or use of pain medication (if needed) to enable continued participation in daily life.

Food Hygiene Behaviours (or food safety) refer to the conditions and practices that prevent food contamination and corresponding food-borne illness. It includes the safe handling, storage and preparation of cooked and uncooked food prior to consumption at home, or in public places such as communal kitchens and canteens. Safe handling and preparation include maintaining a hygienic food preparation or processing environment, working with clean hands, washing and safe cooking or reheating of food. Stored food should be covered and protected from flies. Drinking vessels and cooking utensils should be clean when used and covered when stored (both in households and by food vendors). Infant feeding practices are particularly important: food hygiene encompasses safe and appropriate infant and young children feeding practices including breastfeeding. If infants are formula-fed (and this practice cannot be changed) a hygienic environment and the use of safe water for preparing the formula should be ensured. Unsanitary living conditions and associated diseases are directly linked to undernutrition, stunting, lowered immunity and increased risk of morbidity and mortality, especially amongst children under five years old.

Personal Hygiene Behaviours refer to maintaining the cleanliness of the body and clothing to preserve overall health and wellbeing. It includes regular washing and bathing with soap to enhance a sense of wellbeing and to remove potential pathogens, dirt and bacteria that cause body odour or skin irritations. It can refer to dental hygiene such as regular tooth brushing, male genital hygiene where it is an issue (the impact of this can be debilitating – especially in challenging environments), regular handwashing with soap or washing clothing and bedding. Privacy, dignity and safety related to personal hygiene are important requirements.

Environmental Hygiene and Behaviours Related to Solid Waste Management refer to all behaviours that ensure a clean and safe household and community environment. It includes waste collection, transport and disposal, drainage, potential site improvements and vector control measures (see next paragraph below). In areas with open defecation or free-roaming animals, environmental

hygiene can have a significant impact on public health and especially for small children, who are in frequent contact with the ground.

Behaviours Related to Vector Control refer to all behaviours and control measures that help prevent disease-carrying organisms (such as mosquitoes, fleas, flies or rodents) that transmit pathogens from wild or domestic animals, plants or the environment to humans. Malaria, dengue, scabies or diarrhoea are all examples of vector-borne diseases. Depending on the context and the corresponding risk behaviours, vector control may include the use of (insecticide-treated) bed nets, tents or curtains, wearing of long-sleeved clothing, regular washing of bedding and clothing, use of repellents, household fumigants, burning coils or aerosol sprays or avoiding being outside when vectors like mosquitoes are most active. The term can encompass other behaviours described above such as adequate personal hygiene, food hygiene, human or animal excreta management, environmental hygiene and waste management. Other measures and behaviours that contribute to the control of vectors include the removal of stagnant water sites (e.g. puddles, cans, tyres) and avoiding entering water where there is a known risk of contracting diseases such as schistosomiasis, guinea worm or leptospirosis.

Behaviours Related to Specific Diseases refer to behaviours relevant to control e.g. epidemics or pandemics such as cholera or COVID-19. Behaviours include hand hygiene (see page 12), physical distancing, wearing of personal protective equipment (e.g. face masks, boots, gloves and clothing), disinfection, avoiding touching one's face with unwashed hands and coughing/sneezing etiquette (coughing or sneezing into the elbow or a tissue and washing/sanitising hands afterwards) and caring for sick people at home. Other behaviours described above may also be included, such as personal hygiene, food hygiene and human or animal excreta management as well as the collection, transportation, storage and consumption of clean and safe water, environmental hygiene and waste management.

Hygiene Away from Home refers to all hygiene behaviours practised beyond the immediate household environment, such as in institutions (e.g. schools, health care facilities, workplaces and prisons) or other public settings such as transport hubs, places of worship, markets, restaurants or displacement and transit settings. It also refers to the access and use of basic WASH services in each location, effective hand hygiene at critical times and, depending on the setting and the time away from home, various behaviours described above (such as sanitation and water-related behaviours, environmental hygiene, solid waste management /or personal hygiene).

→ **References and further reading materials can be found on page 285**

Why Hygiene Promotion?

Hygiene promotion that supports behaviours, community engagement and actions to reduce the risk of disease is fundamental to a successful WASH response. It is increasingly recognised that HP is well placed to respond to broader public health programming and to the outbreak of diseases, such as Ebola or COVID-19, where a comprehensive emergency WASH intervention may not be required.

The following are some of the key reasons why HP must be included in a WASH or outbreak response:

Hygiene promotion aims to ensure the effective, sustained and optimal use of WASH facilities by all users. If water, toilets or handwashing facilities are provided without consideration of the context or users, they may not be used optimally by all members of the community. Nor will they be maintained.

Hygiene promotion aims to involve people in decisions about the WASH or outbreak response, such as the design, siting and management of facilities or how best to communicate with a community. It enables affected communities to participate in the programme.

Hygiene promotion can identify different needs and concerns within the affected population, so that the programme responds to those needs and helps to increase equitable access to WASH.

Hygiene promotion provides a mechanism to actively listen and respond to feedback from different community members. It can increase the accountability of the response. There is always an opportunity for dialogue and discussion with those affected – even in the acute phase of an emergency when it can be overlooked.

Hygiene promotion carries out formative assessments to understand and respond to the social and behavioural determinants that affect people's health and hygiene in a specific context.

Hygiene promotion's emphasis on community engagement and participation can link humanitarian work to longer-term development.

Hygiene promotion may be one of the most cost-effective ways of improving public health outcomes.

Evidence of the Effectiveness of Hygiene Promotion

There is a lack of quality research into WASH and HP – especially in emergencies. Hygiene promotion research often focuses on handwashing, household water treatment or development contexts (**see Yates et al. 2017 and De Buck 2017**). The use of control groups (and the implication that aid might be restricted for one group) is considered unethical in an emergency response. It is difficult to separate and identify the impact on the behaviour and health of different factors and intervention sectors.

Few studies have looked at the effect of WASH interventions on mortality, and, according to academic review, those that have tried have often been of poor quality due, for example, to poor study design, or inconsistent data collection (**see for example, Ramesh et al. 2015 and Share 2016**). But there is evidence that inadequate WASH accounts for the burden of diarrhoeal diseases and adverse effects on health (**see Prüss-Üstün et al. 2014**). There is also evidence that handwashing in particular substantially reduces diarrhoeal disease (and respiratory tract infections) in the community. Findings also indicate that improved excreta disposal, household water treatment and an increase in the quantity of water can reduce the risk of diarrhoea and other WASH-related diseases and that sustained behaviour change is instrumental to these reductions (**see for example, Yates et al. 2017 and Share 2016**).

It can be difficult to evidence the effectiveness of HP due to its complex and often interrelated mix of components (such as availability and access to safe excreta disposal, community ownership and participation). However, several reviews have emphasised the effectiveness of community-based approaches and stressed the importance of HP approaches that go beyond a narrower focus on messages and increasing knowledge (**see Oxfam 2012 and De Buck 2017**). A variety of studies have shown that knowledge and beliefs about health or hygiene risks are often less important than an exploration of other factors such as attitudes, ability, beliefs and social norms (**see Alemu et al. 2018**). There is however a lack of evidence of the effectiveness of specific behaviour change approaches (**see De Buck et al. 2017**). Recent reviews have called for a more systematic assessment of hygiene behaviours and their determinants (**see Czerniewska, A, White, S. 2020**).

→ **More information on the latest available research can be found on page 285**

Emergency and Crisis Scenarios

Emergencies can arise in a range of contexts and can be either acute and time-limited or chronic and protracted. Hygiene promotion interventions need to take account of the various WASH challenges and community dynamics in different scenarios. Traumatic events associated with conflict, or losing loved ones, can interfere with people's ability to process information and communicate; hygiene promoters must be aware of how to respond to people who are grieving. In some contexts, hygiene promoters will be working with both displaced and host communities. In others, the initial focus may be to support community reorganisation and, in some situations, work will only be possible remotely.

The scenarios leading to emergencies can be broadly categorised as follows:

Emergencies Triggered by Natural or Technological Hazards: earthquakes, volcanic eruptions, landslides, floods, storms, droughts, temperature extremes and disease epidemics/pandemics (e.g. cholera, Ebola or COVID-19) are natural hazards that can cause humanitarian disasters, claiming many lives, causing economic loss and environmental and infrastructure damage. However, humanitarian disasters only occur if a hazard strikes where populations are vulnerable to the specific hazard. Such emergencies often result in deteriorating environmental health conditions, particularly of access to basic WASH services. Infrastructure such as schools, roads, hospitals and water and sanitation facilities are often directly affected, reducing access to clean water, sanitation and the ability to practice safe hygiene such as handwashing – increasing the risk of water and sanitation-related diseases.

Conflicts: refer to societally created emergencies such as political conflicts, armed confrontations and civil wars. Many internally displaced people or refugees have to be housed in camps, temporary shelters, or host communities where access to clean water, sanitation and other hygiene facilities and requirements needs to be guaranteed at very short notice – and often maintained over long periods. The majority of displaced people are absorbed by host communities. This can overburden the existing water supply (and sanitation) infrastructure, making it difficult to identify and quantify actual needs; upgrades to existing infrastructure may be required. Funding for WASH interventions – either for large populations integrated with host communities or in long-term camps – can be challenging; HP can be seen as a luxury rather than a necessity. If people are displaced in large numbers, community structures and support mechanisms are often disrupted; response plans may need to support community reorganisation. Additional challenges arise if the conditions in the camp become better than those in the host

communities, creating tension between the local and refugee populations. Such cases should be seen as opportunities to improve WASH services for both host and refugee communities.

Fragile States: states can be considered fragile when they are unwilling or unable to meet their basic functions. For the affected population, safety may be at risk if basic social services are not provided or are poorly functioning. Weak government structures or a lack of government responsibility for ensuring basic services can increase poverty, inequality and social distrust and potentially develop into a humanitarian emergency. The provision of basic WASH services is frequently neglected by such states and external support using conventional government channels is often ineffective. A lack of adequate infrastructure can make HP very challenging; advocating for increased funding and support may be vital. Affected communities may easily tire of the efforts of hygiene promoters unless they are based on genuine capacity, collaboration and engagement to address the problems.

(High) Risk Countries Continuously Affected by Disasters and Climate Change: many countries face enormous challenges from climate change and the increasing likelihood of associated natural hazards. The risk that natural events will turn into a disaster is largely determined by the vulnerability of each society or group, the susceptibility of its ecological or socio-economic systems and the impact of climate change on both occasional extreme events (e.g. heavy rains causing floods or landslides) and on gradual climatic changes (e.g. temporal shift of the rainy seasons). Climate change also exacerbates problems in countries that are already suffering from disasters. All WASH interventions require a stronger focus on preventative and Disaster Risk Reduction (DRR) measures: HP will need to adapt accordingly.

Disasters can be a mix of several categories (e.g. fragile or conflict-affected states hit by a natural disaster). This makes response targeting more difficult (deciding for example whether to target those affected by the natural disaster or those affected by more chronic conditions). Disaster and crisis scenarios can be sudden onset (e.g. earthquakes or conflicts) or slow-onset (e.g. droughts that may lead to a prolonged food crisis) or fragile contexts that lead to a deterioration of services over time. Depending on the type of crisis, the population and infrastructure may be affected very differently. While some disasters lead to massive population movements (with implications for a comprehensive public health response) others may only affect the infrastructure (shifting the response focus to repairs and respective improvements). In the latter case, HP would focus on facilitating community engagement and ensuring that the improvements or repairs to infrastructure deliver the greatest possible impact.

Response Phases

Hygiene promotion interventions differ according to the context, including the phase of an emergency. Common categories used to distinguish phases are **(1)** acute response, **(2)** stabilisation and **(3)** recovery. Additional longer-term phases that may need to be taken into consideration are **(4)** protracted crisis and **(5)** development. The identification of these broad phases is helpful when planning assistance, whilst recognising that the division is theoretical, offering a simplified model of a highly complex emergency situation.

Acute Response: this usually covers the period from the first hours and days up to the first few weeks or months, when rapid, short-term measures are implemented until more permanent or durable solutions can be found. Rapid humanitarian relief interventions are made immediately following natural disasters, conflicts, epidemics/pandemics, or further degradation of a protracted crisis. The purpose of interventions in the acute response phase is to secure and ensure the survival of the affected population, guided by the principles of humanity, neutrality, impartiality and independence. It usually takes time for external support agencies to mobilise; those affected typically have to deal with the emergency initially themselves – even though they may not be adequately prepared.

An initial (rapid) assessment (**chapter A**) identifies the acute public health risks, priority needs and leads to a better understanding of the context, community profile, available capacity and current hygiene-related practices. Hygiene promotion actions must also facilitate intersectoral and cross sector communication and coordination with all relevant stakeholders. It must enable the involvement of local hygiene promoters and community mobilisers (**chapter P**). To ensure that the response includes the entire affected population, HP makes sure that local authorities and local first responders are involved from the outset and that there is equitable participation of men, women, children and marginalised and vulnerable groups in planning, decision-making and local management (**chapter E**). These consultations may also inform the initial provision of basic WASH infrastructure (primarily on a communal level to reach many people quickly), access to relevant hygiene items (such as soap, buckets, or menstrual products) as well as measures to ensure a hygienic and safe environment (**chapter P**). Depending on the context it may also involve the use of different participatory or mass media communication tools (**chapter C**) and targeted behaviour change strategies (**chapter B**) to address the most critical hygiene behaviours.

Stabilisation: the stabilisation or transition phase usually starts after the first weeks/months of an emergency and can last six months or longer. The main focus, as well as increasing service coverage and an incremental upgrade

and improvement of temporary structures, is to enable people to practice basic hygiene-related behaviours and ensure their active participation and engagement. During the stabilisation phase, relevant pre-emptive resilience and DRR measures should be implemented, particularly if another disaster is likely. The equitable participation of men, women, children, marginalised and vulnerable groups in planning, decision-making and local management (**chapter E**) remains as important as in the acute phase. Participation helps to ensure that the entire affected population has safe and adequate access to WASH services and practises key hygiene behaviours.

Additional in-depth assessments of the factors underpinning behaviour may be needed (**chapter A**) to respond adequately within a given local context and increase the longer-term acceptance of the planned interventions. Monitoring the effectiveness of initial interventions should also lead to adaptations and improvements (**chapter M**). Hygiene promotion interventions may include the establishment of additional community-supported structures (**chapters P and E**) and, where possible, the increasing involvement of development actors. The scope for using Market-Based Programming (**P.8**) should also be examined.

Recovery: the recovery phase, sometimes referred to as the rehabilitation phase, aims to recreate or improve the pre-emergency situation of the affected population by increasingly incorporating development approaches and principles. This phase usually starts after, or sometimes during, relief interventions (usually >6 months) and can be viewed as a continuation of completed relief efforts. Overall, it can prepare the ground for longer-term development interventions and for handing over to medium-long-term partners. Depending on local needs, the general timeframe for recovery and rehabilitation interventions is usually between six months and three years. Difficult and complex situations, such as in conflict-affected areas, may need much longer and can move in and out of crisis (**see Protracted Crisis on page 17**).

Recovery and rehabilitation programmes are characterised by the active participation of local partners and authorities in planning and decision making, strengthening local capacity and promoting the sustainability of interventions. The scope for using Market-Based Approaches (**P.8**) should be further assessed here. Hygiene promotion recovery interventions vary; they continue to depend on local conditions as well as the affected population's immediate and structural needs (e.g. promoting gender equity and human rights). Beyond the technical implementation of relevant WASH infrastructure, these interventions include significant efforts to strengthen WASH service structures and systems as a whole.

Recovery interventions also include longer-term capacity strengthening and training, including working with relevant local authorities and development partners. Stronger collaboration with utilities, civil society, private sector

and the handing over of responsibilities is important and requires the increasing participation of stakeholders in planning and decision-making early on (**chapter E**). Where possible, recovery interventions should provide a foundation for further development of WASH facilities and services and include relevant resilience and DRR measures. Effective recovery plans have clear transition or exit strategies, including hand-over to local governments, communities or service providers to ensure that the intervention's service levels can be maintained.

Protracted Crisis: refers to populations affected by recurrent disasters and/or conflicts, prolonged food crises, the deterioration of people's health and a breakdown of livelihoods. In these environments, a significant proportion of the population can become acutely vulnerable to a prolonged increase in mortality and morbidity rates. Protracted crises often occur in already fragile environments (**see Fragile States on page 15**), where the state is unwilling or unable to fulfil its basic functions and to manage, respond to, or mitigate risks. The context may cause social tensions (e.g. between refugees or internally displaced people and host communities). It may then be necessary to explore complementary and alternative approaches to WASH service provision, mainly working at a more decentralised level with non- and sub-state actors. Even if funding is (commonly) more constrained in a protracted crisis, HP needs, at a minimum, to ensure community engagement in all WASH service provision.

Development: the development phase is characterised by a stronger focus on universal access and the longer-term sustainability of WASH services, with global targets set by the Sustainable Development Goals. As well as improving access to WASH services, development aims to strengthen the local, regional or national WASH systems as a whole, including all actors (people and institutions) and factors (e.g. infrastructure, finances, policies, coordination and environmental conditions) needed to deliver sustainable WASH services. Hygiene promotion interventions in the development phase can have various forms and objectives, depending on the local conditions and the needs of the target population. Interventions often revolve around creating demand for and ensuring the use, operation and maintenance of WASH services, longer-term behaviour change and habit formation, ownership and empowerment.

In disaster and crisis-prone regions, preventative measures such as DRR, preparedness and Climate Change Adaptation activities should be considered and addressed during the development stage. Such interventions aim to reduce disaster risks through systematic efforts to analyse and reduce the causal factors of disasters and to take precautionary measures. They also aim to strengthen the ability of governments, organisations and the affected population to mitigate risks and to respond promptly.

Key HP measures include working with national clusters

or sector coordination mechanisms to develop standard operating procedures, agree on local standards for HP and hygiene items and develop contingency and emergency preparedness plans. Development HP can include the stockpiling of WASH equipment and consumables, the preparation of emergency services and stand-by arrangements (with a clear assignment of responsibilities and jurisdiction) as well as the establishment of support networks among different regions. It also includes capacity strengthening and training of volunteers and emergency personnel and the strengthening of local structures through community planning and training. It may include pre-crisis market assessments, operational research and/or compilation of information on, for example, hygiene practices, risk perceptions and trusted communication channels that can be rapidly used in a new emergency.

Principles and Standards Related to Hygiene

There are several standards and guidelines for HP in emergencies, including the Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, UNHCR's WASH Manual for Refugee Settings, World Health Organization (WHO) guidelines (e.g. for hand washing hygiene) and national standards and guidelines. This section describes the Sphere Handbook (referred to hereon simply as 'Sphere') in detail as it is the main, globally agreed reference for WASH principles and standards. Whatever the balance between national capacity and international support mobilised in response to a crisis, all parties must respect and observe the national regulatory environment. This includes relevant national policies, laws and standards. Local regulations at the municipal level are unlikely to be familiar to external actors but must be understood and adhered to. This is of particular importance when transitioning to longer-term solutions during the stabilisation and recovery phases.

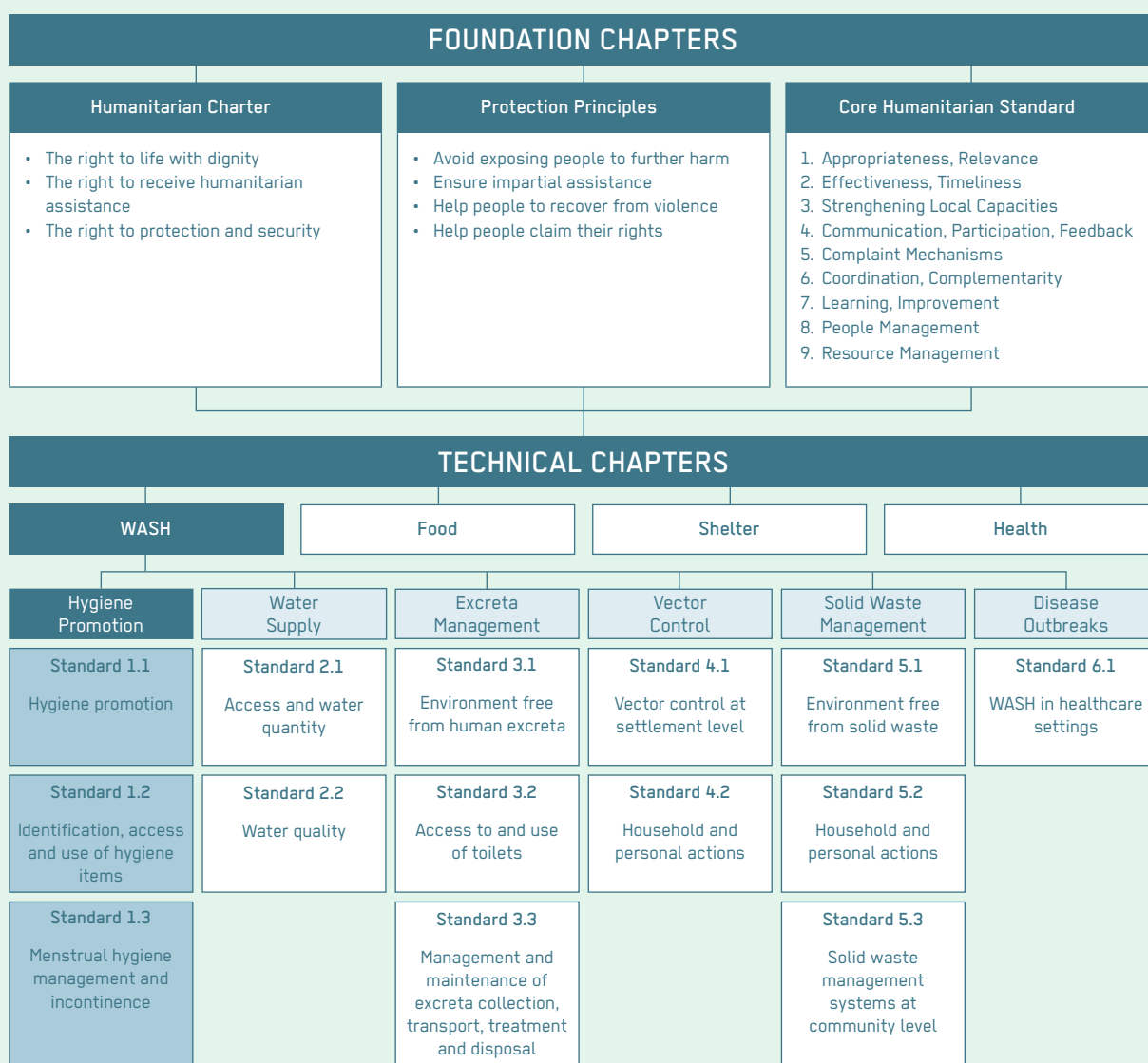
However, national hygiene standards may not exist or be easily adapted to crisis situations. In these cases, Sphere should be referred to for guidance and/or UNHCR's WASH indicators and targets for refugees and adapted based on the context, response phase and existing national targets. Whenever possible, government stakeholders should be engaged in the discussion about the application of emergency standards and indicators.

The Sphere Handbook

Sphere provides a set of globally agreed and universal principles and standards in core areas of humanitarian assistance. With its rights-based and people-centred framework, Sphere aims to improve the quality of assistance provided to people affected by disasters and to enhance the accountability of the humanitarian system in disaster response. Sphere is a practical translation of its core belief that all people affected by disaster have the right to life with dignity and the right to receive humanitarian assistance. It consists of both foundation and technical chapters (see figure 2). The **Foundation Chapters** include the Humanitarian Charter as its backbone with common legal principles and shared beliefs, the

Protection Principles and the Core Humanitarian Standard that defines nine commitments applicable to all humanitarian actions. The **Technical Chapters** outline response priorities in four key life-saving sectors: WASH, food security and nutrition, shelter and settlement and health. These technical chapters must be read in conjunction with the Foundation Chapters.

In the technical chapters, standards state the minimum to be achieved in any crisis for people to survive and re-establish their lives and livelihoods in ways that respect their voice and ensure their dignity. These standards are universal, general and qualitative. Key actions outline practical steps for attaining the standard, though these are considered to be context-specific suggestions. In addition, indicators are outlined for each standard; they



Structure of all Technical Standards

Standard:	Universal, general and qualitative, state to be reached
Key Actions:	Practical steps to attain the standard
Key Indicators:	Signals to measure progress and whether a standard is being attained
Guidance Notes:	Additional information on how to consider context and operational requirements

Figure 2:
Sphere Overview and the
WASH Technical Chapter
(adapted from Sphere 2018)

signal whether it is being met. Indicators also provide a way to compare programme results over the life of the response. Minimum quantitative requirements (where provided) are the lowest acceptable level of achievement and are only included where there is sectoral consensus. Guidance notes provide additional information on how to link the standards with the principles and how to consider context and operational requirements.

The hygiene promotion standards should be used in conjunction with the standards for the whole WASH chapter. They include many promotive and preventive measures enabling individuals and communities to exercise their human right to life in dignity. These rights are translated into three specific HP standards entitling everyone to access the means to reduce public health risks and enable hygiene, health, dignity and well-being as outlined below.

The Sphere Hygiene Promotion Standard 1.1 (Hygiene Promotion)

Minimum Standard: People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.

Key Actions:

1. Identify the main public health risks and the current hygiene practices that contribute to these risks.
 - ▶ Develop a community profile to determine which individuals and groups are vulnerable to which WASH-related risks and why.
 - ▶ Identify factors that can motivate positive behaviours and preventive action.
2. Work with the affected population to design and manage hygiene promotion and the wider WASH response.
 - ▶ Develop a communications strategy using both mass media and community dialogue to share practical information.
 - ▶ Identify and train influential individuals, community groups and outreach workers.
3. Use community feedback and health surveillance data to adapt and improve hygiene promotion.
 - ▶ Monitor access to and use of WASH facilities, and how hygiene promotion activities affect behaviour and practice.
 - ▶ Adapt activities and identify unmet needs.

Key Indicators:

- Percentage of affected households who correctly describe three measures to prevent WASH-related diseases
- Percentage of target population who correctly cite two critical times for handwashing

- Percentage of target population observed to use handwashing stations on leaving communal toilets
- Percentage of affected households where soap and water are available for handwashing
- Percentage of affected population who collect water from improved water sources
- Percentage of households that store drinking water in clean and covered containers
- Percentage of carers who report that they dispose of children's excreta safely
- Percentage of households using incontinence products (pads, urinal bottles, bed pans, commode chairs) who report that they dispose of excreta from adult incontinence safely
- Percentage of affected households who dispose of solid waste appropriately
- Percentage of people who have provided feedback and say that their feedback was used to adapt and improve WASH facilities and services
- Local environment is free of human and animal faeces

The Sphere Hygiene Promotion Standard 1.2 (Identification, Access to and Use of Hygiene Items)

Minimum Standard: Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.

Key Actions:

1. Identify the essential hygiene items that individuals, households and communities need.
 - ▶ Consider different needs of men and women, older people, children and persons with disabilities.
 - ▶ Identify and provide additional communal items for maintaining environmental hygiene, such as solid waste receptacles and cleaning equipment.
2. Provide timely access to essential items.
 - ▶ Assess availability of items through local, regional or international markets.
3. Work with affected populations, local authorities and other actors to plan how people will collect or buy hygiene items.
 - ▶ Provide information about timing, location, content and intended recipients of cash-based assistance and/or hygiene items.
 - ▶ Coordinate with other sectors to provide cash-based assistance and/or hygiene items and decide on distribution mechanisms.
4. Seek feedback from affected people on the appropriateness of the hygiene items chosen and their satisfaction with the mechanism for accessing them.

Key Indicators:

- All affected households have access to the minimum quantity of essential hygiene items:
 - ▶ two water containers per household (10–20 litres; one for collection, one for storage);
 - ▶ 250 grams of soap for bathing per person per month;
 - ▶ 200 grams of soap for laundry per person per month;
 - ▶ Soap and water at a handwashing station (one station per shared toilet or one per household); and
 - ▶ Potty, scoop or nappies to dispose of children's faeces.
- Percentage of affected people who report/are observed using hygiene items regularly after distribution
- Percentage of household income used to purchase hygiene items for identified priority needs

The Sphere Hygiene Promotion Standard 1.3 (Menstrual Hygiene Management and Incontinence)

Minimum Standard: Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.

Key Actions:

1. Understand the practices, social norms and myths concerning menstrual hygiene management and incontinence management, and adapt hygiene supplies and facilities.
2. Consult women, girls and people with incontinence on the design, siting and management of facilities (toilets, bathing, laundry, disposal and water supply).
3. Provide access to appropriate menstrual hygiene management and incontinence materials, soap (for bathing, laundry and handwashing) and other hygiene items.
 - ▶ For distributions, provide supplies in discrete locations to ensure dignity and reduce stigma, and demonstrate the correct usage for any unfamiliar items.

Key Indicators:

- Percentage of women and girls of menstruating age provided with access to appropriate materials for menstrual hygiene management
- Percentage of recipients who are satisfied with menstrual hygiene management materials and facilities

- Percentage of people with incontinence that use appropriate incontinence materials and facilities
- Percentage of recipients that are satisfied with incontinence management materials and facilities

→ **References and further reading materials can be found on page 285**

Human Resources and Capacity Strengthening in Hygiene Promotion

All HP interventions require the management and staff capacity to deliver the programme effectively. There is no recognised professional qualification for hygiene promoters; as a result, emergency responses recruit from a wide variety of professions and backgrounds. Therefore training, capacity strengthening, support and supervision are key responsibilities of the programme.

The main role of a hygiene promoter is to support community-level decision making and ensure that what is often a technically driven intervention is also people-focused. As a result, hygiene promoters' main skill sets and competencies relate to communication and facilitation (e.g. active listening, empathy and the confidence to work with groups and communities).

Where possible, hygiene promoters should be able to communicate in the preferred language of the affected community, have an open, positive attitude to diversity and inclusion and have some experience of working with communities. These skills are often more important than public health, behavioural or WASH knowledge. Depending on their job responsibilities, hygiene promoters may also need to keep records and write clear reports.

It is important to recruit locally whenever possible and to strengthen the capacity of existing development staff to respond to emergencies. Staff may be seconded from government ministries or identified through local and national NGOs, helping to increase the resilience of national staff and communities to future crises.

Human Resources

Hygiene promotion can be implemented by a variety of people and institutions such as a government department, Community Based Organisation or NGO. Interventions can be carried out by paid national or international staff, volunteers, community organisations or a mixture of any of these. In a WASH emergency response, dedicated human resources for HP is recommended, to ensure that time is fully allocated to work supportively and interactively with communities.

Staff and volunteers must know what is expected of them and be provided with up to date job descriptions and codes of conduct. New staff should also receive briefings and inductions. Recruiters should aim for a balanced and diverse team (e.g. in terms of gender, disability,

background) including in management positions.

On-going support for staff and volunteers must be provided and they must be aware of who will directly manage them. Competency frameworks should be developed to inform discussions with staff, helping to identify strengths, weaknesses and further training and support strategies. As soon as possible, a training plan for all staff and volunteers should be established. Organisations have a duty of care for their workers and must take measures to ensure their safety, manage stress, health and safety and personal security. At the same time, staff and volunteers must take responsibility for their own security and well-being and adhere to organisational guidelines and policies. Hygiene promotion staff and volunteers also need the resources to enable them to do their job, such as materials, equipment and means of travel.

Short staff deployments often lead to high staff turnover, undermine continuity and programme quality. They can result in a reduced sense of personal responsibility for the work. Regardless of whether the deployments are short or long staff should feel supported; whenever funding allows, turnover can be reduced if deployments are planned strategically and staff trained and motivated.

Community Based Volunteers

If the programme strategy is to work with community volunteers, the affected community should select them according to agreed, specific criteria. Existing outreach systems can be identified – they can also be mobilised more quickly. It is critical, however, that these outreach systems are respected and accepted by the community. Alternative systems for outreach such as Community Health Clubs (F.1) may also be appropriate.

Ideally, community-based volunteers would be:

- From the same broad cultural background and ethnicity as the community with whom they work
- Motivated to work to improve the community and able to commit sufficient time for activities
- Respected and trusted within the community and a positive role model
- Have strong social and verbal communication skills and strong participatory facilitation skills
- Have an open and positive attitude to diversity and inclusion
- Have active listening skills, empathy and the confidence to work with groups and communities

The competencies expected of community-based volunteers vary. Some agencies demand literacy and numeracy, but this may exclude talented communicators and mobilisers in communities with low overall literacy rates or where women or persons with disabilities have not had the opportunity to attend school. Volunteers with disabilities are often more aware of the challenges faced

in accessing and using water and sanitation information and facilities and in managing their personal hygiene (with or without the help of others). Organisations may differ in their staff and volunteer policies e.g. some may require that volunteers be insured or wear a particular uniform.

Volunteers make a significant contribution to the response; they need to be trained and well supported. They also bring their own beliefs, ideas and experiences to the work, which may include biases, misconceptions and prejudices against certain individuals or groups. Through formal and on-the-job training, practice, mentoring and continuous encouragement, volunteers can develop as open-minded facilitators rather than information providers or didactic teachers.

Compensation for volunteers is often a source of debate and disagreement in emergencies, especially when volunteers are from the affected population and have no other source of income. The term 'volunteer' means that people do not normally receive payment but can be compensated in kind through the provision of training, materials and equipment and the respect of the community they are working for. Expenses for travel or meals when working can also be provided. The argument against paying volunteers is that it is not sustainable. However, it is often unrealistic in an emergency to expect people to work for more than a few hours a week for free. Compensation arrangements should therefore be context-specific, discussed and clarified in interagency meetings (P.9) and discussed with community members before work commences.

Capacity Strengthening

Capacity strengthening can take place at an organisational, (inter)sectoral or community level. It aims to strengthen knowledge, skills and behaviour to enable people and organisations to effectively address WASH needs and increase their resilience to future crises. For the same reason, DRR and preparedness should incorporate capacity strengthening. Training and learning must support the development of key HP competencies and be based on job descriptions.

The community-based work of hygiene promoters may require training in facilitation and communication skills, including active listening, community participation and accountability. They will also require training in the specific tools and approaches used by an organisation. Embedding community engagement in a programme will also require managers, water and sanitation engineers, logisticians and others involved in the response to be trained. A competency framework (see Human Resources above) and a capacity strengthening plan should be developed, based on a learning needs assessment. Capacity strengthening is a continuous process; one-off training sessions or 'workshops' are insufficient. Each plan must be monitored and evaluated to ensure that it is achieving its aims. There are various methods for supporting

capacity and learning other than classroom or workshop-based training. Learning by doing and using participatory exercises in the field provide practical experience. Coaching and mentoring are also ways to build capacity, as are one to one and group meetings.

Opportunities for formal staff development may be limited in the first phase of response, but induction and on-the-job training should be provided as a minimum. Staff and volunteers can also be encouraged to set their own objectives for development and training. A coaching system for staff that ensures that they are continually trained, supervised and monitored can be useful.

Joint training sessions can be organised at an interagency level and should be a mixture of on-the-job and classroom based. On-the-job training is more likely in an acute emergency phase, concentrating on the specific activities that are required immediately. Training of trainers in the community can be useful, but all trainers should develop good training and facilitation skills – in reality, there is often a loss of quality when ‘cascading’ training from ToT level down to the community.

Regular meetings with teams of staff and volunteers are beneficial. They provide a chance for team members to learn from each other, discuss progress and field-related problems as well as strategies for managing them, changing and adapting action plans where required.

Budgets for training, capacity strengthening, monitoring and supervision must be written into proposals.

Human Resources and Adult Learning

Effective training provides adults with an opportunity to build on existing beliefs, knowledge and skills and to share them. Respect and relevance are critical to effective adult learning and adults need to feel that the learning is of immediate practical benefit. Learners must feel that their existing knowledge is recognised and that they are being listened to. Learning should bolster their self-esteem and never feel belittling or humiliating. Learners must be able to identify how they can use new knowledge, skills and attitudes immediately rather than in the future. It is said that adults retain 20% of what they hear, 40% of what they see and hear and 80% of what they do and discover. The best way to develop participants’ confidence, skills and self-esteem is to create opportunities for them to practise new skills and knowledge (e.g. role plays or going into the community to practise).

The role of the ‘trainer’ is to facilitate learning and to understand how to meet the different learning needs of the group by using a variety of methods and approaches. Didactic training methods that simply aim to supply information should be avoided in favour of developing critical thinking and reflection and the practical application of what is learned.

→ **References and further reading materials can be found on page 285**

Implementation Guidance

The implementation of an HP programme must be guided by the Humanitarian Programme Cycle (HPC), as used by the Inter-Agency Standing Committee (IASC). It provides a framework for preparedness (which encompasses the whole programme cycle) and for the implementation of an intervention through five sequential steps.

Hygiene promotion interventions however are not linear or one-off: they span the entire programme cycle (see **Figure 3 on page 24**). This HP Compendium informs the full programme cycle, providing a comprehensive collection of guidance, information, components, tools and methods, and frameworks and approaches with which programmes can be assessed, designed, implemented and adapted. Some chapters correspond directly to the HPC (Assessment, Analysis and Planning, **chapter A**, and MEAL, **chapter M**); others can be selected, as required, at any stage of the programme cycle (e.g. Community Engagement and Participation, **chapter E**). Additional resources are provided in the Reference section.

Some approaches will only be appropriate in particular contexts and programmes. There are however four key elements of HP implementation that should be applied in every programme:

- At the heart of implementation is the principle of Community Engagement and Participation (**chapter E**). This should be seen as a process that begins even in the acute phase of an emergency. It aims to respond meaningfully to different WASH needs and enable affected communities to feel they have a voice in how the response is implemented. This Compendium provides a variety of resources that can be used in HP, but all tools (**chapter T**) and approaches (**chapter F**) need to respect the principles of community engagement.
- Empathy with the affected population and efforts to understand their perspectives are also crucial. Active listening is a vital component of Communication (**chapter C**); listening, rather than simply providing information, should be HP’s starting point.
- The successful implementation of HP also requires an understanding of Preconditions and Enabling Factors (such as access to facilities and markets, **chapter P**) and realism about what is possible in their absence. Similarly, programmes need to recognise the importance of the social and behavioural determinants of hygiene (**chapter B**) and to assess and monitor barriers and motivators for change; most of the frameworks (**chapter F**) draw on a model of behaviour change. All these factors must be included in an HP programme.
- Coordination and communication between all international, national and local WASH actors and other relevant sectors in planning and decision making is essential (**P.9**). It facilitates the timely

delivery of WASH services and enables participation, reduces duplication and helps to prioritise interventions. It can optimise the quality of the WASH response and the use of available resources. Collaboration within and between government departments and agency WASH teams also increases the effectiveness of the response.

The choice of approach or tool will depend on the context, funding, resources, access and the time available. It also depends on the specific population group the responders are working with and where. For example, the Integrated Behavioural Model (T.21) or the RANAS (F.20) approach could be used to assess and design the programme. The Community Perception Tracker (F.24), 'Mum's Magic Hands' (F.5) and a variety of tools could be used to understand and respond to community feedback (accountability) and increase handwashing rates.

The overview matrices for the HP Tools (pages 168–169) and the HP Frameworks (pages 230–231) provide details on a variety of criteria to aid with decision making.

The Programme Cycle

Preparedness: emergency response preparedness activities begin with communities recognising that they are at risk and hence developing potential response strategies. Responders (including governments) need to prepare by understanding local strengths, weaknesses and vulnerabilities. Responders can help communities with assessments (chapter A) to identify risky hygiene practices and ways to address them, and to identify their communication preferences (chapter C). Preparedness assessment should also consider access to adequate stocks of hygiene items or markets (P.6 and P.8), access to minimum WASH infrastructure and services (chapter P) and the scope for Market-Based Programming (P.8).

Needs Assessment and Analysis: in the early stage of an emergency it is essential to understand the context and existing local capacity (A.6). Assessments aim to find out who is affected, their needs and vulnerabilities, the affected communities' perceptions, existing norms, leadership structures and priorities. The coping strategies of the communities and their capacities can be mapped out so that interventions address gaps in hygiene facilities, services and corresponding behaviours. It is also essential to understand the various motivators and barriers (B.3, B.4, B.5, B.6, B.7) that influence change and to understand the difference between knowledge, skills, ability and self-efficacy and how they can be used beneficially in HP (B.3 and B.4). Attitudes and beliefs also motivate behaviour change (B.5) and are linked to social norms as an important influence on individual behavioural change (B.6). It is also important to use an understanding of cues and habit formation to encourage successful and sustainable behaviour change (B.7). A community profile (A.7) should be

developed to determine which individuals and groups are vulnerable to which WASH-related risks and why. This profile can guide interventions throughout all phases: acute response, stabilisation and recovery.

Many factors affect people's health and wellbeing, not only access to WASH (A.2). It is vital to design and plan the assessment with others (A.3) and to select appropriate data collection methods (A.4) in order to carry out an effective assessment (A.5) and an appropriate plan (A.9) that responds to the needs of the affected population. A combination of quantitative and qualitative methodologies is ideal, though care should be taken when carrying out quantitative surveys (A.8). It is also essential to engage, enable and listen to different groups during the assessment (E.1 and E.2). The WASH needs in different settings and institutions such as schools (E.6) should also be considered.

Strategic Planning: the planning phase (A.9) of an intervention involves analysing and prioritising the information gathered during the assessment and using it to design and resource the programme. It is a vital step in any HP intervention. For WASH-related interventions, incorporating gender (E.3) and diversity is particularly important. The needs of babies, children and young people (E.4), older people and those with disabilities (E.5) must be considered. Menstrual Hygiene Management (P.7) must be incorporated early in the programme. Involving a diverse group of affected people in discussions about the assessment findings and understanding their concerns early on is important to review the plans and decide together on realistic and context-specific options. Planning also includes the process of procurement or development of the necessary materials and resources for the programme's activities as well as identifying human resource needs, including staff training (see Implementation and Monitoring below).

Resource Mobilisation: refers to ensuring sufficient financial resources (funding is not covered in the Compendium). In the initial stage of an emergency, a large share of the resources may be dedicated to water supply (P.3) and sanitation facilities and services (P.4) and enabling access to hygiene products and materials (P.5 and P.7). There will often be recurring costs for such items. Handwashing with soap and access to handwashing facilities (P.2) should be a priority, even if funding is constrained, as it is a highly effective intervention to prevent the spread of disease.

Implementation and Monitoring: hygiene behaviour change (B.1) is fundamental to emergency HP implementation. It can be defined as the adoption or increase in key hygiene behaviours (such as the safe handling of water) and a decrease in risky behaviours (such as open defecation). Various behaviour change models and theories are outlined (B.2). An overview matrix is provided of existing

frameworks and approaches appropriate for different target groups, humanitarian contexts and settings (**chapter F**). Hygiene Promotion Tools and Methods (**chapter T**) also support the implementation of behaviour change strategies.

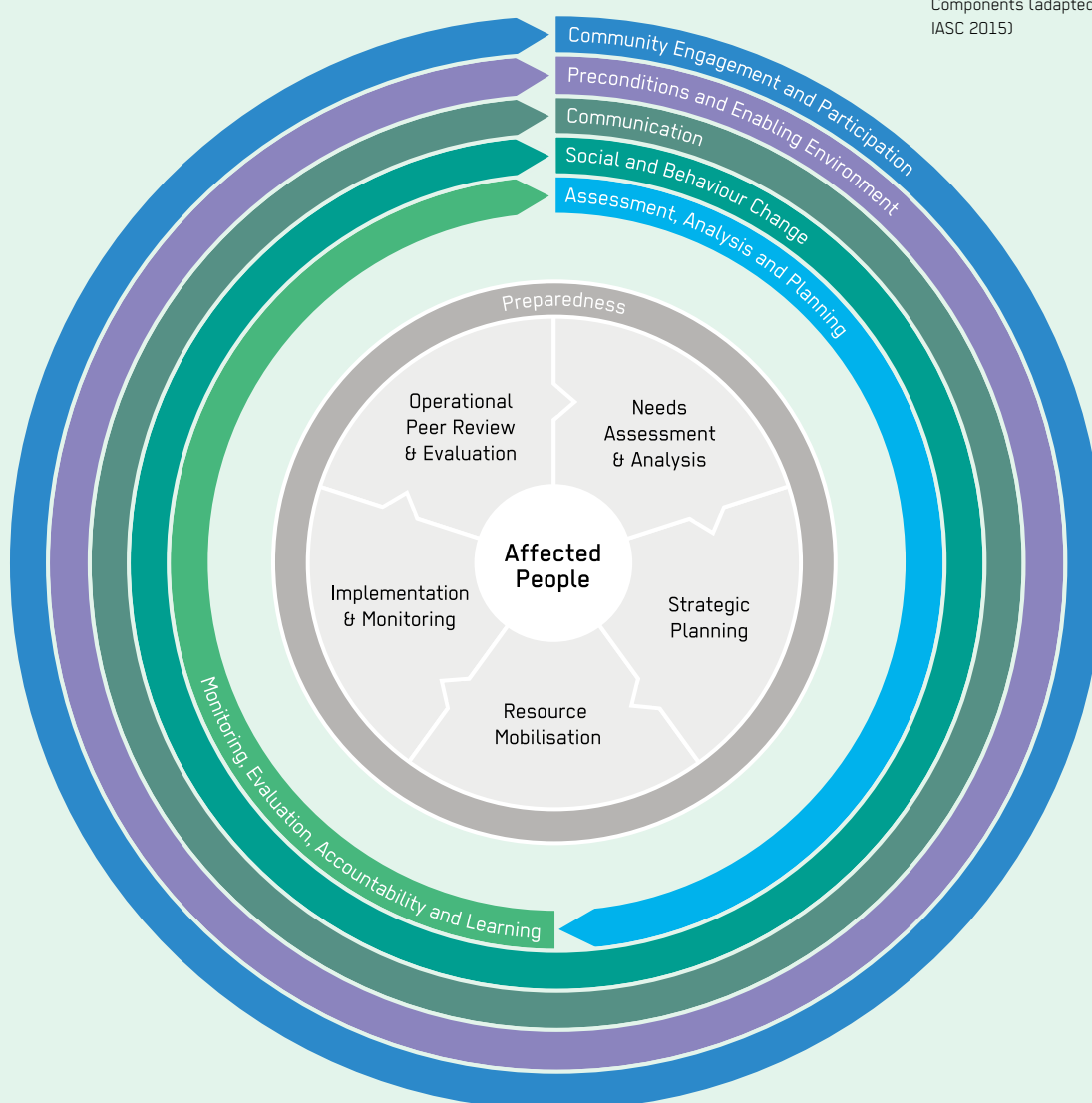
Successful implementation requires promoters with appropriate communication (**C.2**) and HP skills and expertise. In an acute emergency there must be dedicated HP personnel (whether volunteers or paid staff). Hygiene Promotion in Schools (**E.6**) requires its own set of considerations and approaches to be effective. For all WASH facilities, at community or institutional level, a feeling of Ownership and Management (**E.7**) responsibility are critical for the continued functionality of the services. Community Capacity Strengthening (**E.9**) should be included in the programme to enable sufficient levels of participation, engagement and skills.

Monitoring (**M.2**) is the systematic and continuous checking of the HP programme's progress to ensure that it is doing what is intended, using allocated funds appropriately and to good effect, seeking and hearing feedback and acting upon it and identifying strengths, weaknesses and gaps so that any required changes can be made.

Operational Peer Review and Evaluation: Accountability (**M.4**) aims to ensure that resources are used appropriately and transparently, that WASH responders take responsibility for their work and that communities benefit from efficient and effective programming. Standards such as Sphere and the CHS provide a framework for accountability, enabling the programme to respond to the needs of the affected community and facilitating peer review, on-going learning and improvement. Evaluation (**M.3**) examines whether the project has achieved its stated goal and what changes have occurred as a result. The main evaluation criteria are relevance, coherence, effectiveness, efficiency, impact and sustainability. Sharing and using evaluation findings encourages transparency and learning in the sector. Research is also important to test innovations, guide and strengthen evidence-based decision-making (**M.7**) in the design, implementation and evaluation of humanitarian WASH programmes.

→ **References and further reading materials can be found on page 285**

Figure 3: The Humanitarian Programme Cycle and its Interrelation with Key HP Components (adapted from IASC 2015)



PART 1:

Hygiene Promotion Components



Preconditions and
Enabling Factors

Preconditions and enabling factors are the resources, processes, services and infrastructural prerequisites that enable the relevant hygiene practices of an affected population and support good hygiene outcomes. They include the provision of adequate water and sanitation infrastructure (P.2, P.3, P.4), the ability of local markets to supply hygiene consumables and WASH services (P.8) and coordination with other humanitarian WASH actors, local service authorities, service providers and other sectors (P.9).

For any hygiene promotion (HP) intervention to be effective, the affected population needs access to handwashing facilities (P.2), water (P.3) and sanitation infrastructure (P.4) as well as related infrastructural requirements for health, solid waste management, drainage and vector control (P.5). Other key prerequisites include the availability and affordability of corresponding products (such as soap and menstrual products, P.6 and P.7) and services such as desludging. To ensure the use of WASH infrastructure and services by the affected population they must be accessible. As importantly, they must be equitable, affordable, culturally acceptable, well-maintained and located close to where the target behaviours should take place. A well-coordinated approach is also needed with local, national and international actors and related sectors such as health, nutrition and protection (P.9) to ensure that infrastructure, products and services are in place and sustainable. WASH advocacy (P.10) and a wider set of planned and coordinated activities may be required to strengthen and prioritise life-saving WASH interventions and improve local conditions and access to WASH services. Coordination and advocacy can also ensure that internationally agreed core principles, standards, codes and human rights are adhered to by all actors and that the affected population can claim their rights.

Sub-Chapters

- P.1 Key Concepts and Good Practice
- P.2 Access to Handwashing Facilities
- P.3 Access to Water Supply Facilities
- P.4 Access to Sanitation Facilities
- P.5 Access to Solid Waste Management (SWM), Health Care Waste Management (HCWM) and Vector Control
- P.6 Access to Hygiene Items
- P.7 Menstrual Health and Hygiene (MHH)
- P.8 Market-Based Programming (MBP)
- P.9 Coordination and Collaboration with other WASH Stakeholders and Sectors
- P.10 Advocacy for WASH and Community Priorities

Key Concepts and Good Practice

Main Purpose

To ensure that all the necessary prerequisites of minimum WASH infrastructure and services are in place for people to practise hygiene in a safe and dignified way.

Key Concepts

- For the affected population to practise satisfactory hygiene behaviours, adequate WASH facilities (including water supply, sanitation and handwashing infrastructure and hygiene items) must be available in sufficient quantities. They must also be accessible, affordable, inclusive, well-maintained, culturally appropriate and close to where the hygiene behaviours are to be performed (P.2, P.3, P.4, P.5, P.6).
- Hygiene promotion (HP) considers both the preconditions for change and how change can be enabled and supported. It is not the same as hygiene education which, traditionally, focuses solely on increasing knowledge.
- Promoting hygiene requires collaboration, coordination and teamwork (P.9) – both within the WASH sector and between sectors such as health, nutrition, protection, agriculture, food security, livelihoods and education.
- Hygiene promoters must work collaboratively with users, local actors, WASH engineers, technicians, logisticians and other sectors to ensure that WASH infrastructure, services and products meet the different needs of the population, are used and maintained effectively and therefore have an impact on people's health.
- Hygiene promotion focuses on improved hygiene practices, Social and Behavioural Change (chapter B) and Community Engagement (chapter E). It works collaboratively with and through representative groups from the targeted community so that they are involved in making decisions about how the programme is delivered such as the design, siting and management of WASH facilities (i.e. Human Centred Design).
- Local, national and international Advocacy (P.10) may be required to address the underlying causes of poverty, poor hygiene and ill health (including underlying causes such as vulnerability and poverty).

Good Practice

- Work together to achieve the common goal of improved hygiene and public health. WASH staff should collaborate through joint assessments, analysis, design, planning, implementation and sharing information. Regular team meetings, shared office space and joint field visits can also contribute to more effective collaboration.
- Ensure that managers facilitate different specialisms to work coherently together, checking that collaboration is written into job descriptions and organising joint training when required.
- Enable Community Engagement (chapter E) in the design of facilities and services and ensure that communication channels (chapter C) between WASH officers, project managers, engineers and technicians and the community are open and accessible. Hygiene promoters play a key role but community engagement should be part of the job of all involved WASH staff.
- Recognise the variety of WASH needs amongst different individuals (or groups of individuals) within a community – for example sanitation for babies and young children (E.4), menstrual hygiene needs (P.7), accessible handwashing facilities for different groups (P.2) or adaptations for those with disabilities (E.5).
- Consider privacy, dignity and safety issues for all those accessing WASH facilities and services. For example, location and distance, locks on toilet doors, adequate lighting, privacy screens and the segregation of facilities can help reduce the risk of abuse and violence.
- Consider communities (even new ones formed through displacement) in their entirety to ensure a more holistic response to an emergency, recognising how sectors overlap and depend on each other. For example, market systems must be adequately assessed and supported where feasible (P.8) and staff must know how to address protection concerns (T.35) and be accountable to the affected population (M.4 and F.23).
- Be proactive in sharing information and attend regular coordination meetings with others working in WASH (and related sectors). Involve government and local authorities and enable them to manage the response where possible; ensure that external actors play only a supporting role (P.9).
- Coordinate with other sectors – especially those which significantly overlap with HP (P.9). Examples include recruiting and managing community

volunteers (e.g. menstrual health is often paired with sexual and reproductive health in the health sector) and addressing protection concerns by referring to specialised teams or agencies.

- Consider from the outset how to make WASH interventions as sustainable as possible so that WASH infrastructure and services will continue to be safely managed and support good hygiene practices, even during a protracted crisis or displacement.
- Adhere to agreed policies, guidelines, codes of conduct and standards, e.g. Sphere (using the WASH Technical Standards together with the Protection Principles and Core Humanitarian Standard **(see Introduction)**, not in isolation).
- Consider and anticipate how the WASH programme may lead to negative consequences for the community, e.g. how will the programme influence power dynamics? What will happen after your intervention? Are you going to 'step on toes'?
- Ensure that all agencies involved in HP practise what they teach, reflected in clean and safe WASH facilities and services at their premises and exemplary staff hygiene practices.

Access to Handwashing Facilities

Main Purpose

To ensure that adequate and enabling handwashing facilities are available so that the affected population has the means to carry out hand hygiene practices.

Important

- Washing hands with soap and water is considered to be one of the most effective and low-cost WASH interventions to reduce the risk of outbreaks of diarrhoeal/respiratory diseases. Access to adequate facilities is a precondition for handwashing.
- Handwashing facilities (at least water and soap) need to be located in an accessible position and close to where the envisioned handwashing behaviour should take place (e.g. in homes, communal facilities such as toilets and kitchens, community centres, markets, health care facilities, religious places, schools and women and child-friendly spaces). Facilities must be accessible to all, regardless of age, sex or disability.
- A safe and sufficient supply of water and soap (or alternative products such as effective hand sanitisers) is needed at all times. Correct drainage, reuse or treatment of the greywater resulting from handwashing facilities must be considered to maintain a sanitary environment around the facility (P.5).
- Handwashing facilities require regular operation and maintenance (O&M), such as cleaning and refilling water containers, minor repairs and restocking of soap. For private households, soap is usually distributed periodically or can be accessed by using market-based interventions such as cash and vouchers (P.8). For community facilities, there must be community involvement and ownership and a plan for the replenishment of consumables (e.g. soap) as well as a stock for the replacement of frequently broken or stolen infrastructure such as taps.
- Links need to be made between community users and public health authorities so that Monitoring (M.2) is carried out and the sustainability of the facilities increased.
- Handwashing facilities form part of a larger group of facilities often termed 'hygiene facilities'; they include bathing/shower facilities and laundry facilities. Laundry facilities (slabs, basins) are usually located next to a water supply. Just as for handwashing facilities, the drainage of greywater is important as stagnant pools, eroded or muddy areas will negatively affect community hygiene.

Overview

The practice of handwashing needs to be strongly promoted in any emergency. Handwashing facilities are a critical precondition; targeted individuals and communities should always have the means to wash their hands with soap and water. Facilities need to be conveniently located for the envisioned handwashing behaviour, e.g. within a maximum of five metres from a toilet (whether private, shared or public), at sites where food is prepared or eaten and at other critical locations in households, schools/learning centres, health care facilities, women and child-friendly spaces, institutions and public spaces. Their functionality and use need to be constantly monitored and they require a constant supply of soap and water.

According to recent studies, the key challenges that reduce the effectiveness of existing handwashing technologies include unreliable access to water and soap; lack of ownership, O&M at the community and institutional level; the prioritisation of distributed or purchased soap for laundry, bathing and dishwashing over handwashing; insufficient drainage around handwashing stations and handwashing stations that break easily or are difficult for some to use.

The recommended minimum handwashing water quantity at public toilets is 1–2 litres per user per day. If the supply is piped, each handwash can use 500 ml of water, though water-saving taps can decrease this volume to 100–250 ml. If piped water is unavailable, alternative ways of providing a constant water supply must be provided (such as using rainwater or establishing rotas for refilling water containers). The minimum amount of soap required for personal hygiene – including handwashing – is 250 grams per person per month. Soap is usually provided in the form of bars, but liquid soap or soapy water may be an alternative, particularly during pandemics like COVID-19 (to avoid shared touch points on soap bars or lack of supplies). If neither water nor soap is available, alternative products may be used (such as a 0.05% chlorine solution if chlorine is sufficiently available and does not compete with other uses such as drinking water disinfection. Soap and a 0.05% chlorine solution should not be used together). Handwashing facilities should be designed to be inclusive and accessible to all adults and children, including persons with disabilities. All disabilities affecting the targeted population should be assessed, e.g. visual, physical or mental impairments. Facilities should be durable, robust, easy to clean, transport and construct. A wide variety of technical options exist, ranging from simple, low-cost facilities such as buckets with a tap (e.g. Oxfam bucket), Tippy Taps or group handwashing facilities (such

Process and Good Practice

as the WASHaLOT) to more robust permanent handwashing stations with tap(s). Drainage of effluent is important to keep the area around the handwashing facility clean and hygienic, not muddy and flooded. Greywater can be collected in a bucket or discharged into open drainage channels or a closed sewer, or directly into a mains sewer. Handwashing facilities near women's toilets should be located within the toilet stall, if possible. This supports dignity and privacy when washing hands after handling used menstrual products, as well as encouraging safe menstrual hygiene practices. Women and girls should not be deterred from changing or washing pads, changing tampons or emptying menstrual cups because of a lack of handwashing facilities within the toilet stall.

Ideally, handwashing facilities should be designed so that they can be operated hands-free to prevent cross-contamination (e.g. using self-closing taps, foot-operated pedals or elbow-operated levers). However, for people with disabilities (e.g. wheelchair users) hand-operated options may still need to be considered. Self-closing taps may be an alternative: they save water, are more durable and people do not have to touch the tap with their fingers to turn the water supply on and off. Handwashing facilities must be inclusive; children and people with reduced mobility (such as persons with wheelchairs) must be able to reach the handwashing facilities to use them. Adequate lighting must be provided so that people can use the facilities safely at night. Attractive looking handwashing facilities may encourage use **(T.4)** and involving users in their design and decoration may increase familiarity and acceptance. Information, Education and Communication materials **(T.19)** such as posters or paintings on handwashing techniques should be available at handwashing stations and be easy to understand for those with limited literacy.

Hygiene promotion (HP) should also encourage adequate hand drying after handwashing as damp hands can re-contaminate quickly and potentially spread far more bacteria than dry hands. The most pragmatic solution is air drying by simply waving hands after handwashing until they have dried.

- Involve users in the design, siting and management of handwashing facilities to enhance community ownership of both public and private handwashing facilities. Consult people, especially persons with different disabilities and children of different ages, to ensure that facilities are accessible to all.
- Strengthen ownership of public facilities through community committees, e.g. WASH Committee **(T.55)**, community health **(F.1)**, school, market or resident's committee **(E.7)**.
- Collaborate with communities to ensure adequate drainage around facilities and, if necessary, establish community and household systems for replenishing water and soap supplies.
- Consult with residents if the theft of infrastructure (such as basins, buckets, taps, soap) is an issue, to understand why it is happening and what can be done about it. Find out which materials are most appropriate for the facility, how they can be secured and how they can be replaced if necessary.
- Coordinate handwashing interventions during outbreaks of infectious disease when handwashing is a particularly critical intervention. Coordinate **(P.9)** the establishment of handwashing stations: they may be required at a variety of locations such as points of entry/exit checkpoints, the borders of an infected area, international borders, entrances to communities or towns or at the entrance to health posts, schools, places of worship or markets.
- Use a chlorine solution or hand sanitiser instead of water and soap where there is a high throughput of people (for example a transport hub).
- Collaborate with WASH engineers **(P.9)** to improve the access and design of handwashing facilities as required. In contexts where there is a shortage of water, the public may not prioritise handwashing. Water may instead be prioritised for agriculture, drinking water for animals or be used for cooling (e.g. with a straw mat and fan). In such cases discuss the importance of hand hygiene with the population whilst advocating **(P.10)** for an increase in the quantity of water where feasible.

→ References and further reading materials can be found on page 286

Access to Water Supply Facilities

Main Purpose

To ensure the affected population has access to a safe and sufficient supply of water for their hygiene needs.

Important

- Access to water is fundamental to people's health and well-being and is considered a basic human right. Everyone should have access to adequate, safe, acceptable, disability-accessible and affordable water for both personal and domestic needs. Access applies to all contexts of an emergency, regardless of where or when it occurs or its scale. Effective hygiene is dependent on access to and the satisfactory use of WASH facilities, services and products.
- Standards and guidelines for emergencies specify and address both the quantity and quality of water required to meet needs. Key references include Sphere's minimum standards for all types of emergencies and phases, UNHCR's standards for internally and internationally displaced people, WHO guidelines for drinking water and national standards and guidelines.
- The priority when establishing water supply facilities in an acute emergency is to provide an adequate quantity of water, even if it is of intermediate quality, until minimum standards for both water quantity and quality are met. Water quality improvements must then be made as soon as possible.
- Proximity to a water source is critical when selecting a location to settle people displaced by a disaster or crisis. The supply must adequately cover emergency requirements and provide scope to address longer-term needs.
- Increases in water supply lead to an increase of grey-water and/or wastewater, which needs to be treated or safely disposed of (P.4). Liquid waste streams can be separated into sludge and water and, in this way, wastewater can be reused, for example, for irrigation in agriculture. This in turn reduces the consumption of domestic water and allows for a more sustainable supply for hygiene and other important uses.

Overview

Access to water is defined as a sufficient quantity and quality of water to meet the needs of the affected population for hygiene, water consumption and sanitation. Users must be involved in the design, siting and management of facilities. Care needs to be taken to enable inclusive access, particularly for children and persons with disabilities.

A water supply system is a multi-step structure providing safe water for drinking, personal hygiene, cleaning and other domestic purposes. It comprises functional groups of technologies and services covering source exploitation, intake, abstraction and treatment to distribution methods and user safety at the point of use. A water supply system includes the management and operation and maintenance (O&M) required for the system to function safely and sustainably. The 'Compendium of Water Supply Technologies in Emergencies' provides a structured overview and in-depth information on water supply technologies and their applicability depending on the context, humanitarian settings and response phase.

In addition to establishing (or rehabilitating) a functioning water supply system or service that provides safe drinking water for all, it is important to provide ongoing protection from re-contamination, usually by adding chlorine and ensuring a sufficient free residual chlorine (FRC) level (amount of chlorine remaining in the water after its full disinfection to extend the protection against re-contamination). This needs to be regularly monitored as in the process of water being transported to, stored and used at home, FRC levels may be used up and the water becomes re-contaminated and unsafe. It is also important to regularly test the quality of water (both at the point of distribution and the point of use).

All humanitarian responders, local and international, must consider national guidelines and regulations regarding water supply, extraction, conveyance and quality standards. Additional local regulations may also apply. Water supply standards and suggested key actions and indicators in an emergency response are described in Sphere. It includes recommendations for the minimum quantity of water to be provided (at least 15 litres per person per day), a recommended distance of fewer than 500 metres from the household to the nearest waterpoint and a maximum queuing time at water sources of 30 minutes.

Water supply in an urban environment is likely to be more intense and complex than in a rural environment due to the interconnectedness of services and the higher density of people. It needs close collaboration with the local water authority, utility or bureau and a coordinated approach with other government bodies, such as the

Ministry of Health, the Department of Sewage, the electricity utility, The Ministry of Planning and the City Council or the local Municipalities concerned **(P.9)**. In urban environments, there is an increased danger that broken water supply lines due, for example, to an earthquake or urban warfare, may be contaminated by sucking in wastewater. In camp and camp-like settings, ensuring that the camp population has access to water provision may be easier than in an urban environment (both in terms of quantity and quality) because the network and systems are likely to have been recently installed, correctly monitored and the water correctly treated. However, ensuring their sustainability remains a challenge. Humanitarian responses often concentrate on the most rapidly deployable solution (e.g. water trucking or extracting water from a ground aquifer) which can be expensive, environmentally damaging and difficult to sustain. After the initial crisis is over, donor and humanitarian attention will move on and funding usually decreases over time. Hence, it is important to consider the sustainability of the quantity and quality of the water supply at an early stage, instigating discussions with the local water authority, communities and other stakeholders. Failure to plan for sustainability at the start can mean that the refugee or internally displaced people's camp will, in the longer term, be transformed into an informal urban settlement.

In protracted, complex emergencies involving multiple settlement typologies, the WASH cluster may issue guidance for partners and humanitarian WASH responders, for example, 'WASH Response by Settlement Typology' which details the response required by partners by settlement type (e.g. planned or emergency camps, transit sites, urban displacement types) and spanning different time phases of the response.

Process and Good Practice

- Involve communities wherever possible in making decisions about the design and siting of water supplies and ensure that plans about the water supply are communicated to them. Even in the acute phase of the emergency, it should be possible to obtain information on water use (e.g. priorities, cultural acceptability, or taboos) and to rapidly consult different users.
- Assess the population's vulnerability in both on-camp and off-camp settings as certain groups, such as female-headed households, elderly or persons with disabilities, will face barriers to access.
- Help water system designers to understand and address the variations in supply and demand. In the acute phase of an emergency, the water supply may

be limited. Water needs may be higher for some populations than others (e.g. nursing mothers, women and girls to wash reusable menstrual products and adults with incontinence or bedwetting children). Collaboration and coordination within the WASH team and the sector **(P.9)** will be required to address these needs.

- Consider the establishment of an inclusive and gender-balanced WASH Committee **(T.55)** to provide oversight of water supplies and help to ensure the O&M of facilities and the fair distribution of water for all. This should be discussed and decided upon by affected communities.
- Involve WASH Committees **(T.55)** and affected communities in water testing if possible. This can be a useful tool to promote hygiene and encourage action to protect water from contamination at the source or in the home.
- Design for disabilities. People with disabilities have special requirements for access to water. The 'Compendium of Water Supply Technologies in Emergencies' provides detailed information on Inclusive and Equitable Design **(X.15)** including a comprehensive list of measures to be considered.
- Discuss measures with the community to minimise the risk of post-delivery water contamination at the point of consumption, including equipping households with safe containers with a lid (and a tap or narrow outlet) to safely collect, store and draw drinking water, ensuring a safe environment and location of the storage containers as well as a cleaning and disinfection regime for collection and storage containers.
- Work with communities when context-appropriate household water treatment technologies are seen to be appropriate. It is important to ensure (and monitor) that they accept and use the technology effectively.
- Consult and communicate with users and involve them in the planning even where more complex water systems are introduced (e.g. urban areas).
- Work with communities to find solutions to inadequate drainage and wastewater which will otherwise lead to increased breeding of flies, mosquitoes, rats and other vectors **(P.5)**.
- Collaborate with WASH engineers and affected communities to solve problems concerning access to and management of water and drainage; facilitate community meetings for this purpose.

→ **References and further reading materials can be found on page 286**

Access to Sanitation Facilities

Main Purpose

To ensure that adequate and enabling sanitation facilities are available so that the affected population has the means to carry out hygiene and sanitation practices.

Important

- Access to sanitation is a human right and essential for people's health, dignity and safety. For the affected population to carry out adequate hygiene and sanitation-related behaviours, sanitation facilities have to be accessible to all, safe, inclusive, well-maintained, culturally appropriate, gender-segregated, close to where people live and provide privacy in line with user expectations.
- The involvement of different users in the design, siting and management of sanitation facilities is crucial; hygiene promoters can facilitate this by working closely with communities and other team members and stakeholders.
- The selected technologies must respond to the needs and preferences of different users so that they are continuously used and managed for the benefit of all.
- The sanitation requirements of babies, young girls and boys, persons with disabilities and those who are incontinent are often neglected – especially in emergencies. Hygiene promoters must advocate (P.10) for their needs to be better addressed.
- The provision of sanitation facilities must address the entire sanitation service chain from the toilet, via collection, emptying, transport, treatment to safe disposal and reuse.

Overview

Access to sanitation facilities is a precondition allowing the affected population to practise safe and dignified sanitation-related behaviours and ensure a safe environment. In an acute response, it includes instant and safe excreta management measures (particularly excreta containment); they are critical to survival and reduced public health risks. It includes the entire sanitation service chain from the toilet via collection, storage, transport and treatment to final safe disposal and/or reuse. It starts at the outset of an emergency and continues through all response phases.

Sanitation facilities need to be disability-accessible, culturally appropriate, well-maintained (including cleaning, re-stocking of anal cleansing material and minor repairs) and close to where people live. They should provide pri-

vacancy in line with user expectations and a handwashing facility in the vicinity (P.2). The technology chosen should be based on a systematic assessment of the local conditions and existing sanitation practices (including anal cleansing practises and preferences for sitting or squatting) as well as of existing infrastructure that can be quickly rehabilitated.

Given the time and resource limitations during an acute response, the progression from open defecation to adequate facilities may be gradual. If acceptable to users, sanitation facilities may initially be communal or shared to rapidly provide for large numbers of people. For example, toilet blocks which include toilets accessible to persons with disabilities. A minimum of 15% of all public toilets must be disability accessible, with all other latrines built as barrier-free and as accessible as possible. Communal or shared toilets should be converted into household sanitation facilities over time, wherever possible. Household toilets are considered ideal in terms of user safety, security, convenience and dignity; they also strengthen the links between ownership and maintenance. The suggested Sphere indicator for a communal gender-segregated toilet is 50 people per toilet (during the acute phase), which must quickly be improved to a maximum of 20 people per toilet. The suggested maximum distance between a dwelling and a communal toilet is 50 metres.

The provision of sanitation facilities must allow for adequate menstrual hygiene management (P.7) and safe child excreta management. It includes the provision of female-friendly facilities (e.g. clearly labelled, lockable doors, good lighting, provision of disposal bins and washing facilities inside the cabin), separate safe containment options for children's and babies' faeces or the provision of hygiene items such as disposable or reusable sanitary pads, nappies or potties. Facilities also need to ensure children's safety and acceptable use (e.g. smaller holes to protect children from falling into pits). Sanitation facilities need to be designed and sited, in close consultation with all at-risk groups, to reduce safety and security threats to users (particularly women and girls).

Special consideration should be given to the culturally appropriate design and implementation of the facilities, particularly if people from different cultural, ethnic and/or religious groups are living together. Sanitation is culture and people always have the choice whether to use a toilet facility or not. They may not use it if it is considered inappropriate, is not convenient or does not correspond to the user's customs and habits. A culturally appropriate design considers an appropriate user interface (for sitters or squatters), anal cleansing materials that users find acceptable (e.g. toilet paper, water, sticks or stones), the

willingness of different cultural groups to use the same latrines, the existing taboos related to toilet use, handling of waste or potential reuse options as well as local preferences and practices for managing menstruation and disposing of menstrual products. Cultural beliefs and norms may also affect the siting (people may not want to be seen visiting the toilet) and the orientation of facilities (e.g. religious rules that the toilet should face away from the prayer point). It may also limit technology choices e.g. urinals in Muslim societies may not be an option. Cultural issues can be manifold and must be addressed during the Assessment (**chapter A**) to understand and respond adequately to people's needs, habits and practices. Safely managed sanitation goes beyond initial onsite excreta containment and provision of toilets. It also considers effective faecal sludge management and the entire sanitation service chain. It needs to be aligned with local systems and authorities responsible for excreta management and to follow national standards if existing. The 'Compendium of Sanitation Technologies in Emergencies' provides a structured overview and in-depth information on all relevant technologies and their applicability. The exact combination of technologies depends on various parameters such as the local context, response phase, available resources, skills and materials, costs, intended resource recovery/reuse or the longer-term operation and maintenance (O&M) requirements. It may also involve market-based approaches (**P.8**) such as engaging local desludging service providers, training local manufacturers, sanitation marketing to create demand for sanitation services (**F.21**) or involving the community in cash for work programmes.

Process and Good Practice

- Start the planning and decision-making for the whole sanitation service chain at the onset of the response and in consultation and collaboration with all involved stakeholders to ensure that human excreta is managed safely and does not pose any public health or environmental risks.
- Plan and design facilities by actively involving the affected population to ensure that facilities are continuously used by all and to achieve an acceptable level of ownership and buy-in from users. Include all segments of the population (such as women and men, older people, people with disabilities and children) during the assessment, planning and decision making. Engagement may include user-centred design, consultation with different user groups or contributions of labour and time from users (e.g. digging of pits, O&M).
- Pay particular attention to short and longer-term O&M requirements: what cannot be maintained should not be built. Responsibilities for all relevant O&M tasks should be jointly discussed and agreed upon. Individual toilet O&M should be carried out by

the household itself, using cleaning materials which can be provided in-kind or through cash and voucher assistance or multi-purpose cash assistance, if households cannot afford it (**P.8**).

- Make decisions about the management of shared toilets with the communities (**chapter E**) which could involve a dedicated structure such as a WASH Committee (**T.55**). Cleaners (voluntary or paid) will be needed for communal toilets in e.g. schools or markets. Cleaning materials and training should be included in the budget.
- Create an annual budget to fund longer-term O&M of shared toilets. Consider tariffs for toilet entrance where the humanitarian community does not (or no longer) fund O&M (e.g. markets and transport hubs).
- Address privacy and safety issues to enable access to all sanitation facilities and services. Locks on toilet doors, adequate lighting, high doors, no windows at human eye-level, solid walls, roof coverage for terraced structures, screened unit blocks, reduced distance to where people live and segregation of facilities can help reduce the risk of abuse and violence. In schools, adult and child toilets must be separated for child safeguarding.
- Follow the RECU principle (reach, enter, circulate and use) for disability-accessible or inclusive design: reaching the facility may include minimising the distance to homes and shelters or improving the access through ramps, wider or string-guided paths, or the provision of mobile devices like potties, buckets or diapers. Entering and circulating inside the facility may require a wider entrance area for wheelchairs, slip-resistant surfaces, easy to handle locks and space inside the facility for wheelchair manoeuvre. Using the facilities may need handrails to support sitting and squatting, movable seats and sitting aids, or handwashing facilities at a reachable height.
- Design to make sanitation facilities more gender and menstrual hygiene management-friendly. Include access to a sustainable supply of locally acceptable menstrual products (**P.7**) including information, provision of culturally appropriate discrete disposal options for menstrual products, privacy and the provision of washing facilities with water and soap either inside the cabin and/or other possibilities for discreet washing, drying and drainage.
- Monitor the use of facilities by different users and seek feedback on their acceptability. Accessibility and Safety Audits (**T.1**) are useful ways to stimulate discussion on these issues.

→ **References and further reading materials can be found on page 286**

Access to Solid Waste Management (SWM), Health Care Waste Management (HCWM) and Vector Control

Main Purpose

To protect public health and the environment by interrupting the transmission of vector-borne diseases in the community, at health centres and in educational facilities.

Important

- Solid waste management (SWM) plays an important role in humanitarian contexts to protect health and to reduce damage to the natural environment. It describes the separation of waste streams, waste reduction, up/recycling of waste and its safe disposal.
- Health care waste has specific requirements for segregation, containment, treatment and disposal. Medical waste and by-products cover a diverse range of materials that must be managed safely to control infection and create a safe and healthy environment for patients, caregivers and personnel.
- The incorrect treatment and disposal of liquid and solid waste can facilitate vector-borne diseases transmitted by vectors such as rats, flies and mosquitoes. The removal of solid waste will prevent the obstruction of drainage channels and protect the community against flooding.
- Hygiene promoters can facilitate collaboration between affected populations and other WASH stakeholders to address various SWM issues.
- There is evidence that when plastic waste breaks down into microplastics, they are ingested by animals and fish and pass into the food chain, affecting humans. Microplastics alter the physical and biological properties of soils and ultimately affect plants.
- Human proximity to domestic (or wild) animals and birds and their faeces creates health risks. A 'one health' approach (which includes measures for the health of people, animals and the environment) should be adopted.

Overview

Solid waste is defined as the unwanted solid products generated by society; they are the by-products of any process, or the unwanted objects that are discarded after use. Solid waste management includes all the steps and processes required to manage waste from households and within communities until its reuse or final disposal. An important part of SWM in humanitarian settings is health care waste management (HCWM). This refers to the safe handling and disposal of any medical waste (such as

syringes and dressings) generated within health structures such as hospitals, nutritional feeding centres and temporary vaccination sites.

The management of solid waste needs to be regulated by the government. The separation of waste streams at the household level is necessary to achieve high levels of recycling and re-use. The collection and disposal of solid waste is usually a municipal responsibility, although usually – where it exists – this service is restricted to the removal of un-separated solid waste to a local landfill. Uncollected solid waste can accumulate in streets or other public spaces and become a source of pollution and a breeding ground for vectors. Residents sometimes set it on fire, creating a fire hazard and the release of toxic chemicals into the environment, polluting air, earth and groundwater. Poor SWM services can create severe health risks and environmental pollution. Waste management in humanitarian contexts requires close collaboration with the community, municipal and health authorities. Municipal humanitarian SWM interventions should prioritise community-based sustainable outcomes using a circular economy approach, reducing waste and pollution and increasing recycling. Waste that must be transported for final disposal or storage should be minimised and disposed of in a sanitary landfill that prevents groundwater pollution and access to vectors. Organic waste makes up a considerable amount of the total solid waste; it can be separated, collected and recycled into value products (e.g. compost), used as an energy or food source for insect larvae, which can then be used as fish or poultry food. The balance of waste consists of plastics, paper, metals and textiles. Recycling possibilities for these dry waste streams exist but are context-specific. Cost recovery aspects of SWM should be considered to ensure sustainability.

HCWM is critical to prevent the spreading of diseases, for example, from contaminated waste during epidemics such as Ebola, cholera and COVID-19. During epidemics, personal protective equipment (PPE) must be provided for staff working in HCWM; however, as a result the volume of single-use PPE may substantially increase. Contaminated waste must be correctly treated to prevent a threat to the health and sanitation personnel in health facilities and the public in neighbouring or local communities. Health care waste should be separated at source, collected, treated and safely destroyed in centralised specialised incinerators. Regulations on HCWM are set nationally and vary from country to country, e.g. in some countries, low tech, high-temperature, decentralised medical waste incinerators are permitted, but in others not. National regulations will also cover the separation of waste at the point of production.

Sanitation workers rarely get recognition for their work, are often badly paid and, as a result, may be unmotivated. To motivate staff it can be useful, with the agreement of the authorities or hospital/clinic department in charge of cleaning, to set up a 'WASH' department within health care facilities and provide training in various WASH and infection prevention and control disciplines for health care sanitation staff.

Vector control is any method to limit or eradicate the mammals, birds, insects or other arthropods which transmit disease pathogens. Vectors are disease-carrying living organisms that transport a disease from human to human or from animal to human. Vectors account for more than 17% of all infectious diseases globally, causing more than 700,000 deaths annually. The most common types of vector are different blood-sucking insects that transmit the disease by transporting the disease-carrying microorganism from one host to another. The most common vector-borne diseases are malaria (spread through *Anopheles* mosquitoes), dengue (spread through *Aedes* mosquitoes) and leishmaniasis (spread through sandflies). Pools of standing water, due to poor drainage of grey and rainwater, are breeding grounds for mosquitoes. There is a strong link between liquid and solid wastes and diseases spread by vectors. Open defecation or poor excreta management increases the transmission of faeco-oral diseases such as cholera due to the presence of flies contaminating food. Inadequate SWM leads to the proliferation of disease-carrying vectors such as rats and sand flies. Solid waste such as plastic bags can also block drainage and lead to stagnant pools of water. Hygiene messaging and information sharing should make residents aware of possible vector-borne diseases. The humanitarian response must ensure that individuals, communities and local governments have the correct tools and resources to determine sources and reduce or eliminate possible infections.

Sphere provides a list of standards and indicators for SWM, HCWM and vector control.

Process and Good Practice

- Plan and implement SWM services and vector control measures in coordination with users, relevant agencies and authorities and potential or existing service providers (P.9).
 - Discuss and make community plans for the removal of debris, standing water (from rain or greywater) and solid waste around their location to protect themselves against vectors.
 - Consider engaging expert advice on how to deal with waste, especially local experts who may understand the context and opportunities better. Ensure that the affected community is involved in the decision-making process and share information on community practices and psychosocial determinants.
 - Consider how solid waste can affect other areas of sanitation. For example, litter can clog storm-water channels, creating standing water and overflows leading to flooding. Solid waste thrown into pit latrines can hamper the desludging, process and reuse/dispose of the faecal sludge collected in the pits.
 - Adapt behaviour change strategies (chapter B), frameworks and approaches (chapter F) to address SWM issues.
 - Advocate for and invest in staff. In many societies, working with waste is considered low status and can be stigmatised, although waste separation, recycling and reuse are highly skilled tasks. Communication (chapter C), Advocacy (P.10) and investment in staff through training, protective clothing and equipment are important.
 - Identify ways to make waste recovery profitable if possible. Provide technical support as well as training and investment in business skills such as bookkeeping and marketing recycled or upcycled wastes if required.
 - Minimise the additional waste brought by a humanitarian intervention whenever possible and/or consider the additional waste management needs caused by the intervention e.g. hygiene kit packaging or the distribution of bottled water can create significant waste. This could also involve advocacy (P.10) to other sectors (e.g. to avoid food delivery in single use containers)
 - Give particular consideration to the disposal of menstrual products (P.7) in schools and other education facilities.
 - Identify mitigation measures for vector control and the spread of disease, including the use of long lasting insecticidal nets or curtains, fumigation and the spraying of insecticides, removal of solid waste, improvements to drainage and the elimination of standing water in or around homes. All these measures require Community Engagement (chapter E) to be effective.
- References and further reading materials can be found on page 286

Access to Hygiene Items

Main Purpose

To ensure that appropriate, timely and sufficient hygiene items are available and accessible to support the hygiene, health, dignity and well-being of the affected population.

Important

- Hygiene items must be appropriate for the specific culture, religion and context. Consider the different needs of men, women and adolescent girls, older people, children, persons with disabilities and those who are incontinent.
- Consultation with the affected population is needed to identify essential and culturally appropriate hygiene items needed by individuals, households and communities.
- Market-Based Programming (MBP, **P.8**) modalities, such as cash or voucher assistance for hygiene, should be the first-choice method for enabling access to the items that people want and need. In-kind distribution (kit distribution) should be arranged only if other options are not feasible (e.g. for security reasons, lack of access to markets, lack of availability or the poor quality of hygiene products on the market).
- As part of the WASH response, existing local markets for hygiene items and other WASH-related goods and services need to be assessed, understood and integrated into the response. Local markets should be supported instead of being replaced and the right MBP modalities and instruments (**P.8**) identified, based on the initial assessment.
- Apply the 'do no harm' principle when providing hygiene items to ensure that they do not adversely affect beneficiaries, the local market and the environment.

Overview

Access to appropriate personal hygiene items is a precondition to enable relevant hygiene practices and is crucial in all phases of an emergency. In the acute response phase, the most essential hygiene items need to be prioritised as these are critical determinants for survival and reducing public health risks. Such items include soap for personal hygiene and laundry, two 10–20 litre water containers (one for collection and one for the storage of water, with lids and taps and of a size and type appropriate for the age and carrying capacity of those collecting the water) as well as locally appropriate menstrual products, including underwear, if needed (**P.7**). It is also important to consider the needs of those who have faecal or urinary incontinence who may urgently require incontinence pads or other items to ensure their well-being and dignity. Additional items that support the wellbeing and dignity of the affected population can also be considered but may be more appropriate for the stabilisation and recovery phase. Depending on the context and in close consultation with the affected population, additional items may include toothpaste, toothbrush, shampoo, hairbrush, shaver, mirror, nail cutter, potty, scoop or nappies, toilet paper, insecticide-treated bed nets or communal items such as cleaning equipment or solid waste containers. In addition to providing access to hygiene items, it is important to consult with users about appropriate disposal mechanisms at home as well as in communal facilities and institutions such as schools. A system to collect and dispose of packaging waste (**P.5**) should be established and space provided for laundry, drying facilities or incinerators, particularly for menstrual products.

The initial assessment (**chapter A**) should include a market assessment (**P.8**) and household income analysis. It should assess gender roles in expenditure decisions and the availability of hygiene items (addressing the specific items needed by some groups) through local, regional or international markets. If possible, local markets should be used and supported. The latter can be achieved through, for example, providing vouchers, conditional or unconditional cash transfers, grants to market vendors to recover stock, transport vouchers or by supporting traders to increase warehousing capacity or infrastructure for hygiene items. The potential risks of offering hygiene items via cash assistance include price increases, the quality of products on the local market, cultural barriers such as women having to buy from male vendors or adolescent girls potentially being dependent on caregivers to make purchasing decisions.

Market-based interventions may also include longer-term economic recovery options through business model

development, access to financial services (e.g. micro-loans) or the rehabilitation of roads, transport or telecommunication networks **(P.8)**. Working through markets partly shifts the management of quality and safety risks away from humanitarian implementers and onto local market actors and beneficiaries. Whether or not the market is providing the quantity and quality of relevant hygiene items needs to be monitored and interventions adjusted accordingly. Giving the affected population the choice does not absolve humanitarian implementers of the responsibility of ensuring access to hygiene items and WASH services that are inclusive, reach the most vulnerable and meet minimum humanitarian standards.

Access to hygiene items should, if possible, have been considered in the preparedness phase. Following an assessment of cultural practices and local preferences, preparedness WASH equipment, hygiene items and consumables can already be stockpiled. The scope for MBP can also be explored in the pre-emergency phase – using, e.g. pre-crisis market analysis. Market-based interventions may also include longer-term economic recovery options **(P.8)**.

Process and Good Practice

- Coordinate with other sectors **(P.9)** to provide market-based assistance **(P.8)** and/or hygiene items or to select distribution mechanisms.
- Involve the affected population (including marginalised groups, such as older persons, children and people with incontinence or persons with disabilities) in selecting context appropriate hygiene items. It may include asking questions such as: what is culturally appropriate? What is the priority? What are the preferences for different user groups? What can people provide for themselves?
- Assess people's different personal hygiene needs. Some people need different or greater quantities of personal hygiene items because of their gender, age, health, disability or mobility status. They may need more specific items such as bedpans, sitting aids, commode chairs, incontinence items or plastic covers for mattresses.
- Conduct pre-crisis hygiene items market assessment whenever possible to understand market functionality before and after the crisis. Monitor and evaluate market prices, quality and the diversity of hygiene products during the whole project period (monitoring both the seller and the buyer/community).

- Work with the affected population, local authorities and other actors to plan how people will collect or buy hygiene items.
- Identify and address all potential barriers to accessing distribution locations or distribution systems (e.g. for women and girls, older or ill people and persons with disabilities, the excluded or outcast population). Consider gender-disaggregated distributions or the inclusion of female staff at distribution locations.
- Provide accessible information about content, location, timing, intended recipients and eligibility criteria for hygiene items/kits or cash/voucher-based assistance **(P.8)**.
- Consider using a dedicated distribution team for a central distribution of hygiene items (or vouchers or cash distributions). It is of utmost importance to assure the safety and security of the population (and the distribution team) and to ensure that households can transport all their distribution items safely home.
- Provide accessible information on the appropriate use of the distributed hygiene items: no distribution without information.
- Establish a reliable and regular supply of consumables such as soap, menstrual and incontinence materials.
- Distribute hygiene items in combination with other essential items (e.g. food) if possible, to address multiple needs at the same time for the convenience of the target population. This also saves time and resources across sectors. Coordination and collaboration with other sectors will be required **(P.9)**.
- Seek feedback from affected people **(M.5)** on the appropriateness of the hygiene items chosen and their satisfaction with the mechanism for accessing them.

→ **References and further reading materials can be found on page 286**

Menstrual Health and Hygiene (MHH)

Main Purpose

To ensure that women, girls and all people who menstruate have the resources they need to manage their menstruation privately, safely, hygienically and with dignity in a humanitarian context.

Important

- Menstruation is a natural bodily function and a phase of the menstrual cycle. The average menstrual cycle is 28 days but can vary from 21–35 days. Menstruation can last from 2–7 days with varying flows and intensity. It occurs throughout the reproductive life, starting in puberty (around 11–14 years) and ending in menopause (45–55 years).
- One out of four displaced people are women and girls of reproductive age who will likely experience menstruation during the emergency. People who menstruate may include trans-men and inter-sex persons who have biological female organs. The WASH sector has a clear responsibility to meet their needs, as articulated in Sphere.
- If menstrual health and hygiene (MHH) is not adequately addressed it increases health risks (e.g. through the use of dirty and/or damp cloths) and the risk of sexual and gender-based violence. Lack of MHH, but also pain and cultural restrictions, may severely restrict people's movement during menstruation, confining them to their home or shelter. This restricts their ability to, amongst other activities, attend distributions, collect water, access health services, go to work or attend school. It also affects children and others they care for, compromising well-being.
- All people who menstruate should be supported by considering their socio-cultural norms, personal preferences and the local context. MHH requires a comprehensive and coordinated response addressing **(1)** access to menstrual products and materials **(P.5)**, **(2)** WASH facilities for changing, washing, cleaning and drying and the disposal of used materials **(P.2 and P.4)**, and **(3)** information and awareness about menstrual hygiene and well-being.
- To overcome the widely existing silence and taboos that will influence the success of the response, it is essential to involve others, not only people who menstruate, and create a supportive environment through awareness building of programme staff, engineers, health workers, volunteers, community leaders, boys and men and the elderly.

Overview

Managing menstruation is often more difficult in emergencies as people who menstruate may face a significant loss of privacy and dignity (e.g. in overcrowded, temporary or transit situations). They face the challenges of safely managing their menstruation in a new environment (e.g. menstrual products of their choice are not available, water for hygiene is limited, there are only shared bathrooms and toilets). People with disabilities or unaccompanied and separated girls **(E.3 and E.5)** may face additional challenges and require increased assistance, e.g. those with mobility disabilities may have to change pads in secluded areas, if WASH facilities aren't accessible and inclusive.

A response to MHH in emergencies needs to address all three components outlined below.

1. Selection and distribution of appropriate menstrual products and supportive materials: different products exist to manage menstruation. Disposable pads are the most widely commercially available product. They are easy to distribute in an early onset emergency or to people in transit. However, these products require constant redistribution, are more expensive and need to be disposed of after a single use, which often leads to uncontrolled disposal in the environment **(P.5)** or in toilets **(P.4)**. Reusable menstrual products such as reusable menstrual pads, menstrual cups or even clean cloth are more environmentally and financially sustainable solutions, though provision for hygienic handling is essential (washing, drying, safe storage). Whichever product is provided, it should meet global quality specifications (see resources). Materials to consider providing include underwear, extra laundry and bathing soap, a container with a lid for storing and soaking of reusable menstrual pads, cloth or dirty clothes and rope and pegs for drying.
2. Availability and access to safe, private WASH facilities, including bathing areas and disposal: female-friendly sanitation facilities should meet minimum standards and consider menstruation needs (disposal, washing and changing of materials). Gender segregation of toilets is crucially important to ensure all women are safe and feel safe to access facilities. Female segregated and, ideally, private areas for personal hygiene need to be provided that include spaces for washing and drying underwear and reusable menstrual products. If these areas are not available, additional materials for washing and drying at home may need to be provided, such as

buckets, extra soap, clothesline and pegs and leak-proof bags. Safe disposal of used products must be provided to prevent blockages of sewage pipes or difficulties in desludging pits or septic tanks clogged with menstrual materials.

3. Information and awareness on menstruation and MHH: age-specific knowledge about menstruation and how to manage should be provided to girls (before they start their first period (9–12 years), adolescents and other menstruating adults. Particularly if products and materials are unfamiliar, users need information on how to use and dispose of them correctly. Education about menstruation is often a good entry point to wider community issues such as reproductive health and gender roles. Awareness can be raised from the start of the response among men and boys, religious and local leaders to address stigma, menstruation-related restrictions on people who menstruate and provide social support.

MHH requires coordination between sectors (P.9) such as WASH, Education, Protection (especially gender-based violence and child protection), Shelter, Health, including sexual and reproductive health and psycho-social support).

Process and Good Practice

- Vary MHH related activities depending on the response phase:
 - ▶ During the preparedness phase MHH mainly involves an assessment of preferences and local practices, the identification and prepositioning of menstrual products and supportive materials, the training of staff and partners and the identification of contextualised IEC material (T.19).
 - ▶ During the acute response the focus is the immediate provision of appropriate basic menstrual products and supportive materials (P.6), establishing access to water (P.3) and sanitation facilities (P.4) and ensuring that the designs are appropriate for the safety and comfort of people who menstruate.
 - ▶ Longer-term stabilisation and recovery phases (and protracted scenarios) include more in-depth involvement of people who menstruate, potentially leading to refinements regarding the MHH approach and components.
 - Co-ordinate with others to improve the quality and coherence of the response, including the establishment of an MHH task group, the inclusion of MHH indicators in cluster updates and the development of a menstrual hygiene management (MHM) strategy (P.9).
 - Work with other sectors to complement general distributions of hygiene items with targeted distributions of dignity kits (including for hard-to-reach populations). Work closely with the Education, Health and Protection sectors to establish female-friendly sanitation facilities in schools and health centres and to coordinate MHH awareness and behaviour change programming (P.9).
 - Use the three MHH components (outlined above) to help guide interlinked programming. For example, the type of products distributed determines whether extra water is required, the design of washing places, waste management (mostly for disposable products, P.5), as well as the tailored information based on local beliefs and practices.
 - Be aware that due to the private nature, silence and shame around menstruation, certain challenges, practices and needs might not be expressed openly. This might affect the overall success of the intervention and response. Identify challenges to Knowledge, Attitudes and Practices (T.24) to menstruation through Observations (T.28), Interviews (T.23) and Focus Group Discussions (T.14). Work with trained female frontline and health workers whenever possible. It may take time to overcome hesitancy to talk openly about menstruation, so ensure safe spaces for learning and sharing. IEC materials (T.19) should be as visual and easy to use as possible.
 - Understand traditional practices and preferences, e.g. the washing and drying of pads might be more traditional, there may be cultural beliefs about menstrual blood and its disposal. A girl's coming of age may be associated with her first menstruation and child marriage. Insertable products (tampons, cups) may not be acceptable.
 - Distribute and replenish menstrual products at regular intervals, otherwise users are forced to use self-made solutions. Ensure quality products to reduce health and hygiene risks and to guarantee the mobility of people who menstruate. The content of kits (hygiene kits, dignity kits or specific MHM kits) provided by different actors should be aligned. It is recommended that the distribution of menstrual products (in kind or cash) is done by women.
 - Consider market-based programming (MBP) modalities such as cash and voucher assistance (P.8) to provide a choice of products and enable humanitarian actors to increase the available product range in the local markets. The Global WASH Cluster's updated guidance on MBP for WASH includes a dedicated section on menstrual products.
 - Seek to identify synergies with general waste management (P.5) in case menstrual products can be collected and treated with other waste streams in the camp, especially if there is a facility for medical waste.
- **References and further reading materials can be found on page 287**

Market-Based Programming (MBP)

Main Purpose

To ensure that (local) markets are used to deliver essential WASH goods and services, that markets are restored and/or the wider market system is developed.

Important

- In the WASH sector there are several markets for water (e.g. water trucking), sanitation (e.g. toilet construction, desludging services) and hygiene (e.g. soap, menstrual products).
- There are no 'market-neutral' humanitarian interventions. WASH interventions can both support or undermine existing markets.
- An initial market analysis is required, as a minimum, in the assessments of all humanitarian WASH programmes in all contexts to identify the scope for market-based programming (MBP) interventions. Hygiene promoters are part of this analysis.
- There are four key dimensions of the WASH market in humanitarian response: **(1)** demand and purchase power versus **(2)** supply, quality and quantity of goods available in relation to **(3)** market norms and policies and **(4)** services and infrastructure. Understanding the demand is critical, as it can be complex and is closely related to people's knowledge and perceptions (**B.3 and B.5**) of the health risks.
- Use a basic needs analysis with the target population to define the 'basic needs' and how much it would cost in the current emergency situation. This is then reflected in the minimum expenditure basket, which includes prioritised (multi-sectoral) items needed regularly by the affected households. It is important to have such a multi-sectoral overview, as shortcomings in access to commodities or services in one sector can adversely impact the performance of (MBP) interventions in other sectors.
- Market-based programming can include engagements with markets for delivering immediate relief including cash and voucher assistance (CVA) as well as activities to strengthen the market, wherever significant disruptions are identified (e.g. rehabilitation of a warehouse or a road for access).

Overview

In 2016, the Global WASH Cluster (GWC) released a position paper on cash and markets and set up a global-level Cash and Markets Technical Working Group (TWiG) to provide guidance and support to WASH partners to deliver quality MBP. A set of guidance documents and training on MBP for WASH has been developed in different languages. Since then, MBP, including CVA, has been increasingly used in humanitarian WASH response.

As markets are a central element of people's life and livelihoods, they should be part of the planning for humanitarian WASH programmes. Humanitarian responders should be aware that they are market actors with a significant impact on local markets and that their interventions are therefore not 'market-neutral'. MBP begins with a market analysis to assess if the market system can supply essential commodities and to assess the demand. Preferably, a pre-crisis market assessment (PCMA) will already have been done and can be compared to the post-shock assessment to support the planning of a quality emergency response. Based on the assessment findings, local markets can either be identified as affected by a crisis or as supportive in meeting the WASH needs. There are four different ways that WASH programmes can be delivered by engaging the local market, as reflected in the MBP framework (see resources section).

1. Improving Market Demand and Access: demand can be strengthened by improving access to local markets. Barriers to access can be financial (lifted through CVA), physical (lifted by improving roads, organising fairs), or socio-cultural (changed through behavioural change strategies or social marketing).
2. Improving Market Supply and Availability: using, supporting and developing markets can strengthen the availability and capacity of the market system to deliver critical goods and services in an emergency. Improvements begin by using existing local market structures to deliver immediate humanitarian assistance; this is usually based on the local procurement of WASH goods and services or the use of CVA. It may also include the restoration of market systems after a shock event, allowing humanitarian actors and beneficiaries to use the market as soon as possible. Methods include grants to market vendors, facilitating access to information, providing fuel vouchers or subsidies or spare parts to transport businesses (e.g. for water trucking or desludging operators) and supporting market traders to increase warehousing capacity (e.g. for hygiene

items). Longer-term interventions to strengthen the resilience of the WASH market system include business model development (e.g. supporting private actors or community-based organisations to set up safe water kiosks), supply chain development (e.g. for construction materials to be made available locally at a more affordable price), product design (e.g. designing affordable water filters) and improved access to financial services. Market-based programming also allows the humanitarian sector to utilise its buying power and the setting of quality standards to drive market actors to increase the quality and diversity of products offered (e.g. menstrual products that meet the global quality specifications developed by UNHCR/UNFPA/UNICEF).

3. Reform of the Market Regulatory Framework: to help markets recover, humanitarian interventions can also include activities to support the reform of the regulatory frameworks of relevant markets (national rules, norms and standards). This could be through advocacy for improved regulations (e.g. water quality assurance for safe water kiosks), direct engagement in policy-making processes or by strengthening the capacities of the actors involved (e.g. governments, regulators, utilities, etc.).
4. Strengthening of Market Services and Infrastructure: for critical WASH market systems to function, the broader market services and infrastructure may need to be supported, restored or developed. This could include loan guarantees for microfinance institutions, digital cash delivery technologies, improved market information as well as the rehabilitation of roads, transportation and telecommunication networks. These activities are often not directly related to WASH and can pose a challenge to WASH actors unless they are carried out through cross-sectoral interventions and/or with multidisciplinary teams.

Process and Good Practice

- Collaborate with other WASH team members to analyse how market systems work and how they are impacted by the disaster; ideally, do this during the preparedness phase (P.9).
- Provide training for local or national WASH teams on MBP for WASH in emergencies. Corresponding training are offered by the GWC and its members/partners.
- Collaborate with the WASH team to conduct a series of assessments, starting with a multisectoral initial assessment, followed by a WASH technical assessment and then a market and risk assessment.
- Identify and select response options, analyse risks and develop programme objectives. If a CVA programme is indicated, identify how this will be carried out.
- Assess CVA's appropriateness in relation to the frequency of a distribution. It is most effective for recurrent needs such as hygiene item distributions (P.6) as it is costly and time-consuming to establish for one-off distributions.
- Ensure that recipients of a CVA are identified, registered and processed and that the assistance is delivered in an equitable, transparent and safe manner. Feedback from recipients must be sought (M.5) and data protection standards adhered to.
- Communicate (chapter C) with the affected community and maintain dialogue with them throughout the programme. Communication is an essential component of all MBP programmes. Ensure that:
 - ▶ People of any gender, age, disability, or social group can access communications from the programme.
 - ▶ Communications are two-way: the responders provide information and receive and act upon information from communities.
 - ▶ Referral information and systems are in place (e.g. referrals for protection-related risks).
 - ▶ Suitable languages (C.7) and communication channels (C.4 and C.5) are used.
 - ▶ Accountability and feedback mechanisms are established (M.4 and T.13) and opportunities are identified for communities to use them for customer feedback (e.g. when receiving goods/services from the private sector).
- Monitor markets and processes throughout the response and look for further opportunities to strengthen local WASH markets.

→ **References and further reading materials can be found on page 287**

Coordination and Collaboration with Other WASH Stakeholders and Sectors

Main Purpose

To ensure the timely delivery of WASH services to the affected population by involving all national, international and local WASH actors – including the affected population – and relevant other sectors in planning and decision making.

Important

- Coordination and collaboration with other WASH stakeholders and sector help to ensure participation, avoid duplication, prioritise interventions and maximise the quality of the response and use of available resources.
- Local coordination structures, such as those established by national government bodies, local authorities, civil society and sector-working groups, should be identified, used, strengthened and supported where they exist.
- If such local structures do not exist, are weak or if the scale of a crisis goes beyond their coping capacities, another time-bound coordination structure such as the internationally developed cluster system is a viable alternative and must be supported by all WASH stakeholders.
- Effective coordination needs the pro-active participation and commitment of all involved partners (including the affected population, relevant ministries and public institutions, UN agencies, other sector/cluster coordinators, local and international NGOs, the Red Cross and Red Crescent movement, donors and the private sector).
- Achieving humanitarian minimum standards in one area may influence progress in other areas as overall public health is affected by numerous factors (A.2). Close coordination and collaboration with other sectors (e.g. shelter, food security, protection and health) as well as with local authorities and other responding agencies is therefore vital to protect public health and optimise the quality of the WASH responses.
- Local development actors, platforms and civil society should be actively engaged in the coordination structures to make use of comparative advantages, their expertise and experience in the area and to ensure an incremental hand-over to development partners (A.5).

Overview

The responsibility for coordination in an emergency is generally assumed by the government and is often described in national disaster management policies. In large-scale crises, ad hoc time-bound coordination mechanisms are often introduced. Where these are included in a national disaster management plan, government leadership will usually be strong and must be supported by international agencies. If nationally led coordination is not possible, the internationally developed cluster coordination mechanism may have to be activated. This is sometimes adopted as part of a government coordination plan, or it may sit alongside other government mechanisms where it must still support government plans to fulfil its obligations. The refugee coordination mechanism, led by UNHCR, may maintain a distance from the national government to retain impartial protection oversight, but communication between the parties is nonetheless essential.

Other sectors such as the health, shelter, camp coordination and camp management (CCCM) or food security and nutrition may have different objectives but they often share wider goals (such as improved health, safety and security of the population, improved information for planning, improved efficiencies and targeting of resources or increased trust in public services). Hence cross-sector coordination is vital to identify and use synergies, develop collective outcomes and ensure a coordinated response. It may include joint training, initial multi-sectoral needs assessments, the continuous sharing of information across sectors and the active involvement of other sectors in planning and coordinating WASH interventions. It may also include coordinated programming with other sectors, for example coordinating the joint distribution of non-food items with the shelter sector and the CCCM, or coordination with the nutrition sector to prioritise WASH interventions in communities where nutrition standards are not met and vulnerability to disease may be higher. Coordination with other sectors can also help address cross-cutting issues such as safety and protection (including child protection and gender-based violence).

Because of the life-saving nature of emergency coordination mechanisms, there can be weaker links to existing development sector coordination platforms. However, coordination efforts must be aligned with the development sector, particularly during the non-acute stabilisation and recovery phase. Coordination with local entities responsible for host communities is also vital to avoid adverse effects and tensions between the affected population and host communities (i.e. 'do no harm'). In refugee or internally displaced contexts, implementing organisations need to coordinate to ensure the continuity of

WASH services and establish comparable service levels in different locations and between refugee and host communities. This coordination will also support longer-term operation and maintenance, build sustained changes in hygiene behaviour and improve the safety and protection of the affected population. In protracted crises it is of particular importance that development and humanitarian actors work side-by-side to address structural and economic impacts and help prevent further fragility and instability.

Process and Good Practice

- Share information transparently with other stakeholders during sector/cluster meetings (e.g. minutes of coordination meetings, assessment and monitoring tools and data, information on existing and planned programmes, intervention areas, disease prevalence, or WASH service levels).
- Ensure that the language used in coordination meetings allows for adequate participation of key stakeholders. Consider how interpreters and translators can be used to support this as required.
- Identify and follow up on the action points from coordination meetings (these should clearly state roles, responsibilities and deadlines).
- Work with the WASH cluster's Technical Working Group (TWiG) dealing specifically with hygiene promotion (HP) to ensure it is given adequate attention. Advocate for a TWiG if none exists **(P.10)**.
- Coordinate with a Risk Communication and Community Engagement (RCCE, **C.9**) working group if one exists. RCCE and HP share common goals that benefit from coordinated activities and information sharing.
- Consider the sustainability of the HP response for the affected population. Any intervention using only INGOs or NGOs will not be sustained once external donor funding ends. In displacement (on and off camp) settings consider providing support through a WASH Committee **(T.55)** with a hygiene focal point and, where possible, coordinate and collaborate with local health visitors or local government hygiene workers.
- Facilitate representation from hygiene committees in WASH cluster, Hygiene TWiG or other sectoral meetings. Coordinate with the committee when donors or senior humanitarian staff visit field projects and ensure that they are introduced to senior staff and included in meetings.
- Share information between coordination meetings in the non-acute stage of an emergency, to reduce the information load during meetings.
- Ensure that there is well-briefed agency representation at the meetings and in the sector working groups to facilitate effective information flow between different sectors.
- Collaborate with government ministries and personnel and involve them in decision making about the WASH programme.
- Train government workers and national NGOs, women's groups, organisations of persons with disabilities, co-operatives and faith-based institutions. Consider using online training services such as MOOCs (Massive Open Online Courses) in hygiene and in subjects such as upcycling waste into valuable products, or treating waste so that it is less harmful to the environment and health.
- Establish links with the development sector for menstrual hygiene management and adolescent sexual reproduction education.

→ **References and further reading materials can be found on page 287**

Advocacy for WASH and Community Priorities

Main Purpose

To influence decision makers and those involved in the humanitarian (WASH) response to fund, develop, adapt or implement relevant WASH-related policies and practices that respond to community concerns, needs and priorities.

Important

- Advocacy strategies and interventions should always be made with the interests and needs of the affected population in mind. Hence it is important to involve affected people in advocacy decisions such as how to present issues and which advocacy messages are appropriate.
- When raising WASH advocacy issues with local authorities as duty bearers, the role and contributions of the users (rights holders) of WASH services and facilities are vital and issues should be jointly developed. The Making Rights Real approach serves as an example of a non-confrontational approach towards WASH advocacy.
- WASH Advocacy is usually based on programmatic priorities and the concerns of the affected population. Those working in hygiene promotion (HP) need to listen to and record those concerns and, with their permission, share them with the wider programme teams in order to develop appropriate interventions and strategies.
- Potential advocacy issues may be identified based on response activities, programme experience, existing research and evidence, or witnessing and observation.
- Advocacy efforts must be informed by a rights-based approach and care must be taken to 'do no harm' when identifying issues and strategies.
- Collaboration and coordination with other humanitarian actors (P.9) can increase the effectiveness of advocacy initiatives.

Overview

Humanitarian WASH advocacy is a deliberate and strategic process that involves a wide set of planned and coordinated activities to strengthen and prioritise life-saving WASH interventions in a humanitarian crisis, improve local conditions and access to WASH services, ensure that internationally agreed core principles, standards, codes and human rights are adhered to by all actors and support the affected population to claim their rights.

Process steps for advocacy usually include: **(1)** the identification and prioritisation of problems or issues, **(2)** the collection of available information and contextual analysis of risks and opportunities, **(3)** the development of an advocacy and communication strategy (including key messages with clear objectives and target audiences) and **(4)** the implementation of advocacy activities including continuous monitoring and adjustments if required.

Advocacy activities may range from media campaigns, local mobilisation, public announcements, lobbying and negotiating with policy and decision makers, building or supporting existing coalitions and networks through to the publication of research or policy papers.

WASH advocacy can be carried out by representatives of the affected population, by local or international NGOs (in close collaboration with the affected population) or by a combination of both. It can take place at different levels, from local, regional to national level, depending on the anticipated effectiveness. It may also involve sharing advocacy concerns at an international level to reinforce locally delivered messages.

Advocacy can address diverse issues. It may include the specific rights, needs and protection concerns of different vulnerable groups, raising the profile of potential taboo topics such as Menstrual Health and Hygiene (P.7), promoting tariffs to recover costs for infrastructure and maintenance, advocating for the same level of WASH services in both refugee/IDP settlements and host communities, promoting the use of existing market systems by all involved in the response (P.8), informing the affected population about their rights and supporting them in claiming these rights, using so-called 'Shit Flow' Diagrams (a way to visualise how human excreta travels around a city, town or camp) to raise awareness on current sanitation challenges, or promoting government investments in preparedness, resilience and disaster risk reduction among many others. Advocacy may also be needed to ensure adequate funding for HP and community engagement.

Increasingly, affected populations live in, or are displaced to urban areas and may be represented by local government officials and structures. Local government needs to be consulted on how to address the concerns and needs

of the affected population. Responding through local government structures and services will strengthen local ownership and response and contribute to sustainability. In displacement contexts, the hygiene of a host population will very likely be affected by the arrival of a newly displaced population using the local water, health, education, sanitation and hygiene services. Addressing shared concerns will contribute to the longer-term sustainability of services for the host and affected populations.

Where displaced populations are settled in camps with limited or no local government representation of the affected population, forming a WASH Committee **(T.55)** can help to represent their interests. The committee should be as gender-balanced as possible and represent the population (including the elderly and youth – especially young women and persons with disabilities) and include all ethnic, geographic and socio-economic groups. If any groups are not represented, alternative mechanisms should be put in place to ensure their views are heard. They should be involved in WASH cluster or hygiene technical working group meetings, in newly planned hygiene interventions and in the response, and in Monitoring **(M.2)** and Evaluation **(M.3)** so that their concerns and problems can be directly heard by WASH actors and be included in the response. If possible, when donors visit affected populations, WASH (and other) committee members should be invited to meet them directly, acting as a representative conduit between the community and the donors.

Process and Good Practice

- Ensure that all WASH staff members have an understanding of the rights-based approach (including their own obligations), the rights and duties that affected communities hold and that they are aware of the role they play in identifying and supporting advocacy interventions.
- Use questions that may help in identifying and prioritising advocacy issues such as: does the problem have a significant impact on the affected population or response priorities? Does the issue affect a large number of people or have a particular impact on more marginalised groups? Where does the organisation fit in the wider landscape of actors and key stakeholders? Who are or could be potential allies and partners?

- Define advocacy objectives clearly and be as specific as possible. Potential questions to ask include: what issues may require advocacy? What are the key messages? What is the purpose of the intervention and what specific actions or changes are expected?
- Identify the roles and responsibilities of different actors and select the right target audience with a tailored approach appropriate for the actor you seek to influence. For example, who will be influenced by your strategy – municipal authorities, politicians, donors or journalists? What specific change is required? What allies can support the process?
- Consider a variety of methods such as lobbying, meetings, negotiation, demonstrations, mass and social media and 'edutainment'.
- Be clear about the roles, responsibilities and expectations of duty bearers and rights holders towards equitable access to WASH for all.
- Ensure that advocacy does not negatively affect access to WASH services or the protection of affected people ('do no harm'). Advocacy messages should not be built on rumours or unconfirmed information **(C.6)**. It is important to consider that advocacy could have unintended indirect consequences (e.g. calls to stop gender-based violence which are not carefully formulated and contextualised may cause families to keep girls at home).
- Make sure that all advocacy messages and products are clear, consistent and evidence-based. Consider how and over what period change will be measured and ensure follow up.

→ **References and further reading materials can be found on page 287**



Community Engagement
and Participation

According to Sphere, ‘community engagement is a dynamic process that connects the community with itself and other stakeholders so that people affected by the crisis are empowered and have more control over the response and its impact on them’. Community participation and engagement processes listen to and enable different community groups to influence WASH programme decisions. Community engagement increases programme effectiveness by recognising and harnessing the communities’ capacities, needs and priorities and, ultimately, by empowering them.

There are different levels in both community Engagement and Participation (E.2). In an emergency, a specific level may be more or less appropriate at any given time. At all levels, the principles of transparency, Accountability (M.4) and promotion of autonomy are relevant. Determining the current level of engagement can help to identify actions that allow greater participation and decision making by different groups. Listening carefully to different people’s opinions, encouraging discussion and seeking feedback from communities are key aspects of participation and engagement.

Engagement and participation are at the heart of effective WASH programming. The emphasis on engagement aims to understand the different needs and priorities in the community and to ensure that users are involved in the design of facilities, as well as how services are provided, to ensure that they are acceptable, well used and maintained. The sub-chapters Gender Issues (E.3), Babies, Children and Young People (E.4) and Persons with Disabilities and Older People (E.5) consider how to respond to the needs and priorities of different groups within the community. Hygiene promotion in Schools (E.6) and Hygiene Promotion in Institutions and other Settings (E.8) identify some key principles for working in specific settings.

Enabling community engagement and participation also encourages the Ownership and Management of Facilities (E.7). Community Capacity Strengthening (E.9) considers the key requirements for developing hygiene promotion and WASH skills in the community. Community Engagement at a Distance (E.10) provides information on how to work with communities when access is compromised due to insecurity or other risks.

Hygiene promotion programmes are often in a unique position to listen to, consult with and learn from communities because they usually include an element of community outreach. Staff attitudes and body language are all important to gain people's trust. Working in an open and respectful way with people will ensure that hygiene communication interventions (chapter C) build people's self-esteem rather than make them feel ignorant. Didactic approaches to health and hygiene education that seek only to feed people with information are more likely to undermine people's confidence and 'self-efficacy' (B.4). Emergency responders are placed in positions of relative power over the community – even if they are part of that community. They must be capable of seeking out feedback and managing complaints (M.5, C.9 and T.13). Training and support will be necessary to enable responders to question and develop their attitudes and practices following careful recruitment of appropriate personnel.

Sub-Chapters

- E.1 Key Concepts and Good Practice
- E.2 Levels of Engagement and Participation
- E.3 Gender Issues
- E.4 Working with Babies, Children and Young People
- E.5 Working with Persons with Disabilities and Older People
- E.6 Hygiene Promotion in Schools
- E.7 Ownership and Management of Facilities
- E.8 Hygiene Promotion in Institutions and Other Settings
- E.9 Community Capacity Strengthening
- E.10 Community Engagement at a Distance

Key Concepts and Good Practice

Main Purpose

To identify, listen to and enable different groups within the affected community to influence WASH programme decisions and ensure greater effectiveness by recognising their capacities, needs and priorities.

Key Concepts

- Community engagement and participation can lead to a more equitable, effective and sustainable WASH intervention and help to build the resilience of communities affected by the crisis.
- Without participation, a small number of people will make decisions for everyone. A WASH programme needs to identify ways to enable greater participation and decision making in the WASH programme – especially amongst those who are most vulnerable.
- More inclusive WASH programmes are not solely about more accessible facilities; it is also about enabling participation and decision making and providing opportunities to challenge the stigmatisation of marginalised groups.
- In an emergency, it will take time to understand ‘who’ the community is, how it works to exclude certain people and how to engage with its different groups. Community engagement is a process and different levels of participation and engagement may be appropriate at different times in the response (**E.2**).
- The people in a community are not all the same. WASH responders need to see and understand the differences in individual characteristics such as gender, disability and age. There are no simple solutions to addressing inequality as situations and communities are complex.
- Not everyone will want to ‘participate’ and levels of participation (**E.2**) often depend on whether people expect to gain from the process and their past experience of it. Tokenistic participation that does not include genuine listening or take account of people’s priorities and preferences may make them sceptical about subsequent engagement.
- To enable greater community participation and decision making, responders must be aware of the power they wield, the bias they might bring to a situation and must be prepared to question their decisions, actions and conduct.

Good Practice

- Ask how community engagement and participation can be improved throughout the project cycle and develop indicators to measure your progress. Community engagement and participation are an integral part of a WASH programme, not a separate activity.
- Find out about the community and develop a Community Profile (**A.7**) that identifies how different groups normally live, work and play and how this has been changed by the emergency. This is also an ongoing process, not a one-off activity.
- Consider social, cultural, economic and physical structures, leadership, gender and power dynamics as well as WASH social norms and coping strategies (**B.6**). WASH Committees (**T.55**) and outreach workers may already exist in some form, but may not be representative of all sections in the community.
- Seek support from other specialists, such as anthropologists or local research institutes. They can deepen the understanding of specific social-cultural beliefs and norms (**B.5 and B.6**). For example, some communities associate cholera with witchcraft or voodoo culture, whilst some religions prohibit measures such as oral rehydration salts.
- Listen and ask questions and be prepared to discuss and debate. Not everything that the community or specific groups want is possible or desirable. Where feasible, groups should be put in touch with each other to discuss any points of contention.
- Avoid making assumptions about vulnerability. Not everyone from a marginalised group is vulnerable. There is an interrelationship between different social factors that can lead to discrimination-based gender and sexuality as well as socioeconomic status, ethnicity and disability. Programme decisions must be based on a careful assessment of the factors that influence vulnerability in a specific context.
- Share information throughout the programme. People cannot participate if they do not have access to information about the response or the opportunity to question and debate it.
- Develop trust as a vital part of a participation and engagement strategy. Trust is reliant on open and transparent Communication (**chapter C**) and Accountability (**M.4**). Actively seeking feedback (**C.9 and T.13**) using accessible informal and formal mechanisms helps develop trust, as does the ability to admit mistakes when they occur.

- Pay attention to the language used and whether it is acceptable and understood by all sections of the community – including those with hearing, visual and intellectual disabilities **(C.7)**.
- Use interactive tools and methods that encourage discussion and draw on visualisation to make information and ideas more accessible to people with different levels of education and literacy **(chapter T)**.
- Understand what people are currently experiencing, their level of trauma, motivation, capacity and availability to participate. Not everyone in a community will want to participate or to participate in everything. In an emergency especially, many people will be traumatised and some may initially want to relinquish decision making.
- Make full use of interpersonal skills, especially empathy, active listening, communication and self-reflection. They are important qualities in hygiene promoters and engineers and can support the process of gaining trust, handing over control and empowering others.
- Be aware of personal bias and the risk of making assumptions, such as only talking to one group in the community, working only in easily accessible areas and looking narrowly at WASH issues without considering the bigger picture.
- Consult with men, women and children (including those with disabilities and older people), on the design, use and maintenance of facilities and WASH services **(chapter P)** and how to adapt them to meet users' requirements. Identify the existing capacity within the affected community and authorities and support the development of partnerships between different stakeholders in an emergency response, e.g. WASH agency staff, government, community organisations and community members.

→ **References and further reading materials can be found on page 287**

Levels of Engagement and Participation

Main Purpose

To actively involve and empower communities to regain control over their lives and to enable their involvement in decisions that will affect them.

Important

- People's level of engagement will depend on their motivation and capacity to engage as well as the opportunities they are given to participate.
- The crisis-affected population will not be all the same and it is vital to understand the differences that exist as well as the factors that separate and unite people.
- Not everyone will want to participate and in an emergency many people may be coping with grief and trauma; hygiene promoters need to be sensitive to this.
- A key role of the hygiene promoter is to help strengthen community bonds so that the affected population can collaborate in or lead the emergency response in partnership with response teams.

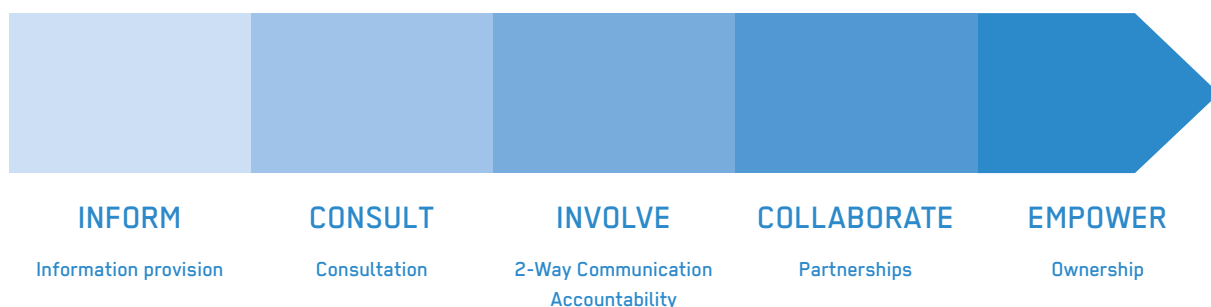
Overview

A community is a group of people who share something in common. In an emergency this may be the location in which they live, or the experience of the disaster itself, but people may have very little else in common. It is important not to assume that a 'community' is a homogeneous group that will think and act in the same way or even share a common purpose. Emergency responses may have to respond to both a displaced and host community that have very different characteristics. As a result of the emergency, and in the course of the WASH intervention, the bonds between communities can be strengthened (or weakened). New communities with a shared interest can be supported to grow and develop, e.g. through clubs (F.1) or committees (T.55). In urban areas, the common links between people may be weaker than in smaller and more rural areas because people often come from a variety of social backgrounds. If groups and networks are to survive in situations where neighbourhood bonds are not strong, they may need significant support.

Conceptualising engagement and participation as steps on a continuum is useful as it enables the current level of intervention to be identified and how progress towards empowerment can be made. In many emergencies, especially during the acute response phase, non-participation and tokenism are still predominant with affected communities being treated as passive recipients of aid. It can also be argued that the urgency of an acute emergency dictates an appropriately lower level of participation.

Meaningful participation is dynamic and is only achieved when people and communities are involved in the decision making process. There are a variety of models of community engagement and participation and most refer to different levels of engagement. An example is **figure 4** which describes five different levels, often referred to as the levels of participation: inform, consult, involve, collaborate and empower.

Figure 4:
Levels of Community
Engagement (adapted from
WHO 2020 and ALNAP 2014)



Process and Good Practice

At the beginning of an emergency, people need vital information about how to protect themselves and where to get help (inform). However, there is always time to ask people about what they need and as time goes on, this consultation should broaden and deepen to help shape WASH programme activities (consult). Even at the start of an emergency there will be opportunities to involve people in making decisions about e.g. the design of facilities and to provide feedback about the programme (involve). As communities begin to organise, they can choose to partner with responders, taking the initiative and proposing improvements (collaborate). Empowerment is usually seen as the highest level and involves communities working collectively to gain control over their lives and make decisions. Some more recent models refer to a level beyond this that describes people recognising the importance and support of others – though they are in control, they may choose to call in outside support and advice. Empowerment necessarily involves changes in power dynamics. People who have power may relinquish it in favour of those with less – or hand power back to people – ultimately creating a more equitable society. Empowerment, however, cannot be forced on people: they need to embrace it willingly. Some people may choose not to participate and there may be numerous reasons for this including lack of confidence, motivation or opportunity, fear, or family and work pressures among others.

- Identify ways to strengthen the participation of different community groups and understand the reasons why people may not be able to or want to participate.
- Look for opportunities to hand over control to affected communities throughout the response.
- Remember that the hygiene promoter should be enabling action and change rather than imposing predetermined programmes and decisions on people.
- Collaborate with other WASH team members and other sectors to strengthen participation in the response as a whole.

→ **References and further reading materials can be found on page 287**

Gender Issues

Main Purpose

To ensure that an understanding of gender equality is incorporated into WASH emergency responses.

Important

- Gender is a social construct built through cultural, political and social practices that defines the roles of women, girls, men and boys, as well as the social definitions of what it means to be masculine and feminine.
- Gender is not only about understanding women's needs (as is often believed). In many situations ascribed gender roles mean that men control resources and decision making and women are subordinate to them. Gender norms can also restrict men's freedoms and choices, such as the assumption that men are the main breadwinners or should not cry.
- In an emergency response, men, women, girls and boys and those with other gender identities will have different access to resources and different ways of coping with the crisis; this will affect their level of vulnerability. Understanding this is important to implement an equitable response that does not reinforce social inequalities.
- Gender norms are socially constructed, learned (and therefore changeable over time) and dependent on the context. In an emergency, opportunities may arise which can lead to change, for example in a redistribution of care roles where men and boys take on more caregiving responsibilities or help to collect water.
- Not everyone from a marginalised group is vulnerable. There is an interrelationship between different social factors that can lead to discrimination based on gender and sexuality as well as class, caste, ethnicity and disability. General assumptions should be avoided e.g. that all women will be vulnerable in any given situation. Programme decisions need to be based on a careful assessment of all the factors influencing vulnerability.

Overview

Cultural practices concerning gender create some of the world's most fundamental sources of inequality and exclusion. A strict and inflexible application of gender-related social codes of behaviour often leads to stereotyping and limits people's choices and their access to resources. For example, women in many contexts do not have the same decision making power as men in either their households or the community. They may have limited control over the resources they need to improve their health and hygiene. However, assumptions about their needs and vulnerability should be avoided. Women have different needs and various factors can have an impact on vulnerability (e.g. pregnancy, disability, female-headed households).

Gender identity is no longer seen as binary – male and female – but on a spectrum. For example, transgender people's gender identity does not correspond to their sex at birth. In contrast, cisgender people's gender identity matches their birth sex. People also identify themselves as non-binary, a third gender or not ascribed to any gender. Gender-based violence (GBV) is often directed against women (although not exclusively) and is a consequence of women's subordinate position in society. Gender-based violence is also perpetrated against members of the lesbian, gay, bisexual, transgender and genderqueer or questioning and intersex (LGBTQI+) community because their sexual orientation and/or gender identity means they do not ascribe to societal norms. Whilst gender norms often influence the behaviour of people who are LGBTQI+, they should not be treated as a homogenous group but as individuals with different perspectives, identities and WASH-related needs.

In emergencies, where societal structures may have been disrupted and resources are limited, women and people who are LGBTQI+ may become even more at risk of discrimination and violence; they may be forced into sexually exploitative situations to earn money. Poorly designed and sited WASH facilities can increase the risk of GBV. Gender analyses should be carried out to understand the specifics of each context. Where possible, specialist expertise should be sought or training by local Women's Rights Organisations and local LGBTQI+ groups to inform the analysis of the particular needs, risks, vulnerabilities and capacities of these groups.

An understanding of gender norms and gender inequality is important in WASH programmes because without it the respective needs, roles and capabilities of women, girls, men, boys and people of different gender identities may go unmet. Gender equality programming is critical to ensuring an effective WASH response. It has two main strategies: gender mainstreaming and targeted actions.

A WASH programme can respond to practical mainstreamed hygiene needs (e.g. safe and accessible facilities **(P.2, P.3, P.4)** or Menstrual Health and Hygiene **(P.7)**) and to targeting social inequality (e.g. changing the position in society of marginalised groups such as women or transgender people through gender transformative targeted actions and opportunities that challenge the status quo). For example, women are generally expected to collect water and manage it in the household but are rarely trained as technicians to repair the water pumps upon which they depend – a gender transformative project would support female technicians whilst also sensitising the community to these role changes to ensure safe programming. Transgender people's WASH needs are often overlooked. Their views on the provision of sanitation are rarely sought due to a lack of expertise on LGBTQI+ rights in the humanitarian community as well limited engagement with local LGBTQI+ groups. Responders should be aware that transgender people may face discrimination when using sex-segregated toilets and be excluded, harassed or even arrested for using a toilet attributed to their gender rather than their sex.

In order to promote gender equality, it is also important to consider both the disaster-affected community and those who are responding to the emergency. Gender disparity runs throughout society so it is also present in aid organisations and governments. Gender policies and procedures can help to promote gender equality through mechanisms such as funding and targeted budgeting, recruitment policies, job descriptions, codes of conduct and training.

Process and Good Practice

- Avoid the assumption that WASH roles and responsibilities are determined by a person's gender – women can be WASH technicians and some men may feel happier in a caring role.
- Ensure that recruitment policies encourage gender diverse applications so that staffing is balanced and representative. Aim for gender-balanced and representative assessment and response teams. Try to ensure that community networks reflect the groups they are working with.
- Conduct a comprehensive WASH and gender assessment and analysis to understand the particular experiences, needs, rights and risks facing women, girls, men, boys, LGBTQI+ individuals, people with disabilities, people of different ages, ethnicities and other aspects of diversity.
- Train staff on the links between gender-based violence and WASH and on how to refer people to a GBV service.
- Involve different groups in the design of WASH facilities and services and consider the needs of pregnant and breastfeeding women, carers of young children, menstruating women and girls, the needs of women experiencing menopause, those who are transgender and non-binary as well as the hygiene needs of men and boys. Where possible, bring groups together to discuss ideas and address problems but recognise that separate groups may sometimes be necessary to counter exclusion and prejudice related to WASH.
- Consult people of different gender identities on WASH-related roles such as who takes responsibility for transporting and distributing water, drilling wells, constructing toilets and operating and maintaining systems.
- Conduct regular safety and privacy audits **(T.1)** of WASH facilities and adapt these based on the recommendations of different groups e.g. siting, door locks, lighting, female-only cleaners for female toilets.
- Collect, analyse and report on gender (and age) disaggregated data throughout the programme cycle and ensure that it is used to influence programme decisions to improve gender equity.
- Understand existing power imbalances and avoid reinforcing traditional gender roles and harmful gender stereotypes through hygiene promotion and WASH behaviour change communication (e.g. by increasing women's workload).
- Identify and engage men and boys who can be positive role models and change agents to promote hygiene within the household and community – not just women.
- Work with schools; they can play a significant role in promoting gender equality in WASH services and facilities.
- Identify opportunities to challenge structural inequalities between women and men and to promote women's leadership within the WASH programme.
- Mirror the terminology that people use to describe themselves where possible, recognising the diversity of gender identities and expressions. For example, not all transgender people wish to be referred to in the same way. Avoid calling people by acronyms only such as 'the LGBTQI+ community' and use 'people who are...' instead.

→ **References and further reading materials can be found on page 287**

Working with Babies, Children and Young People

Main Purpose

To ensure that the needs of babies, children and young people are considered in WASH programming.

Important

- Children's lives are particularly disrupted by emergencies. Young children are especially vulnerable to WASH-related disease and death. There is a significant link between malnutrition and the incidence and severity of diarrhoea in children **(A.2)**.
- The first 1000 days of a child's life – including life within the womb – are critical to health; prioritise not only babies and infants but pregnant mothers too.
- All WASH programmes must consider the specific WASH needs of girls and boys of different ages and give them and their carers a say in how WASH programmes are carried out.
- Child-friendly WASH facilities, hygiene items and promotional material and activities in the community, at schools, health and feeding centres and in child-friendly spaces must be promoted.
- Every organisation working with children and adolescents must have a child safeguarding strategy (to include child protection and health and safety) and provide training on child safeguarding for all staff to ensure they are aware of their responsibility to keep children and adolescents safe.

Overview

According to the UN convention on the rights of the child, a child is defined as anyone under the age of 18 years. Children under five represent between 15–20% of the population. They are frequently neglected in WASH responses although they are often the most vulnerable to WASH-related diseases and malnutrition. Recent research has confirmed that the first 1000 days of a child's life from conception to two years old are critical to lifelong health. Children under 18 years can represent up to 50% of the population and are therefore major stakeholders in a WASH response.

In emergencies children are often affected by the change in routine; anxiety, fear and stress can affect their mental health and wellbeing. Bedwetting may become an issue or be exacerbated in some children. Schools may be damaged or destroyed or lessons interrupted; parents may be grieving or unable to respond to their children's needs in the same way as they did before. Children's space and time for play may have been reduced significantly. WASH activities can play a role in providing a voice for children

and supporting their mental health.

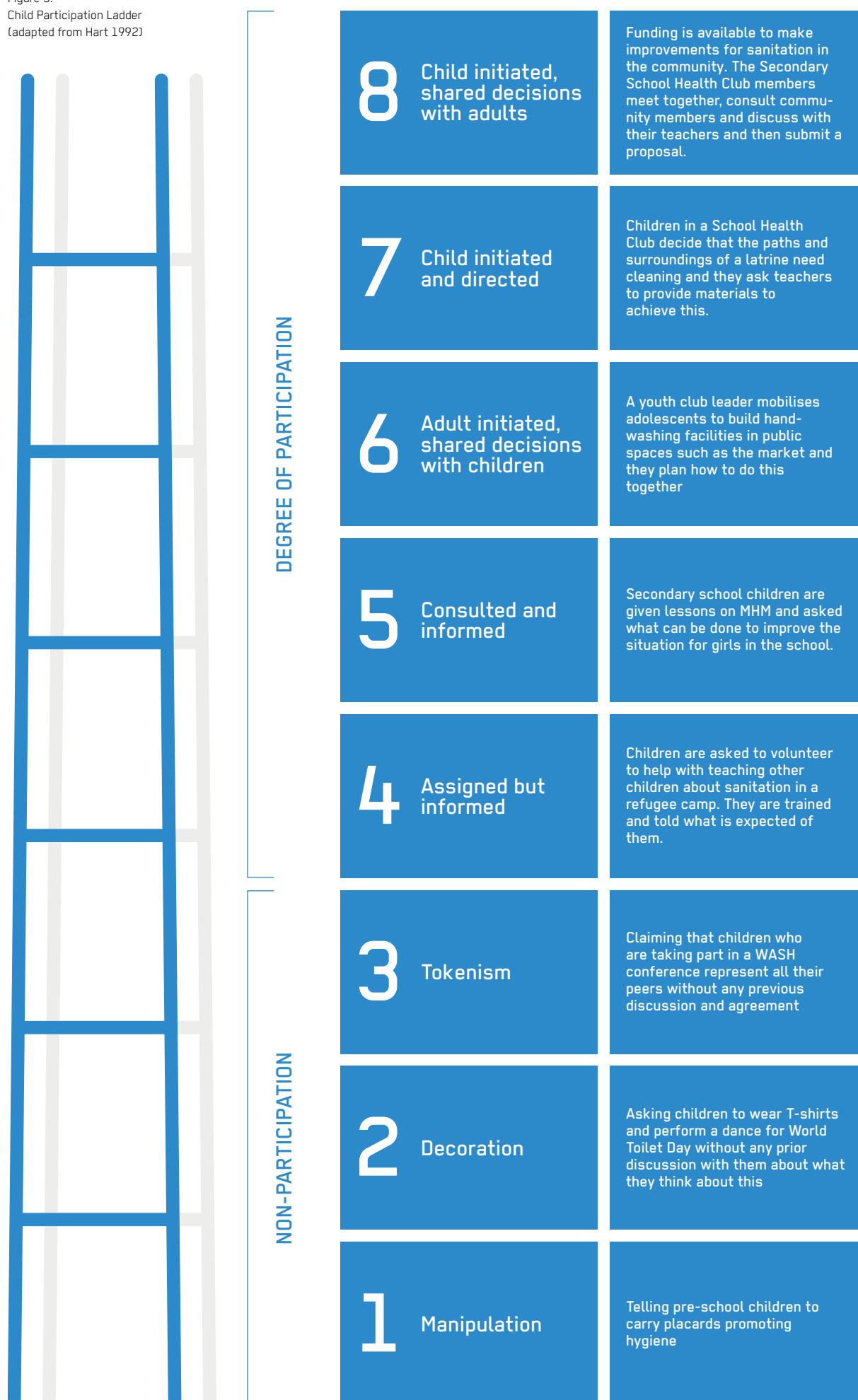
The specific age of the child has important implications for WASH programming and children should not be treated as a homogenous group. The age that young children start to use an adult toilet varies from one culture to another, but most children will not be potty trained until they are at least two years old. They will probably not use an adult toilet or latrine until they are over three or four years old and then only if accompanied by an older sibling or another caretaker. Even older children (between the ages of five and seven) may be prevented from using a latrine because it is thought to be too dangerous (due to its location or because the squatting hole is too large) or because they are afraid to go to the toilet in the dark. Babies and young children under 18 months will usually need nappies – either disposable or washable. Disposing of or washing nappies is difficult in many situations where people are displaced and it can become a health risk – especially in communities that believe children's faeces are not harmful. Ensuring child-friendly WASH facilities and promoting hygiene is also important as children are often responsible for collecting water and caring for younger siblings or other hygiene-related tasks in the household.

Babies, children and their carers therefore represent a very important target group and every effort should be made to understand the specific issues facing these groups and to identify opportunities for working with them. Baby WASH **(F.13)** is a relatively new approach focusing on pregnant women and children from conception to two years. Schools **(E.6)**, women's groups, community centres, crèches, youth groups and sports clubs **(E.8)** can all offer important entry points for working with children and young people.

Participation is a fundamental right and children should be given the chance to meaningfully participate in decisions that affect them – including those relating to the provision of WASH. It is also critical that Gender **(E.3)** and Disability **(E.5)** are considered when responding to children's needs and rights. The Children's Participation Ladder **(figure 5)** illustrates different levels of child participation.

Child protection is essential when working with children and every agency must have policies and procedures in place to ensure safeguarding. All staff working with children must know how to ensure children's and adolescents' safety and what to do if a child discloses abuse.

Figure 5:
Child Participation Ladder
(adapted from Hart 1992)



Process and Good Practice

- Work with children in all WASH programmes where possible. This should include both software and hardware components such as staffing, child-friendly latrines, hygiene materials and colourful and fun IEC materials **(T.19)** for different age groups.
- Collaborate with others working in health, food security and nutrition **(P.9)** to ensure a coordinated approach to supporting children and to understand the diseases affecting babies and children in a given context. This may involve working with nutritionists, midwives and lactation support workers amongst others.
- Identify ways to integrate WASH into health, nutrition and education interventions. Examples include child-friendly facilities in health centres, integrated hygiene promotion (HP) and health materials that address key risks for children of all ages in schools and the community, safe and secure access to WASH for adolescent girls and boys as well as training staff to recognise symptoms of serious ill health such as pneumonia or mental health problems.
- Develop a strategic approach to HP at an institutional level; HP school activities should not be confined to schoolchildren. Aim for a sustainable and integrated vision of WASH in schools, working with parents, carers, teachers and authorities to ensure a programme that integrates the software and hardware aspects of WASH **(F.1, F.2, F.8, F.10, F.11, F.12 and T.29)**.
- Work with girls and boys of different ages rather than with 'children' as a homogenous group. Identify the different barriers they face as well as the different contributions they can make. Initially prioritise the children most at risk (those under two years old) which may require dedicated staff. It may be useful to identify male and female children's WASH champions or 'inclusion advocates' **(T.22)** to promote greater awareness of vulnerability and exclusion and ensure integration of children's issues into WASH programmes.
- Promote the meaningful participation of children in WASH programme by giving them a say about how facilities and services are designed and by asking for feedback on the facilities and their preferences.
- Collect detailed and systematic assessment information **(chapter A)** which should include **a)** what barriers children of different ages, gender and disabilities face when using WASH facilities and **b)** how mothers manage the excreta of babies and young children and how they can be supported in this (include questions about bedwetting).
- Work with monitoring and evaluation (M&E) teams to ensure that child-centred WASH indicators are included in M&E frameworks.
- Work with both children, teachers and parents on HP interventions to encourage the care and correct use of facilities **(E.7)** e.g. ensuring that WASH facilities are not damaged during play (climbing on tap stands or putting covers down toilets) and preventing misuse and wastage of water.
- Support the teaching and learning of children's self-hygiene tasks. Children's personal hygiene needs change dramatically as they grow and learn how to manage their own hygiene needs.
- Ensure the provision of accessible handwashing facilities at all latrines (e.g. make sure children can use them comfortably) and the safe siting of toilets so they are as close as possible to home. Consider providing torches and sandals for children's use in latrines as part of a hygiene kit.
- Consider children's comfort in latrine design e.g. lighting, cubicle width and height (consider if a parent needs to help a child to use a latrine), the position of foot plates and hole size, so that children are not afraid of using the latrines.
- Address the distinct needs of girls: incorporate Menstrual Health and Hygiene **(P.7)** and consider laundry or disposal requirements for sanitary products when designing toilets.
- Keep children safe: work in pairs and always ask for parents' consent. It is preferable to work with groups of children rather than a child on their own and children should know that they can refuse to answer questions or can withdraw from the process at any time. Make sure you know what to do if a child discloses abuse of any kind.
- All staff including contractors or partner organisations must adhere to health and safety regulations and child safeguarding policies when carrying out construction projects or using vehicles (including water tankers) or machinery. These regulations must be enforced.

→ **References and further reading materials can be found on page 288**

Working with Persons with Disabilities and Older People

Main Purpose

To ensure the active participation of persons with disabilities and older people in the emergency WASH response.

Important

- Persons with disabilities and older people have a right to water, sanitation and hygiene but often face a daily struggle to safeguard this right.
- The main barriers that hamper the meaningful participation and inclusion of persons with disabilities in society and their access to humanitarian relief interventions are attitudinal, physical, institutional and communication. If the barriers and needs of persons with disabilities are not actively identified, they risk being excluded.
- As part of the community, persons with disabilities and older people have an important contribution to make to an emergency response (e.g. as influencers or gatekeepers) and need to be actively involved in all stages of the project cycle to enable access to a WASH response for all.
- Collaboration with the organisations that represent persons with disabilities (OPDs), as well as their families and caregivers, can provide a useful entry point and support for WASH programmes **(P.9)**.
- Making WASH programmes more inclusive is not only about more accessible facilities but also about enabling participation and decision making and providing opportunities to challenge stigmatisation.

Overview

The UN Convention on the Rights of Persons with Disabilities (UN-CRPD) defines disability inclusion as the ability of persons with disabilities to actively contribute and participate in society and requires that the barriers preventing this participation be addressed.

Persons with disabilities are disproportionately affected by poverty and vice versa. Limited or no access to WASH services severely affects health and socioeconomic outcomes, even more so for persons with disabilities, exacerbating inequalities for them and their caregivers. It can also perpetuate poverty, as this is both the consequence and the cause of disability.

According to the WHO and World Bank World Report on Disability, around 15% of the global population – or one in seven people – are women, men, girls and boys with disabilities. In addition, more than 46% of older people (60 years and over) have a disability.

Persons with disabilities and older people are active members of the affected community and important stakeholders in humanitarian assistance. A variety of sociological factors, such as poverty, security, traditions or cultural practices and access to education and health, can nonetheless (negatively) influence how they are regarded in any specific community. This can vary significantly between communities in the same region or country.

In 2016, the International Community committed to making humanitarian assistance inclusive of persons with disabilities (as required by international humanitarian law and human rights law) by signing the 'Charter on Inclusion of Persons with Disabilities in Humanitarian Action' and committing to interventions that are non-discriminatory, participatory and based on cooperation and coordination. All those working in emergency response must commit to identifying the needs of persons with disabilities and overcoming the barriers that they face in accessing humanitarian interventions. This can be done through:

- Direct consultation and involvement of representative organisations e.g. those that represent people with various disabilities, including intellectual and psychosocial, as well as families and caregivers throughout the project.
- Carrying out needs assessments **(chapter A)** to identify and understand the barriers that persons with disabilities and older people face in accessing WASH services, recognising that these barriers go beyond merely physical accessibility and are linked to the availability, accessibility, affordability, appropriateness and quality of WASH services.

- Understanding that a key barrier is the attitude of humanitarian actors towards persons with disabilities and older people.
- Integrating disability-sensitive measures into training and implementation, awareness raising and disability rights at different levels with various stakeholders (OPDs, community, government, or non-governmental organisations).
- Ensuring that MEAL systems (**chapter M**) include data about disability and that inclusive feedback mechanisms are established.
- Involve people with different disabilities when designing new WASH facilities, and ensure existing facilities are modified to be fully accessible. Carry out Accessibility Audits (**T.1**) with older people and people with different disabilities to identify what needs to change and how people can access facilities in a dignified and safe way.
- Assess whether there is a need for specific hygiene products or additional supplies (e.g. water for additional washing, incontinence pads, soap, bedpans, commodes, urine bottles or potties, **P.6**).
- Encourage and support the inclusion of persons with disabilities and older people on WASH committees as outreach workers, caretakers or paid agency personnel and include their representation in WASH IEC material.
- Support or encourage WASH school clubs that are inclusive of children with disabilities (**E.6**). They can support wider attitudinal change to disability by, for example, involving children with disabilities as WASH champions (**T.22**), discussing disability and ensuring that facilities are accessible.
- Ensure that outreach activities are conducted in addition to school-based WASH or menstrual hygiene activities to include the many children with disabilities who are not in school.
- Train persons with disabilities and older people as facilitators, technicians, hygiene promoters or WASH committee members. They may need additional support such as assistive devices, sign language or the help of caregivers.
- Integrate disability-inclusive programming into capacity strengthening initiatives for agency and government staff, hygiene promoters and/or community health workers. This can be done in partnership with local OPDs and other representative organisations.
- Ensure that data is collected on gender, age and disability and make disability-inclusive feedback mechanisms available. Use the 'Washington Group' Short Set of Questions on functioning as a tool for disaggregation of data by disability.
- Consider holding regular workshops about the rights of persons with disabilities and disability-inclusive WASH at an interagency, agency and community level, ensuring close follow-up by the implementing organisation.

The participation of persons with disabilities and/or their OPDs is essential to understand the barriers that women, men, girls and boys with disabilities face in accessing hygiene programmes and to address them accordingly. Hygiene programmes need to be inclusive, but persons with disabilities must also be actively involved in decision making, in line with 'nothing about us without us!' and the general principles of the UN-CRPD.

Process and Good Practice

- Assess each situation carefully. There is no 'one size fits all'; persons with disabilities are not a homogenous group. Implement an inclusive WASH response by collecting and recording information on disability as soon as possible.
 - Identify OPDs or older people in the assessment and work with them to assess the affected population's different needs as well as the policy environment and existing support available for people with disability and older people.
 - Involve persons with disabilities, their families and carers, OPDs and I/NGOs working in the sectors of disability and age-inclusion when planning and implementing the WASH intervention (**P.9**).
 - Consider people's communication needs such as the use of sign language, large font or subtitles. Use easy to understand and context-specific materials. A mix of formats is a good way to reach as many people as possible (**chapter C**).
 - Carry out Household Visits (**T.18**) where possible. They can increase access to information for all and help to identify the unmet needs of older people, persons with disabilities (such as incontinence), those who are housebound or those with intellectual or cognitive impairments.
 - Hold events nearer to people's houses where possible to ensure better access. Consider help with transport if this is not possible as well as access at the specific venue.
 - Ask persons with disabilities or their caregivers for their feedback to ensure that communication is inclusive. Ensure that promotional material does not portray persons with disabilities or older people in a way that perpetuates stigma.
- **References and further reading materials can be found on page 288**

Hygiene Promotion in Schools

Main Purpose

To promote improved hygiene within the school and surrounding community and support the appropriate use and maintenance of school WASH facilities.

Important

- Children can be catalysts in their environment and may be more receptive to behaviour change interventions carried out by other children. They can also influence other school children as well as their siblings and parents at home.
- Hygiene promotion (HP) should be made as sustainable as possible by involving key stakeholders such as school children of different ages (including those with disabilities), teachers, education authorities and parents. All schools should have disability-accessible WASH facilities and include children with disabilities in HP activities.
- Consider how to overcome common gender pitfalls such as girls always being assigned to clean toilets or boys not being involved in education sessions relating to puberty and menstruation.
- Avoid one-off activities, that 'use' school children as passive actors rather than active participants in promoting hygiene; plan the intervention strategically.

Overview

Many children spend most of the day at school, so the school can represent a hygiene risk (if hygiene is poor) and an opportunity to promote improved hygiene practices. Children may also be influential in promoting hygiene at home with their siblings and parents. If there is no menstrual hygiene provision, adolescent girls often miss school during menstruation.

Working with children in schools can draw on numerous well-defined approaches such as School Health Clubs (F.1), Child-To-Child (T.29), School Led Total Sanitation (F.2), Three Star Approach (F.11), Fit for School (F.10), Toilets Making the Grade (F.12) and Blue Schools (F.8) and others such as WASH Friendly Schools. Some approaches can be combined and most draw on similar principles of active engagement.

A WASH-Friendly School is one where everyone – children, teachers and the wider school community – carry out three essential practices to secure better health **(1)** Wash hands with soap regularly at critical times – after using the latrine or cleaning a small child and before touching food or eating, **(2)** Always use a latrine – no open defecation and **(3)** Drink safe water that has been collected, treated, stored and retrieved correctly.

A School Health Club (F.1) is a voluntary club formed and managed by pupils and teachers to promote good health practices and behaviour change in the school and the surrounding communities. It typically comprises 20–35 pupils and 1–2 teachers. The club is often headed by a School Health Committee, often part of the School Management Committee.

The Child-to-Child approach aims to promote the use of interactive educational activities focusing on health and wellbeing and to move away from didactic instruction. The approach can be used with children in both school and the community. It recognises that in many countries children are partly responsible for caring for their younger siblings and can therefore influence their siblings' hygiene practices as well as those of their peers (T.29) and even their parents.

School-Led Total Sanitation applies Community-Led Total Sanitation (F.2) principles and methods to schools.

The Three Star Approach (TSA, F.11) is a pathway for schools to promote more effective hygiene and to meet national WASH standards by defining benchmarks and setting incentives for reaching them. Fit for School (FIT, F.10) is an approach that supports education ministries to apply school-based management to national WASH in schools programmes. Both the TSA and FIT approaches are more suitable for longer-term contexts but may exist already.

Toilets Making the Grade (TMG, F.12) is a school contest framework aiming at triggering and enabling school actors to improve their school's sanitation and hygiene situation. Blue Schools (F.8) focuses on both health and environmental issues.

Many of the principles for working with children (E.4) apply to work in schools. All interventions should be planned in collaboration and coordination with the key stakeholders: schoolchildren, teachers, education authorities and parents, or at the very least should include a plan for engagement with these stakeholders (P.9).

In an emergency context, education may have been severely disrupted. Schools may be damaged, destroyed or occupied by people displaced from their homes. However, makeshift schools may have reopened in some locations and it is important to identify these.

Children with disabilities are not always sent to school and, if they are, they may be excluded from participation in HP activities. It is important to include them and their caregivers where appropriate in any HP intervention in schools.

Process and Good Practice

- Discuss with key stakeholders (school heads, education department, UNICEF and other agencies) to establish what work has already been done and what support is most appropriate. Provide adequate training on HP methodologies.
- Draw up a strategic plan in collaboration with others rather than plan isolated activities in one location (P.9).
- Locate and work with teachers who are teaching in makeshift schools even when their schools have been destroyed.
- Consider how the whole school (including children with disabilities) can be involved, including school hygiene club members or small groups.
- Include parents and others in the community so that opportunities are taken to influence the broader community.
- Identify pupils in school clubs who already show an interest in hygiene and are good at motivating others (T.22). Aim to make any group inclusive of children with disabilities and from minority groups.
- Train teachers or older pupils to train others using interactive rather than didactic methods (where possible).
- Enable participants to identify their own solutions to the specific WASH problems they face in their school, rather than impose strategies upon them that may not work effectively.
- Design interventions for children of different ages and ensure that information is relevant for different age groups.

- Include menstrual hygiene management in the design of WASH facilities and hygiene activities (P.7), ensuring support for those with disabilities.
- Encourage pupils to hold sessions and exhibitions in schools and communities to promote hygienic practices through:
 - ▶ Songs and Stories (T.47), poems, debates, Role Plays (T.41), Drama (T.6), Games (T.15) and Competitions (T.8)
 - ▶ Planning solutions and the way forward at the end of each regular meeting
 - ▶ Conducting a baseline of the school water, sanitation and hygiene practices and disseminating the results
 - ▶ Recording and sharing progress
 - ▶ Providing out-reach to children within and outside school
 - ▶ Pairing the children for mentorship by older pupils (T.29)
 - ▶ Writing notice board news or articles on water, sanitation and hygiene
 - ▶ Conducting health parades (T.11)
 - ▶ Holding reproductive health talks with senior female or male teachers together with club members
 - ▶ Nominating star pupils or classes each term (T.40).
- Discuss and debate negative perceptions about hygiene with school stakeholders to influence the way it is viewed. For example, in some schools cleaning of toilets is used as a punishment or may be assigned only to girls.
- Use a monitoring framework to track progress and encourage participants to be involved in designing and using it. Participatory monitoring is vital for encouraging effectiveness and sustainability (M.5).
- Ensure that the children are involved in establishing a feedback system on school community WASH activities and facilities for schoolchildren.
- Recognise and reward achievements in the form of certificates or incentives; they can be powerful motivators (T.40).

→ **References and further reading materials can be found on page 288**

Ownership and Management of Facilities

Main Purpose

To ensure that users are involved in the design and siting of WASH facilities and take responsibility for their use and maintenance.

Important

- Although urgent construction of emergency WASH facilities may be required (**P.2, P.3 and P.4**), speed and coverage are not acceptable excuses for omitting user engagement: it is always possible to speak to at least some community members and it is important to remain open to modifying designs as time goes on.
- Discuss and identify strategies for the management of facilities with the users as early as possible.
- Incorporate design modifications that make facilities easy and pleasant to use, where possible.
- Lack of community ownership should not be used as an excuse by authorities or agencies for the poor functioning of facilities. Use and maintenance can be promoted through sustained community engagement and support.
- Community management may not always be an effective solution. Providers should be realistic about what level of maintenance (especially for more complex systems) is feasible, particularly following only short training sessions.

Overview

Affected communities have a right to participate in decisions that affect them. Additionally, engaging people meaningfully in the design and management of WASH facilities and services can lead to more effective programmes, ensure that facilities are accessible, meet different needs and help to create a sense of ownership and responsibility. Design tweaks and ‘beautification’ (making visual improvements to an environment, **T.4**) such as providing mirrors, hooks or decoration can also help to make facilities pleasant and more appealing to use and increase people’s pride in them. Effective solid waste disposal (**P.5**) also contributes to a more visually appealing environment. Ensuring that facilities feel safe and private for all is also vital to creating a sense of ownership and responsibility.

The affected communities and local authorities will not automatically assume the responsibility for maintaining the WASH systems; they often assume it is the responsibility of the provider. Even in an emergency, it is therefore essential that providers address how the WASH facilities will be managed after their departure or in the longer-term.

This planning is a team activity involving both WASH engineers and hygiene promoters. However, it will often fall to the hygiene promotion team to hold discussions with communities about the maintenance and care of facilities and how and by whom it will be done. Care may include cleaning toilets and communal bathing areas and replenishing soap and water at handwashing facilities. Over time, various levels of repair will be required to both toilets and water points.

Some damage can be prevented by ensuring that facilities are used correctly and young children do not play on them. In some situations, it may be appropriate and feasible to pay for caretakers (e.g. at public toilets that are shared by many people, during epidemic outbreaks to reduce contamination risks or where water rationing is required), but encouraging community members to also take responsibility for the care and monitoring of facilities remains important.

It is a widely held belief that communities can autonomously manage their water supplies, but this is not always borne out in practice. Outside support from local authorities and others is often required for effective and sustainable management – especially in the emergency context or in the case of more complex systems.

The disaster-affected community may be made up of men and women from different backgrounds and with different levels of education and access to resources. There may be social divisions related to gender, disability, socio-economic background and religion. These differences can undermine or prevent a sense of shared ownership. In emergency situations, social organisation may be further disrupted when people have been displaced from their homes. Creating a sense of ownership and responsibility may then be challenging and household sanitation facilities become the only viable longer-term solution. Leadership may be strong in some communities and weak in others. People may be so traumatised that they do not want to participate or engage with aid organisations at all. This diversity and lack of homogeneity can make community management more challenging. Moreover, each emergency is different. As a result, no standard model can be applied to operation and maintenance (O&M). Community management may not always be the solution.

Capacity strengthening and support for O&M will almost certainly be required and, ideally, should be sustained after the end of the project. Short community training courses on maintenance are insufficient. It is unrealistic to simply hand over facilities to a community when they are not fully prepared to meet the challenges of O&M on their own.

Process and Good Practice

- Promote links between the project and relevant government sectors and involve any established organisations that might contribute to sustainability, such as water authorities, health departments, welfare departments, local non-governmental organisations, faith-based groups or the private sector. If the situation permits, initiate (or support and facilitate) meetings between local and national government representatives to discuss policy and strategy. Make provision for this in budgets.
- Understand community toilet design preferences and speak to as many people as possible, even in an acute emergency. Seek feedback on designs and make sure that modifications are introduced and designs changed as needed (**F.7 and F.15**). Accessibility and Safety Audits (**T.1**) are useful tools to support this.
- Identify existing O&M structures and mechanisms (rather than automatically setting up new WASH committees) and work with them where possible and appropriate. A planning group may be more suitable than a committee in a short-term situation and can encourage a sense of ownership that government programmes can later build upon.
- Enable men, women, girls and boys to identify how facilities will be maintained if problems arise. Pictures can be used to facilitate discussion about the range of O&M options.
- Consider making formal agreements and contracts with the community in contexts where community structures (such as committees) are appropriate. Make the contracts once discussions have been finalised and roles and responsibilities are clearly defined. Ensure that existing or new community structures (such as committees and management groups) are inclusive of all community groups – men and women, persons with disabilities, older persons and youth.
- Select relevant training sessions and adapt them, rather than provide uniform training. Ensure that people (men, women and children) understand the issues and practical implications of maintenance and facilitate them to make their own plans. Bring the wider community into the process through structured community meetings.
- Start training as early as possible in the programme: do not leave it until the end. Allocate resources at the outset and provide the opportunity for refresher training before the end of the programme.
- Identify ways to increase ownership. Recent research has shown that if communities add their names or the name of the community to facilities, their sense of ownership is increased. Formal opening ceremonies may also help as can the avoidance of agency or donor branding. Community defined contributions of money or labour – whilst not always appropriate in an emergency context – may also be useful strategies.
- Assess whether there is a need to pay incentives to caretakers or to outsource maintenance and cleaning to specialised companies. This may be necessary, especially where sanitation facilities are shared by large numbers of people and need regular cleaning to keep them usable. Allocating facilities to a smaller number of families may help to avoid this, but it will need to be discussed and agreed upon with the communities.
- Assess the willingness and capacity of stakeholders to support toilets in public places (markets, community centres, canteens, way stations etc.). Such settings usually require a paid attendant but, in some situations, a well-motivated community group may be prepared to take them on. Traders may be prepared to contribute a small amount to fund a caretaker for latrines in markets. Committees or associations can be useful structures for discussing such issues.
- Set tariffs or cost recovery mechanisms, if required, through discussion with key representatives from the community (e.g. community leaders, women and vulnerable groups). Cost recovery must be discussed at the earliest opportunity and be based on people's ability and willingness to pay and in collaboration with those who can support either income generating initiatives (such as village savings and loan associations) or cash and voucher assistance (**P.8**).
- Ensure that Monitoring (**M.2**) and Feedback Mechanisms (**T.13**) are in place at the earliest opportunity and that they reach out to all sections of the community, including those with disabilities. Feedback will help to identify problems such as acceptability, privacy, safety and the functioning of committee/user groups.
- Engage the water department or equivalent in monitoring; their involvement is particularly important. Community members and groups should also be encouraged to monitor issues as a means of raising awareness about sustainability. Problems and breakdowns could be simulated to assess whether people know what to do (**M.2**).

→ **References and further reading materials can be found on page 288**

Hygiene Promotion in Institutions and Other Settings

Main Purpose

To promote improved hygiene in different institutional settings and with different groups within the community.

Important

- A settings-based approach (see definition below) considers the way that particular groups function within their specific setting or location and uses this as an entry point for health and hygiene promotion (HP).
- Identifying the various settings within an emergency location can help hygiene promoters to reach more people and strengthen community capacity to improve hygiene.
- Consideration should be made of the impact of the emergency on previous community structures and settings and how these can be re-established.
- All community structures and organisations, such as schools, clinics, women's groups or disabled people's organisations, will have specific organisational characteristics and social norms associated with being a 'member'.
- Before working in any setting, it is important to understand and work with these norms – changing them from within if necessary.

Overview

WHO defines a 'setting' as 'the place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing. A setting is also where people actively use and shape the environment and thus create or solve problems relating to health.'

A settings-based approach recognises the potential of places where people gather together and aims to understand and make use of the social norms and hierarchies associated with being part of that group setting (B.6).

The most common approach to hygiene promotion (HP) in emergencies involves training networks of outreach workers to visit people in their homes and/or school settings. But there is a variety of community settings that offer both WASH risks and opportunities for engaging with the community and motivating them to improve hygiene. Markets for food and other commodities often spring up to meet the needs of refugees or displaced people, but may not be regulated or have public WASH facilities such as toilets and handwashing stations. Canteens or community kitchens and food distribution points may also be places where hygiene provision can be improved. Hospitals, clinics, care homes and crèches may have some WASH facilities, but lack cleaning regimes or adequate supplies of consumables such as soap. A WASH assessment should be carried out in all of these locations. Settings can also provide opportunities to discuss hygiene and provide information to different groups of people. Beauty parlours and barbers have also been used to good effect as locations for health and HP in various countries. Women's groups, self-help groups, disabled people's organisations, elders' groups or youth groups may have existed pre-emergency and can be easily reconvened or initiated. Clubs can also be started or re-started for sports or other pastimes and used as entry points for health and HP. Religious settings, such as churches, temples or mosques, are also important gathering places in a community; hygiene can be promoted to different groups by working with religious leaders.

Strengthening community groups and organisations through a common purpose can unite the capacity of the disparate communities found in some emergencies and motivate people to work together to improve hygiene.

Process and Good Practice

- Find out how a particular setting is organised, the leadership, hierarchy, behaviour and social norms (B.6) expected of different members – and how the emergency has influenced them. Identify what makes a given social setting differ from others through questions and discussions with members.
- Identify the specific hygiene needs and problems in that setting and what members think can be done about them. How do members understand the influences on hygiene and health and how relevant are they to them?
- Find out who is influential in this setting and who sets the agenda. Work through them initially but find ways to enable the less influential to participate.
- Understand how different settings can influence and interact with each other e.g. relationships between youth groups and schools or religious institutions and community kitchens.
- Be aware that each hygiene promoter will bring specific qualities to each setting; they can cause friction and/or develop affinities depending on their skills, capacities and background and language. For example, some older women may find it difficult to talk to teenage girls and a woman might not be accepted in a male barber shop. Consider reassigning staff to different settings if appropriate.
- Explore how the setting itself can promote hygiene more broadly as well as encourage members to adopt specific hygiene behaviours. For example, the setting may encourage handwashing but also support collaborative group action to influence others or to develop policies, regulations, systems and facilities.
- Give the group a key role in making decisions about strategy, plans and activities. In any setting, different levels of engagement can apply, but the surest way to make progress is to be as participatory as possible.
- Define indicators of success with the group and explore with them how these will be measured.

→ **References and further reading materials can be found on page 289**

Community Capacity Strengthening

Main Purpose

To identify and respond to the learning needs of community members and support the successful implementation of the WASH programme and the longer-term resilience of communities.

Important

- The members of a community (including children) have existing knowledge and skills. Training should build on this existing capacity rather than simply fill people with information.
- Capacity strengthening to increase community resilience and their ability to respond to emergencies should be part of emergency preparedness.
- A capacity strengthening plan can ensure that learning is structured, strategic and practical; it should be based on a learning needs assessment and an analysis of barriers to learning.
- Adults, especially, need to feel that the purpose of training and capacity strengthening is relevant to them.
- People can learn from each other as well as the 'teacher'; training and learning should be as interactive as possible.
- Didactic training methods that aim solely to convey information rather than develop critical thinking and reflection should be avoided.
- Communities are diverse and they have diverse learning and training needs. Capacity strengthening must cater to these differences. There are a variety of different strategies for learning and the focus should not be solely classroom or workshop-based learning.
- People will easily forget the content of a training session and need to have the opportunity to practise and periodically refresh knowledge and skills.

Overview

Community capacity strengthening must recognise the existing knowledge and skills in the community whilst understanding and prioritising their different requirements for training and learning. Capacity strengthening should not only strengthen knowledge, ability, skills and behaviour to ensure an effective WASH response but also strengthen the ability of the community to respond to future crises.

Training may be needed for, amongst others, hygiene promoters, community mobilisers, WASH groups, clubs or committees and community leaders. Training can take different forms, such as classroom-based learning sessions, field work, mentoring or even self-study and on-line training, but it must respect the principles of adult learning and be as practical and interactive as possible. Didactic training methods that aim to fill people with information rather than develop critical thinking and reflection should be avoided.

Capacity strengthening for WASH can cover a variety of issues such as communication (especially active listening, **C.2**), facilitation and mobilisation skills, behaviour change (**chapter B**), menstrual hygiene management (**P.7**), community or household water testing (**P.3**), latrine construction (**P.4**), soap-making (**P.6**) and handwashing facilities (**P.2**).

A community capacity strengthening plan should be structured and based on a rapid assessment of behavioural and learning barriers and needs. Some or all community members may have limited literacy skills and be unused to attending training sessions. This must be considered when planning mixed groups. Short training sessions with longer breaks and energisers may help. Communities affected by a crisis often have limited time available – especially women who carry the main burden of childcare and household responsibilities. Other groups, such as older people or persons with disabilities, may also be deterred from attending training if arrangements are not made to facilitate their access.

One-off training sessions for hygiene promoters will be of little value unless accompanied by a plan for ongoing support. Ideally, all training should be planned and structured with training objectives identified with participants and linked to learning needs and expectations. Shadowing more experienced staff or volunteers can be very effective for learning, but it should be done in a structured way and provide opportunities for questions and reflections on what has been observed. Interpersonal skills such as empathy, effective listening and communication are vital for hygiene promoters and can support the process of handing over control and empowering others. Training

and ongoing support may be needed for hygiene promoters/community mobilisers to develop such skills and attitudes and to promote greater community engagement. Hygiene promoters and volunteers will require supervision of some kind to support learning; regular meetings and mini training sessions can be organised to achieve this.

In an acute emergency, any training conducted in a classroom or workshop may have to be broken down into short blocks. Training activities that are focused on implementation in the field should be prioritised. Training should focus on immediate and priority needs.

In some situations, people have become accustomed to receiving incentives for attending training sessions. Financial incentives are to be discouraged, but the provision of transport and food may be required (although where possible training should be organised locally).

Training and capacity strengthening plans should be coordinated with other organisations and involve local facilitators and other training providers. Community members and learners should be involved in developing the plans.

Process and Good Practice

- Coordinate with others working in WASH to identify learning needs and develop and carry out joint training where appropriate **(P.9)**.
- Carry out a rapid learning needs assessment and develop this throughout the response. Training should be linked to key competencies and job descriptions and cover both job-related skills (such as 'active listening') and hygiene behavioural issues (such as the barriers to and motivators for change, **T.3**).
- Coach trainers in facilitation skills. Peer to peer **(T.29)** and training of trainers may be appropriate, but coaching may also be required.
- Include self-help groups and community support networks in capacity strengthening plans if appropriate.
- Identify objectives for capacity strengthening and training – adults need to know why the training or specific session is important and how it is relevant to them.
- Learn about adult learning principles and avoid didactic education and training. Bear in mind that people will come to the training with existing knowledge, understanding and capacity. They are not blank pages to be written upon.
- Use visual aids as much as possible (even for people with high literacy levels) and keep group sizes low – no more than 20 people.
- Adapt existing training materials to the context and draw on local examples.
- Make time at the end of every session to review what has been learnt.

- Consider how to involve women and men and how to enable the participation of diverse participants, including persons with disabilities and those with visual, hearing and intellectual disabilities.
- Provide participants with the opportunity to practise new-found skills and to apply learning to their households and contexts **(B.4)**.
- Remember to monitor and evaluate training and seek feedback from participants on how to improve it. Monitor how the learning is put into practice **(M.2)**.
- Keep a record of all completed training courses. Participants are often keen for their achievements to be recognised e.g. by giving out certificates or holding a formal ceremony.
- Organise refresher training only when and if it is needed, not as a matter of course. Focus on the gaps in needs, skills and application of knowledge.
- Budget for training and capacity strengthening, including costs for venues, stationery, visual aids and follow up.

→ **References and further reading materials can be found on page 289**

Community Engagement at a Distance

Main Purpose

To support community engagement with crisis-affected communities in locations where in-person contact is prevented due to insecurity or other risks to community members or humanitarian personnel.

Important

- Engaging and listening to communities can improve the effectiveness, acceptability, local ownership and sustainability of hygiene programmes. It is a core element of hygiene programmes, not an add-on component. When done well it will – and should – be time-consuming and resource-intensive.
- The key principles and processes of community engagement (**E.1**) continue to apply – even when working remotely. Active listening and adaptation still need to happen throughout the project life-cycle.

Overview

Community engagement aims to listen to and enable different community groups within the affected community to influence WASH programme decisions. Remote community engagement has the same aims but seeks to achieve this partially or fully ‘at a distance’ due to safety or security concerns (**C.8**).

All the principles that shape face-to-face community engagement still apply when working remotely. Often it is in these challenging circumstances that community engagement is most vital.

Community engagement should be planned and systematic despite taking place in dynamic contexts and with ever-changing community perceptions. Identifying community intermediaries or stakeholders with whom to hold discussions and through whom information can be communicated is a key first step of community engagement at a distance. It requires an understanding of existing socio-cultural and political structures and context so that the stakeholders tasked with connecting the community with humanitarian staff are trusted by a diverse range of community members (**A.7**). These intermediaries are likely to be the key interface with the community, but may also be busy individuals with limited prior experience of working in crises. Listening to communities effectively is likely to raise issues that are broader than the work of one organisation, so it is important to establish ways of sharing information or referring issues to others who may be able to act upon them.

Process and Good Practice

- Map community stakeholders (**A.7** and **T.49**). Ideally, networks of stakeholders and their contact details should be set up in advance of a crisis. If not, it should be a priority during the first phase of a remote response. Try to build upon local community networks, innovations and coping mechanisms through, for example, supporting local action plans.
- Be mindful of whose voices might not be represented by some of the stakeholders and identify people who can speak on behalf of these groups. Proactively ask questions such as ‘whose voice is not being represented?’ and ‘what are the unintended consequences of our programmes or the behaviours we are encouraging?’ Avoid making assumptions about which individuals or delivery channels are trusted by the community.
- Set up a communication tree or plan (**C.10**). It should describe how the intermediary stakeholders will share information ‘up’ to humanitarian agencies,

‘sideways’ among the network and ‘down’ to others in their communities. In addition to connecting a diverse set of stakeholders, a communication plan may also involve strengthening the networks within the community so that they can be contacted remotely if necessary. Useful tools for remote communication include local radio stations **(T.38)**, closed social media groups or WhatsApp groups **(T.44)**. Where possible, some Household Visits **(T.18)** may be necessary to involve marginalised groups: safety measures should be put in place to facilitate this.

- Provide support and assess whether Capacity Strengthening **(E.9)** or other support is needed so that stakeholders can perform their role effectively during a crisis. This may include training that can be delivered remotely, developing resources such as frequently asked questions with standardised answers (adapted over time) or providing phones, charging (solar) facilities and credit to stakeholders so that they can keep in touch.
- Strengthen the qualitative skills of staff and volunteers as community perceptions are difficult to obtain through surveys and quantitative tools.
- Build-in opportunities to share views and decide how to adapt programmes. Set aside an hour a week to meet with intermediaries remotely and identify how to adapt programmes in response to community perceptions and changed circumstances. Share this information at regular humanitarian coordination meetings **(P.9)** to make sure the interventions are aligned.
- Establish mechanisms for all members of the community to share their views, in addition to working with stakeholders. Potential mechanisms include telephone hotlines, online chat groups or social media pages, information points in communities, radio call-in sessions or proactively calling or messaging populations. It is useful to use a mix of approaches that allow for rolling feedback as well as dedicated periods of active data collection to focus on emerging issues.

→ **References and further reading materials can be found on page 289**



Assessment, Analysis
and Planning

Hygiene promotion (HP) assessments aim to understand the WASH vulnerabilities and capacities of affected populations and to identify how best to prioritise and respond to their diverse and changing needs. It is a continuous process that should shape and inform the WASH Programme.

This section covers both the importance of the assessment of specific hygiene behaviours and the broader assessment process factors, such as coordination and planning. It is not a how-to guide or checklist, but a Compendium of good practice, frameworks and tools. It provides links to additional assessment resources throughout the chapter.

As well as considering the needs, an assessment must consider the existing capacity of national and local authorities and affected populations (A.6). Assessments also consider how the population is structured (A.7) and the specific public health risks, social, behavioural and cultural factors that will influence the WASH intervention (A.2).

It is important to design and plan the assessment and to ensure coordination with others (A.3). Equally, it is important to fully understand the various risks and influences on public health (A.2) and to understand people's different vulnerabilities to those risks (A.5).

A significant amount of information can be obtained using secondary data, such as existing assessments, surveys and reports; these should be quickly reviewed and used to guide the focus of the primary assessment. Data Collection Methods and Analysis (A.4) explains the types of data and sources and how to analyse and use the data. Conducting Quantitative Surveys (A.8) examines how and when to conduct a questionnaire survey.

An HP assessment should be conducted systematically and objectively and be recorded in a way that allows others to understand how decisions about the programme were reached. Assessments are the basis of effective emergency response: the failure to obtain, analyse and use assessment information can lead to a response that does more harm than good. Planning Frameworks (A.9) describes the importance of analysing and using assessment data collaboratively to identify objectives and indicators for the intervention.

Sub-Chapters

- A.1 Key Concepts and Good Practice
- A.2 Risks and Factors Affecting Health and Hygiene
- A.3 Assessment Process and Planning
- A.4 Data Collection Methods and Analysis
- A.5 Assessment Content and Scope
- A.6 Existing Capacity
- A.7 Community Profile
- A.8 Conducting Quantitative Surveys
- A.9 Planning Frameworks

Key Concepts and Good Practice

Main Purpose

To ensure that the WASH response is integrated, appropriate and relevant to a diverse population and to provide a basis for planning, implementation, monitoring and evaluation.

Key Concepts

- Hygiene promotion (HP) assessments aim to understand the WASH vulnerabilities and capacities of the affected population (often including the host community) and to identify how best to prioritise and respond to their diverse (chapter E) and changing needs.
- An emergency HP assessment process usually entails: (1) Planning the assessment, (2) Immediate rapid assessment, (3) In-depth assessments or formative assessment as time allows, (4) Ongoing discussions with and feedback from the community and other stakeholders (A.3).
- The process, resources, tools and teams should, ideally, have been identified and developed during the preparedness phase and included the collection and analysis of pre-crisis information (e.g. pre-crisis market analysis or epidemiological data), to make the assessment during an emergency easier.
- An assessment is preferably undertaken before the implementation of the programme, but in a fast onset emergency, immediate actions may need to be taken based only on a rapid assessment and be refined over time.
- Assessment is not a one-off activity. In an emergency data can quickly become out of date as the situation may be rapidly evolving: ongoing assessment and analysis will be necessary.
- Assessment data must be analysed and then used to inform programme planning (data not intended to be used should not be collected).
- The scale of the assessment will depend on the phase of the emergency and the resources available. In the acute phase, concentrate on collecting and analysing information that is 'essential to know' for programme planning.
- Coordination and collaboration with all stakeholders (P.9) are vital to minimise resource wastage, use existing information and knowledge efficiently and effectively, inform the response and minimise community assessment fatigue.

- Assessment, analysis and planning must consider both the needs and the context, priority risks and determinants of hygiene behaviour (A.2 and chapter B) as well as the existing capacities of national and local authorities and affected populations (A.6).
- A significant amount of information can be gathered from secondary data sources such as existing assessments, surveys and reports; these should be rapidly reviewed. However, assessments cannot be based only on secondary data: collecting some 'primary data' and engaging the affected population is non-negotiable, even in an emergency.
- An HP assessment should be conducted systematically and be recorded in a way that allows others to understand how decisions about the programme were reached.
- Participatory assessments encourage community members to assess and analyse their own situation and can be powerful tools to identify and stimulate community-defined actions.
- Uncoordinated, lengthy and repeated assessments can contribute to frustration and an erosion of trust with communities. It is important to recognise that in an emergency people will often be traumatised and may find an assessment intrusive.
- Analysis and planning frameworks, such as a Log-frame and Problem Tree (T.25), can aid the process of defining what the programme hopes to achieve and how.

Good Practice

- Coordinate, plan and share the assessment and analysis with others (P.9) to avoid duplication. Decide who does what, where and when. Assessment working groups with clear roles and responsibilities are useful.
- Pay attention to the safety of both staff and communities and train and prepare the assessment team. Ensure that they only ask relevant questions and know how to refer onwards any issues of concern relating to protection, mental health or security.
- Review the available secondary data and decide on its relevance and applicability to the specific context. Then identify the key additional data that needs to be collected. In the acute phase especially, focus on what is essential rather than nice or useful to know (figure 6). It can be helpful to identify the indicators you want to assess e.g. the number of children under five using potties – and then design the questions

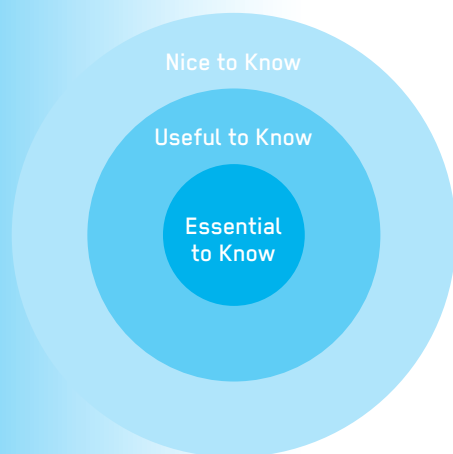


Figure 6:
Prioritising Information

you would need to ask to capture this indicator. Identify a sampling strategy (A.4) and draw up a plan of action (A.3 and A.9).

- Involve both primary (affected communities) and secondary (local and national government departments) stakeholders. This could include invitations to members of the affected community or the local WASH department to join the assessment team. Identify the capacity and role of local HP actors in, e.g. health and social services and local community networks/committees/organisations, as well as the volunteers.
 - Identify different community groups (e.g. men, women, adolescents, elders, persons with disabilities) and establish who is marginalised or particularly vulnerable. Recognise that the affected community members are 'experts' in their situation and have knowledge to share.
 - Ensure that assessment processes are inclusive and accessible, including for people who have difficulty leaving their homes or communicating.
 - Establish gender-balanced teams (including interpreters) where possible and collect information that is disaggregated by age, sex and disability, as a minimum.
 - Remember the importance of communicating with people in their own language and ensure that interpreters are well briefed before commencing the assessment.
 - Train assessment teams (including basic psychological first aid) and provide support and debriefing. Interpreters may be needed for the assessment; Checklists (e.g. T.2) will need to be carefully translated. Ideally, training would take place as a preparedness measure.
 - Decide on the tools that will be used in the assessment (chapter T). Focus Group Discussions (T.14), Observation (T.28) and Key Informant Interviews (T.23) are often used in the first phase of an emergency to collect primary WASH data. However, numerous tools can be used such as picture sets and mapping activities (T.7).
 - Assess the appropriateness of questionnaire surveys (e.g. T.24); they require more time and planning and may not be useful in the acute phase of an emergency response unless dedicated resources are available.
 - Carry out a market analysis (P.8) using both qualitative and quantitative methods to identify and ensure Access to Hygiene Items (P.6).
 - Use a combination of methods that are both quantitative (e.g. how many functioning toilets are in operation) and qualitative (e.g. how do women feel about going to the toilet at night?). Triangulation of information using different methods and sources and cross-checking findings can minimise the bias from using a single method and ensure that the data is more reliable.
 - Consider using Assessment Checklists (T.2) to remind data collectors of the breadth of the investigation. These checklists should be used as aide memoirs (containing only key words and possibly short phrases) rather than 'questionnaires' that often provide only closed questions and answers (e.g. Yes or No). It is also important to collect public health data from clinics and health centres (T.17) to understand local public health risks.
 - Ensure that the assessment data is analysed. Different methods can be used to analyse qualitative and quantitative data. Check that you have staff on the ground able to perform the types of analysis needed. Start analysing raw data during the assessment to check for gaps and inconsistencies and problems with the methods.
 - Use planning frameworks with clearly defined aims, objectives, activities and timeframes to make the rationale behind any HP intervention transparent (T.25). The analysis and sharing of the data are also vital steps in the assessment process and enable more effective response planning.
 - Avoid over-assessing by either collecting too much information that will not be analysed and used or by collecting the same information in different sectoral assessments, leading to frustration in the affected community and eroding trust. There is little point in collecting data without analysing it and using it to inform programme planning.
- **References and further reading materials can be found on page 289**

Risks and Factors Affecting Health and Hygiene

Main Purpose

To assess and deepen an understanding of the factors that affect public health and hygiene practices.

Important

- Public health is affected by many factors apart from water, sanitation and hygiene. It is important to understand how food and nutrition, access to healthcare, shelter, protection and the environment interact with WASH.
- Coordination and collaboration with others **(P.9)** is crucial for an effective assessment of the factors that influence health and hygiene.
- The use of timely epidemiological data is essential to ensure that the hygiene promotion (HP) intervention is designed and planned according to current public health risks.
- A variety of Behaviour Change **(B.2)** and WASH models can facilitate a deeper understanding of the different factors affecting hygiene behaviour.
- In many acute emergencies, the initial WASH assessment focus is on the use of safe water, excreta management and handwashing, as they are likely to have the biggest impact on disease transmission. However, an ongoing assessment of different risks in each specific context is necessary and risks will evolve over time.

Overview

Multiple factors affect people's health and wellbeing, not only access to WASH. In many emergencies, people will have been displaced from their homes and may no longer have a livelihood or access to adequate food, shelter or healthcare. Promoting health is a complex and multifaceted task; it requires all sectors to work together and co-ordinate their assessment efforts. Interventions need to be prioritised to achieve the greatest possible impact for the largest number of people. Some interventions, such as providing a rapid means of disposing of faeces or supporting community organisations and networks, should be implemented in parallel with the assessment process when the risk to health is high.

The risks and influences affecting health span across different sectors and interventions. There is a particularly important association between malnutrition and the incidence and severity of diarrhoea. Food hygiene is also vital for improving public health. WASH interventions are also important when responding to outbreaks of certain infectious diseases such as Ebola, COVID-19 or malaria. Even where infectious diseases are not widespread, poor environmental health conditions can have a detrimental impact on physical and mental health and wellbeing and it may still be important to assess and target water and sanitation issues. An important objective of the WASH assessment and response is also to ensure that people can live in dignity and safety. The design of a WASH intervention should contribute to achieving this goal.

The main pathways for pathogens to infect humans are faeces, fluids, fingers, flies and food and the assessment should identify the specific pathways for the context. The main objective of WASH programmes in humanitarian response is usually to reduce the risk and/or incidence of diarrhoeal diseases by creating barriers along those pathways.

The 'F diagram' **(figure 8)** is a useful model for understanding the transmission routes for faecal oral diseases **(T.53)** and showing ways in which the transmission may be interrupted. It is important to assess and understand these transmission routes to identify which practices are causing a risk to public health. It is also important to assess and understand how different groups in the community understand transmission and the behavioural factors that influence risk and the perception of risk **(chapter B)**. The process of motivating changes in hygiene behaviour is complex; social, cultural, spiritual, political and legal factors may come into play. The factors that influence hygiene behaviour and practices **(chapter B)** therefore need to be assessed. Behaviour-influencing factors are usually grouped as 'behavioural influences or determi-

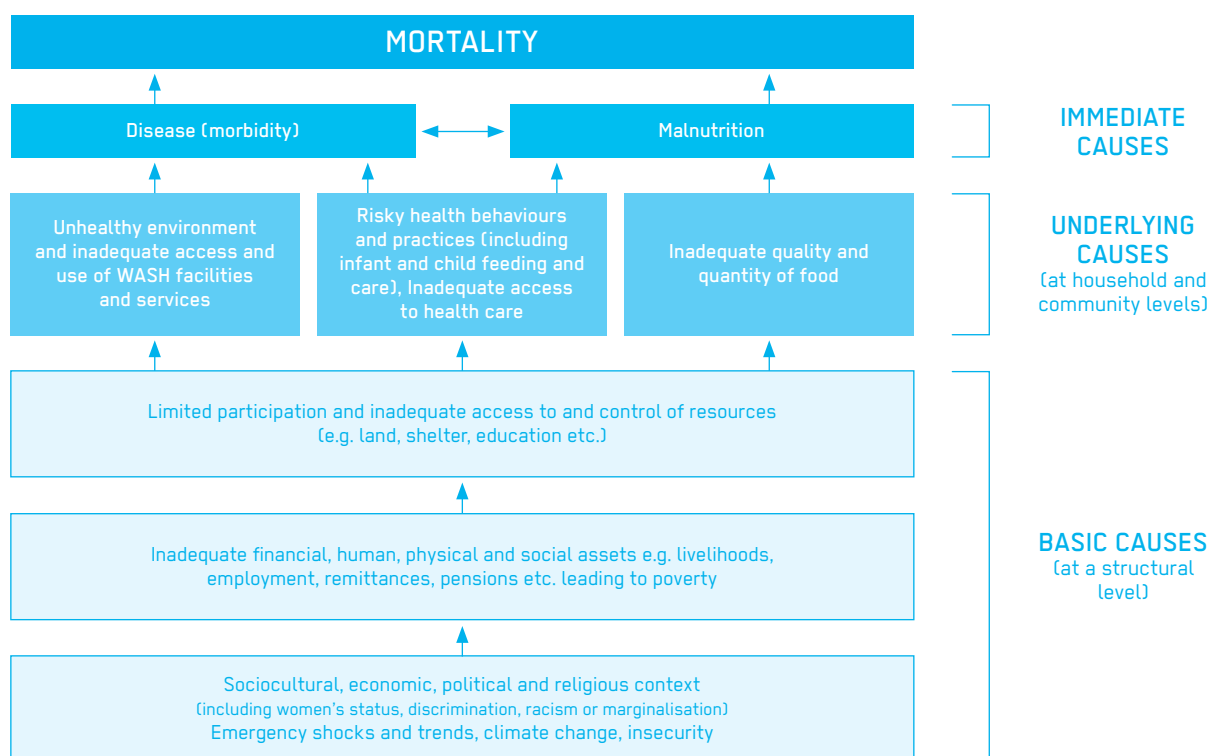


Figure 7:
Influences on Health
(adapted from UNICEF 2013)

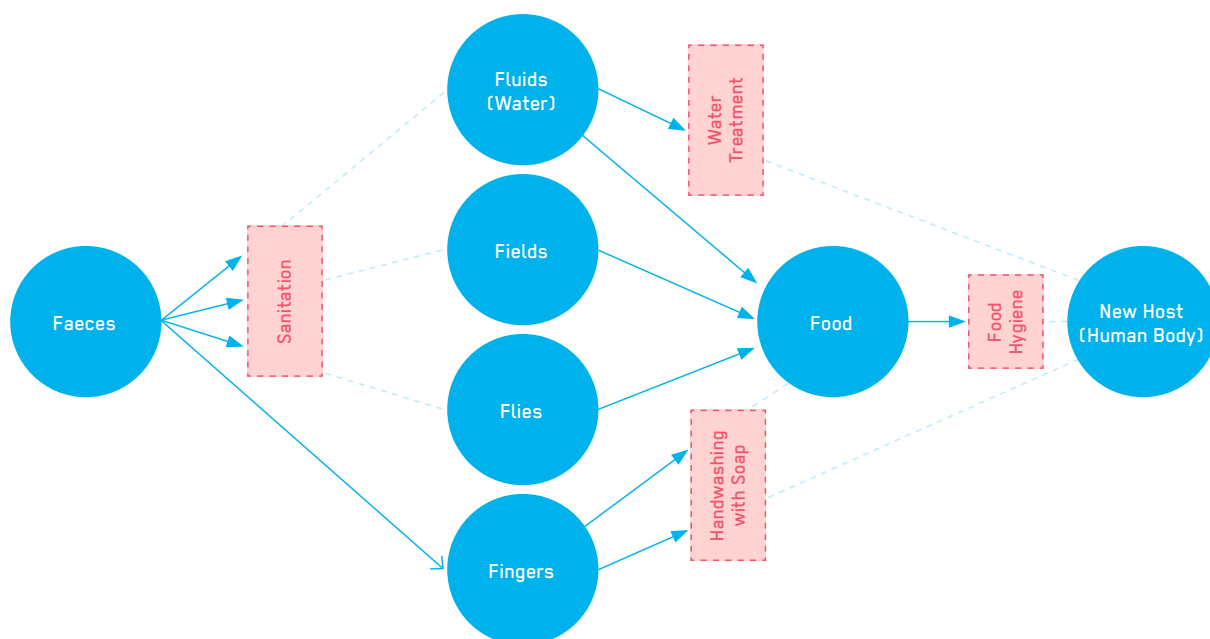


Figure 8:
F-Diagram
(adapted from Wagner
and Lanoix 1958)

nants'. They can either facilitate change or be a barrier to change. Drivers of, or barriers to change include strong beliefs or feelings (sometimes unconscious) that can positively or negatively influence change. For example, the Community-Led Total Sanitation (CLTS, **F.2**) approach uses disgust (**T.45**) as a negative 'driver' of change and pride as a positive 'driver'. Different behavioural models (**B.2**) group these drivers and determinants in different ways. The different behavioural determinants need to be assessed to identify which are most important. These determinants often vary in different groups of people and may change over time, creating a need for ongoing assessment.

WASH assessments include multiple factors. Access to appropriate WASH facilities and people's specific hygiene needs varies between different groups within the community. The response also needs to support people's dignity, privacy and sense of well-being, as well as interventions to reduce mortality and morbidity and influence behaviour. Women may need support to manage their menstruation effectively and hygienically (**P.7**). Incontinence may be an issue for some groups, such as older men and women and effective means to manage babies' and children's faeces will be important for those with young children. Some people may be bedbound, use a wheelchair or have a visual impairment: their hygiene needs will vary. Safety, access and privacy of WASH facilities are important if they are to be widely accepted and used by all sections of the community and these issues will also need to be assessed.

Process and Good Practice

- Collaborate with all other sectors when assessing, analysing and responding to public health risks (**P.9**). Be aware of the findings from other sectoral assessments to inform priority interventions.
- Highlight the priority communal, personal and domestic hygiene practices during the assessment. They are often handwashing with water and soap (or when not available ash), after contact with faeces and before eating, safe disposal of adults' and children's faeces and drinking clean water. In some contexts it may be important to focus more on specific issues such as food hygiene or waste management.
- Assess hygiene behaviour and public health risks in various settings such as schools, clinics, feeding centres, community kitchens, child safe spaces and other public places (**E.6 and E.8**), not just in households and communities.
- Understand people's previous hygiene situation and how they have adapted to the current situation.
- Identify the various behavioural determinants that can influence hygiene behaviour during the assessment to understand how best to influence them. This can be difficult in a rapid onset emergency but it should be possible to conduct formative (in-depth) assessments within the first few months. In-depth studies can be useful at different stages of the response especially if the current HP approaches do not appear to be effective.
- Develop and pre-test a communication strategy, methods and tools – an understanding of behavioural determinants will not automatically generate effective communications (**chapter C**).
- Manage the quantity of data collected. Numerous factors influence behaviour and the data can quickly become too unwieldy to analyse. The assessment design (**A.3**) should build on what is already known about the different population groups and the context and seek to understand where interventions can have the greatest impact.
- Vary programme design according to the specific context, using the context-specific data collected during the assessment. For example, to meet the objective of ensuring clean drinking water, one context may require the use of buckets with covers and taps, another may need repairs to household water tanks.
- Coordinate with other relevant sectors (**P.9**). The health sector may also carry out (overlapping) health promotion and risk communication activities (including assessments) in the community, making collaboration vital. WASH interventions contribute to wider effects. For example, as well as preventing diarrheal disease, hygiene communication (**chapter C**) ensures that people know how to manage disease at home and when they should seek medical help.

→ **References and further reading materials can be found on page 289**

Assessment Process and Planning

Main Purpose

To design a coordinated assessment to inform WASH or hygiene promotion (HP) programmes.

Important

- Coordination and collaboration with all stakeholders **(P.9)** are vital to ensure that resources are not wasted, existing information is used efficiently and effectively to inform the response and to minimise community assessment fatigue.
- Assessment objectives and questions should be clearly defined and concentrate on essential information needs; for example ask 'what information is missing to be able to develop the HP strategy?'
- An assessment should be initiated before programme implementation but, in a fast-onset emergency, immediate priority action may be needed based on a rapid assessment and refined through further assessment over time.
- The optimum possible level of engagement with the affected communities **(E.2)** and local stakeholders should be discussed and ways found to engage appropriately. Different types of data must be collected from all segments of the affected population to ensure that the voices of the most marginalised are heard.
- Effective assessment planning identifies constraints and opportunities in resources, accessibility and expertise so that data collection and analysis **(A.4)** is realistic and the information timely.
- It is impossible to respond to all the needs at once; the assessment will need to identify the areas of greatest risk, the people who are most vulnerable and use a phased approach to meet their needs.

Overview

The emergency HP assessment process usually entails: **(1)** Planning the assessment and identifying tools and resources, **(2)** Immediate rapid assessment, **(3)** In-depth ('formative') assessments as time allows and **(4)** Ongoing discussions and feedback with and from the community and other stakeholders.

Baselines determine the starting point for subsequent monitoring **(M.2)**. The term 'baseline' is used in different ways by different organisations. For some, it refers to the situation before the emergency. For others, a baseline survey provides initial data to compare with an 'endline' survey to determine the changes attributable to the programme. Information from the initial rapid assessment and analysis should feed into the development of the programme baseline and help to identify what needs further investigation.

Designing and planning an HP assessment (either stand-alone or as part of a broader assessment) is a crucial step towards ensuring that the data collection and analysis process **(1)** is relevant to inform HP programmes and strategies, **(2)** does not duplicate the efforts of others and **(3)** can realistically be carried out with the available capacity and resources.

Assessment planning and design help to define the objectives, identify what to assess, plan the assessment process and mobilise the resources and expertise required. It is essential to focus on essential information, rather than what is nice or useful to know **(A.2)**. Human resources to conduct the HP assessment should be identified based on the objectives of the assessment. Different skills, roles and responsibilities are needed to ensure a timely and relevant process and can come from different sources (community-based organisations, volunteers, or staff).

The purpose of the assessment is to identify gaps in existing information to inform subsequent HP programmes. During the acute scaling up phase the main information needed will be about the scale of the crisis and priority needs. Later, data will be required to address known issues, collect evidence, produce findings and investigate previously unknown problems.

In emergencies, many actors from different organisations and sectors will carry out needs assessments. Information collected and analysed by others can be useful for understanding the crisis and communities. When the decision to undertake an assessment is taken, coordinate with key stakeholders **(P.9)** to identify the type of assessment required and who will do what, where and by when. Participation or leadership of multisectoral or joint coordinated assessments are good options for producing

a joint analysis of the overall situation and to ensure that key elements of HP are integrated.

The assessment process must ensure the participation of all segments of the population to enhance the relevance, ownership and success of the programme. The data collected must also yield added value to the population and be used to support their dignity and autonomy. Their permission must be sought to collect, use and store their data. It is also important to recognise that in an emergency people will often be traumatised; some may find an assessment intrusive. Hygiene promoters will need to know how to listen and communicate effectively in such situations (C.2).

Process and Good Practice

- Coordinate internally between HP, other WASH actors and other organisations and humanitarian sectors conducting HP assessments (such as health, nutrition and protection) during the assessment design and planning stage, using the appropriate coordination mechanisms (P.9).
- Plan and share your assessment and analysis with others to avoid duplication and decide who does what, where and when. An assessment working group with clear roles and responsibilities can be useful.
- Coordinate and collaborate with relevant authorities at a national and local level (e.g. health, social welfare, education) (P.9) in the assessment design and planning phase. This can empower institutions to sustain their efforts and reinforce their capacity. However, it is important to recognise that institutions and their staff have been affected by the crisis. Early collaboration may be confined to sharing information, strengthening as time goes on.
- Participate in, or lead, the development of common indicators and assessment questions to facilitate the collection and analysis of the harmonised and comparable data required to design and plan HP interventions.
- Develop clear terms of reference: define the purpose and objectives of the data collection and analysis and clearly formulate the 'assessment' questions you would like to answer.
- Express the assessment purpose and objectives clearly by using words such as 'understand, map, identify, determine, review and assess', to help frame the actions. Be specific about why the information is useful as well as about the target population, geographical area, sampling strategy and methods to be used.
- Ensure that the assessment process is inclusive and accessible, including for people who have difficulty leaving their homes or communicating. Ensure gender-balanced teams where possible, including interpreters and collect information that is disaggregated by age, sex and disability as a minimum.
- Identify ways to enable the participation of both the affected community and local authorities. This could include inviting members of the affected community or the local WASH department to form part of the assessment team.
- Participatory assessment encourages community members to assess and analyse their own situation and can be a powerful tool to identify and stimulate community-defined actions.
- Decide which methods and tools will be used (A.4 and chapter T). Focus Group Discussions (T.14), Observation (T.28) and Key Informant Interviews (T.23) are often used in the first phase of an emergency to collect primary WASH data; other tools include picture sets and mapping activities (e.g. T.51 and T.7). Questionnaire surveys (A.8 and T.24) require more time and planning and may not be useful in the acute emergency phase unless dedicated resources are available.
- Assessment teams will need to be trained (ideally as a preparedness measure and including basic psychological first aid), supported and debriefed. Interpreters may also be needed on the team; checklists must be carefully translated.
- Consider including social scientists on the team; they can make a valuable contribution towards understanding social pathways of disease transmission and barriers to care and help in defining the methodology. Having their expertise at an early stage of the emergency is highly recommended.
- Approach administrative offices (such as statistics offices and survey units), research bodies (such as universities and polling companies), or community-based organisations for assessment information.
- Communicate the findings and share information with affected communities and other humanitarian stakeholders.

→ **References and further reading materials can be found on page 289**

Data Collection Methods and Analysis

Main Purpose

To ensure that appropriate methods, sources and tools for data collection and analysis are selected.

Important

- Collecting and analysing primary quantitative and qualitative data requires different resources and expertise, so the choice of methodology must be made carefully.
- Quantitative data, if collected rigorously using the appropriate methods and analysed critically, can provide information that can be applied to the larger population. It does not however provide an in-depth qualitative description of the experience of the affected population.
- Qualitative data can provide rich and detailed information about different groups and their perspectives on specific social and cultural issues related to WASH. It can capture diverse opinions from all sections of the community.
- It is essential to consider gender, age and specific vulnerabilities (such as disability) in the selection of assessment methods (E.3, E.4, E.5).
- Sampling bias is often a major flaw in an assessment and can lead to inconclusive and unreliable results.

Overview

A combination of different sources and types of data is required to design and plan a WASH response. Sources of information include both primary and secondary data. Types of information include qualitative and quantitative data. It is important to select the most appropriate methodologies in order to conduct timely, relevant and effective assessments.

Primary data is gathered directly from the affected population. It is collected by assessment teams through fieldwork, most often through face-to-face interviews (T.23) or discussions with members of the affected community (T.14). It may also be gathered through other methods including Community Mapping (T.7), phone interviews, social media and email exchange (T.44), radio communication (T.38) and direct Observation (T.28). For hygiene promotion (HP) purposes, primary data collection is an important way to engage with the population (chapter E) at an early stage of the programme design. It also ensures that the project is inclusive and relevant at the local level and that the assessment builds a holistic and accurate picture of the affected population.

Secondary data has usually been collected before the primary data and has undergone at least one layer of analysis before its inclusion in the assessment. Secondary data may be in the form of published research, media reports and/or data that has been cleaned, analysed and collected for purposes other than the assessment (such as academic research or agency or sector specific monitoring reports).

Both primary and secondary data can be collected and analysed using quantitative or qualitative assessment methods.

Quantitative methods collect numerical data through surveys or by working with pre-existing statistical data. Findings can either be applied across groups of people, to explain a particular phenomenon, or to describe a characteristic. They are useful during the assessment phase as they measure coverage, knowledge and practices. Data collection methods may include structured Observation (T.28), surveys and checklists (T.24 and A.8), polls, telephone or face-to-face Interviews (T.23). Analysis of quantitative methods requires some knowledge of statistics but software is available to support this.

Qualitative methods are useful during the assessment phase to collect and analyse data that reveals attitudes, perceptions or intentions e.g. to determine people's perception of risk or the barriers to healthy behaviours (chapter B).

Qualitative data is what people describe or illustrate (through photographs for example). It is usually analysed by identifying common themes and issues of concern and grouping them to draw broader conclusions. The results of qualitative data analysis should not be translated into percentages or numerical data without a clear explanation (e.g. although numbers can be obtained using Pocket Chart Voting **(T.31)**, they cannot be used to represent the rest of the population). The use of more general terms can help to indicate, for example, if the majority or only a few people expressed a particular view.

Triangulation compares several different data sources and methods to cross check and confirm findings. For example, teachers, community health workers, children and parents' perspectives on HP at school can be compared to prevent assumptions from being made. Triangulation can strengthen conclusions or identify areas for further work.

Process and Good Practice

- Weigh up the advantages of qualitative and quantitative methods relative to your assessment purpose to decide which methods are appropriate and when in the response.
 - Use a combination of methods that are both quantitative (how many functioning toilets are in operation?) and qualitative (how do women feel about going to the toilet at night and what barriers to access do they face?).
 - Gather secondary data. Common sources of quantitative secondary data are the Demographic and Health Survey, the Multi-Indicator Cluster Survey and any existing Knowledge, Attitude and Practice (KAP) or Knowledge, Practices and Coverage (KPC) reports, as well as current mortality, morbidity and other epidemiological data from the health sector.
 - KPC and KAP surveys **(T.24)** are the most common quantitative methods used in the WASH humanitarian sector to assess, plan, monitor and evaluate WASH programs but may not always be feasible in the acute phase of an emergency.
 - In recent years, the Wash'Em approach **(F.22)** the Doer/Non-Doer **(T.32)** and Barrier and Motivator Analysis **(T.3)** have been used more broadly to inform HP programmes in the humanitarian sector.
 - Choose between collecting primary data using pen and paper or tablets. First, consider the most convenient method for the affected population and then which collection method will allow quick and accurate analysis of the collected data.
 - Ensure that the competencies needed for quantitative methods are in place: specific skills and data are required (e.g. household lists in villages) to ensure the validity of the results.
 - Plan using the four basic steps to analyse qualitative data: **(1)** Organise data, **(2)** Shape or code the data, **(3)** Interpret and summarise the information and **(4)** Explain the information.
 - Triangulate information using different methods and sources and cross-check findings to minimise the bias of using only one method and increase the reliability of the data.
 - Consider using a two-stage stratified random sampling method (cluster sampling or Lot Quality Assurance Sampling) if it is not possible to acquire a list of units when carrying out a quantitative survey. A technique called 'sampling to redundancy' is often used with qualitative methods. This is where several individuals or groups may be asked to discuss an issue such as access to water until it is clear that no new issues are being revealed.
- **References and further reading materials can be found on page 289**

Assessment Content and Scope

Main Purpose

To identify which individuals and groups are vulnerable to which WASH-related risks and why.

Important

- The assessment must cover public health risks, WASH needs, hygiene behaviour, communication preferences and identify how different groups can best be supported.
- It is important to understand the complexity of the affected community (**A.7 and chapter E**) and to identify the different hygiene needs that may be present in a given context (e.g. for menstrual hygiene materials, incontinence aids or child-friendly toilets).
- The use of Behaviour Change (**B.2**) and WASH models can help to ensure a more in-depth assessment leading to a more effective response. These models should be employed throughout the response.

Overview

The hygiene promotion (HP) assessment should identify the main public health risks and current hygiene practices that contribute to the risks (**A.2**). It should determine which individuals and groups are vulnerable to which WASH-related risks (**A.7 and chapter E**) and why. It should identify factors that can both hinder and motivate positive behaviours and preventive action (**A.2 and chapter B**).

Assessing WASH-related public health risks and how to address them will require an understanding of:

- Current use of WASH facilities and services,
- Access to essential household hygiene items (**P.6**),
- Current coping strategies, local customs and beliefs,
- Social structures and power dynamics in the community (**A.7**),
- Where people go for healthcare (including traditional healers, pharmacies, clinics),
- Who is responsible for operating and maintaining WASH infrastructure,
- Disease surveillance data linked to WASH,
- Social, physical and communication barriers to accessing WASH facilities and services, particularly for women and girls, older people and persons with disabilities,
- Income-level variations,
- Environmental conditions and seasonal trends for diseases.

The assessment must also try to understand the social and behavioural factors (**chapter B**) that influence different peoples' hygiene practices and how these can be used to influence change as shown in **figure 9 on page 90**. It will also need to identify the communication preferences of different groups to design an effective response (**chapter C**).

Process and Good Practice

- Consider different community groups (e.g. men, women, adolescents, elders and people with disabilities) and identify those who are marginalised or particularly vulnerable (**A.7 and chapter E**).
- Recognise that the affected community are 'experts' in their situation and have knowledge to share.
- Remember the importance of communicating with people in their language and ensure that interpreters are well briefed before commencing the assessment (**C.7**).

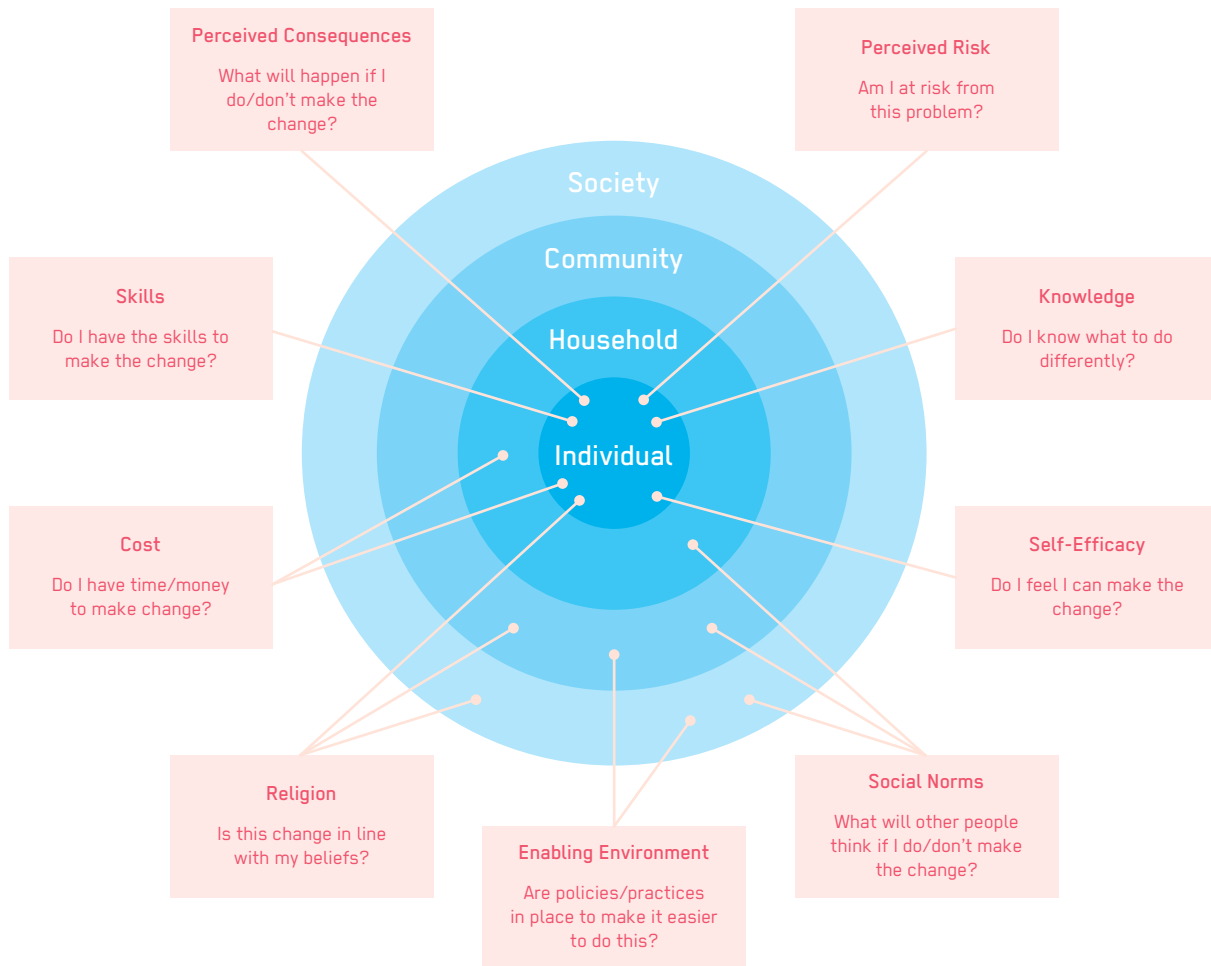


Figure 9:
Example Areas for
Assessment Based Around
the Socio-Ecological Model
(adapted from UNHCR
and RANAS)

- Use the 'F' diagram, influences on health graphic (A.2) and social and behaviour change models (B.2) to help identify a broad range of assessment factors and continue to deepen understanding as the programme progresses.
 - Aim to answer the following ten questions through the HP assessment:
 - ▶ What were 'normal' practices before the emergency and how have people adapted to the emergency?
 - ▶ What are the widespread 'risky' practices in the community?
 - ▶ What are the different motivators and barriers to practising safer hygiene for different groups?
 - ▶ How can we enable changes in practice and improvements in hygiene?
 - ▶ Who uses 'safe' practices and who and what motivates and influences them to do so – can this be used to influence others?
 - ▶ What communication channels are available and which are trusted for promoting hygiene?
 - ▶ What facilities or materials do people need in order to carry out the 'safe' practices?
 - ▶ How much time, money or effort are people willing to contribute for those facilities/materials?
 - ▶ Where will those facilities/materials be available?
 - ▶ How will people know that the facilities/materials exist and where they can be obtained?
 - Use different senses to gather information. It is not enough to just ask questions; use other senses such as Observation (T.28) to cross check and deepen understanding.
 - Some questions about hygiene can seem intrusive and there may be taboos about some issues e.g. menstrual hygiene (P.7). It can be useful to ask such questions indirectly such as 'what do women here do?' rather than ask 'what do you do?'
- **References and further reading materials can be found on page 289**

Existing Capacity

Main Purpose

To ensure that the assessment of WASH needs takes account of the existing local capacity to respond.

Important

- WASH programmes should strengthen existing state, district and community systems, rather than establish parallel efforts that will not last beyond the duration of the response. It is important to seek out and work with municipal authorities and local government **(P.9)** as much as possible and advocate that they are treated as equal partners with the autonomy to design and/or lead a response **(P.10)**.
- Support the initiatives of local groups and organisations where possible and involve them in the assessment, planning and training.
- Where possible, channel funding and support to build the resilience of local responders. For example, funding or providing training for local community strengthening and WASH NGOs will have sustainable effects.

Overview

The impact of disasters will be specific to the context in which they take place and the resources and capacity available to manage them. Many emergencies are managed locally or nationally; in others governments may request the support of other countries and agencies.

Humanitarian response should strengthen local capacities and avoid negative effects. In the past, emergency assessments have often focused solely on the vulnerability of communities, treating them as victims and contributing to a sense of helplessness and dependency. However, communities and authorities are usually the 'first responders' and intervene before outside agencies arrive. They possess diverse knowledge, skills, resources, ingenuity and leadership that can contribute significantly to the response. An assessment process must strive to identify how to support, rather than undermine, their capacity. Even when government services have been disrupted by an emergency, structures relevant to hygiene promotion (HP) such as health care, health education and social welfare departments will still often exist. In addition, national and local NGOs, faith-based organisations and social entrepreneurs may be involved in WASH or community work and already be responding. Affected communities may have experienced crises before so some people may already be trained in emergency response and HP.

It is important to collaborate with communities, partners and government structures **(P.9)** because they have a right to be involved in decisions that directly affect them, have significant knowledge of the culture and context and can contribute significantly to the response. Handing over power can help to build resilience and reinforce dignity and self-esteem. They are there for the long term and if they are involved from the beginning, it will enable a smoother exit for humanitarian agencies at the end of the programme or facilitate remote working if needed.

In most emergencies, people will be traumatised to some degree, but the level of trauma and capacity to recover will vary for different people. Hygiene promoters should tread sensitively when communicating with people and be ready to respond to their grief and sense of loss. At the same time, they should recognise that many people will want to play a part in the response and this engagement may support their readjustment and recovery.

Process and Good Practice

- Identify key people to contact and consult to help understand the situation, including local authorities, different groups in the community, local NGOs, civil society networks and other key informants **(T.23)**.
 - Build up a Community Profile **(A.7)** and document it for future responders.
 - Try to understand how people lived their lives before the emergency and how they have adapted to the current situation.
 - Identify government departments relevant to WASH such as the Ministry of Health and local health clinics, Ministry of Social Welfare or Community Development, Ministry of Public Information and Communication, Departments of Health Education/Promotion, Ministry of Sanitation/Water, or Departments of Disaster Risk Reduction.
 - Aim to understand the national frameworks for public health, health promotion and community welfare. Obtain copies of relevant current guidelines, policies, plans and national standards (such as WASH guidelines or health/HP strategies) to ensure that response strategies are in line with local and national priorities where appropriate.
 - Seek out the support of local advocacy and support groups, such as organisations of persons with disabilities or women's groups, to understand how to ensure that WASH facilities and services are accessible.
 - Obtain the necessary approvals before visiting communities and familiarise yourself with the common community leadership structures. Be aware that these may exclude women and vulnerable groups and identify local organisations that may help to access these groups.
 - Carry out a market assessment in collaboration with others to identify possible impacts of the programme on the local economy. Consider what form of WASH assistance and market-based programming **(P.8)** modality (e.g. cash, voucher, or in-kind) will have the greatest positive outcome.
 - Identify existing self-help groups, committees and outreach networks when identifying community volunteers. Agree on transparent mechanisms for volunteer selection with the community. Try to understand the vested interests that might be operating to help avoid conflict. Voluntary HP networks may not always be the most appropriate model for communicating WASH concerns.
 - Draw up Memoranda of Understanding or joint action plans (where possible) with local actors or communities that define the different WASH roles and responsibilities.
 - Find ways to enable the participation of local actors in coordination groups – this may involve providing interpreters and translating WASH meeting minutes.
- **References and further reading materials can be found on page 290**

Community Profile

Main Purpose

To understand the different WASH needs, vulnerabilities, capacities and priorities of different groups within the affected community.

Important

- The people affected by an emergency will not experience it in the same way. Within any community, there will be different groups with different capacities, needs and priorities.
- Building up a community profile is an ongoing element of the assessment process; information requirements need to be prioritised.
- The process of compiling and analysing the community profile should be as interactive as possible so that decisions are made with the people whose lives they will affect.

Overview

A WASH Community Profile aims to understand community structures and dynamics and determine which individuals and groups are vulnerable to which WASH-related risks and why. A good community profile is a participatory exercise designed to deepen understanding of the situation in order to design and adapt an effective and sustainable response.

Communities are rarely homogenous entities, yet broad-brush assessments tend to assume that everyone in the community is affected in the same way (**chapter E**). In any setting, refugees and displaced persons will often come from many different backgrounds. They may speak different languages and belong to different social groups, clans or castes, have different educational levels and different religions. Some people will have more power and influence than others; some will be marginalised. The community will be composed of men, women, boys and girls. There may be people who are transgender or non-binary. Within families, it is important to understand who makes the decisions about health and hygiene and how this can compromise or support the objectives of the WASH intervention.

A gender analysis focuses on the different roles and responsibilities that society assigns to men and women, boys and girls and the power differences inherent in such roles. Women and girls may have certain WASH roles expected of them, for example they are often expected to collect water but not to mend broken pumps and they may not have control over household or community finances to be able to do this. Addressing the problem often requires an understanding of these different roles and power dynamics (**E.3**).

Particular groups are often assumed to be more vulnerable than others (e.g. women or refugees). Community dynamics are complex and, in many emergencies, roles and responsibilities may have changed. Families may have become separated. Men may be left caring for children and need extra support to maintain their children's health and hygiene. A community profile can help to identify the gender roles and responsibilities of women and men concerning water management and health-seeking behaviours and how these might have been altered as a result of the crisis.

Understanding the community is important because it can lead to a more effective WASH response. For example, some groups may be forbidden from accessing water points or from sharing sanitation facilities and face pressure from more powerful groups. Children under five can represent between 15–20% of the population but are often a neglected group in WASH responses (**E.4**). Some

people will have specific WASH needs due to their disabilities (E.5). Women and girls will have particular needs for Menstrual Health and Hygiene (P.7) and older people and persons with disabilities may have mobility or incontinence issues that prevent them from easily using sanitation facilities (E.5 and P.4).

Community profiling can also help to identify existing local WASH capacity (A.6) and where and how community capacity can be strengthened. For example, engineers, technicians and community workers may already exist within the affected population, or the assessment might reveal that grandmothers play a key role in influencing health behaviour.

Process and Good Practice

- Develop community profiles as part of an iterative assessment process. During an acute emergency it will not be possible or desirable to gather all the information required at once and in some responses the profile may change as new groups arrive. Information from various sources should inform the profile and triangulate the findings.
 - Set regular time aside to review any gaps in the community profile. There will always be more to learn and it is important to remain open to challenging the findings and assumptions that are being made.
 - Start by reviewing social and economic characteristics using secondary data sources when available.
 - Cross check profiling information by talking to a variety of stakeholders in the area. This could include staff from different agencies working in the area, male and female community members and the local administration.
 - Ensure that inclusion and disability are considered across all categories of the profile. For example, findings about access to education, health care and transport should include those with disabilities.
 - Include the following information in the profile where relevant:
 - ▶ Religions and ethnicities (including minorities)
 - ▶ Influential groups or individuals
 - ▶ Marginalised groups
 - ▶ Leadership structures
 - ▶ Livelihood groups
 - ▶ Land ownership
 - ▶ Gender and power relations
 - ▶ Access to education
 - ▶ Access to health care (who, how far, cost, trust, availability of staff and medicine)
 - ▶ Access to transport
 - ▶ Public health profile including WASH risks, immunisation coverage, nutrition and infant feeding
 - ▶ Recreational facilities
 - ▶ Historical and cultural facilities
 - ▶ History and experience of crises/emergencies or similar disasters
 - ▶ Socio-cultural value systems and beliefs
 - ▶ Community WASH and response priorities for different groups
 - ▶ Existing WASH-related capacity and skills
 - ▶ Formal and Informal trusted communication channels and communication preferences
- (chapter C)**
- ▶ Gather the information by talking to the following potential community stakeholders:
 - ▶ Grassroots/community-based organisations such as youth groups or cooperatives
 - ▶ Religious groups and leaders
 - ▶ Schools, colleges and universities
 - ▶ Health centres and clinics
 - ▶ Disability groups – including organisations of persons with disabilities
 - ▶ Senior citizen groups
 - ▶ Commercial facilities (markets, shops, businesses and trade organisations)
 - ▶ Public interest groups
 - ▶ Representative bodies such as co-ops and unions
 - Use a variety of tools to build up the profile. Community Mapping (T.7) can provide an overview of the local situation and explore specific issues such as who might use, or be excluded from, specific water sources or WASH resources and why. Focus Group Discussions (T.14), Key Informant Interviews (T.23) and interactive assessment methods such as Exploratory (Transect) Walks (T.52) and Three Pile Sorting (T.51) may also be used.
 - Consider using a visualisation method (such as a large whiteboard or poster) that allows the whole team to access and provide input to the profile and cross check the findings through discussion and feedback with affected communities.

→ **References and further reading materials can be found on page 290**

Conducting Quantitative Surveys

Main Purpose

To support decision making in the planning, implementation and assessment of hygiene promotion (HP) interventions through accurate, statistically significant data gathered from quantitative surveys.

Important

- A quantitative survey is a key method of primary quantitative data collection. It enables the collection of broad population-wide information if carried out well.
- Quantitative surveys are carried out during the establishment of baseline project data and are either repeated throughout the WASH response (in longer responses) or at the end. Monitoring surveys are used during post distribution and when it is important to know, in a statistically significant way, what the attitudes and knowledge of the affected population are.
- Surveys can only gather information about the things they specifically ask about (as opposed to qualitative assessments which are often exploratory). Therefore, they must be piloted and developed alongside an understanding of the community, together with qualitative assessment data and analysis.
- Conducting a quantitative survey that is representative of the target population requires knowledge of population numbers and geographic distribution, expertise in quantitative data collection, processing and analysis and a team trained in the use of questionnaires. Although it varies according to the equipment available and choice of survey methodology, it takes time to organise, execute and analyse.
- Surveys using tablets or phones remove many of the logistical and security challenges of coordinating large household surveys. They can also make it much easier to reach people who are on the move, such as pastoral communities or those fleeing a shock event.

Overview

Quantitative surveys are a data collection tool used to gather close-ended responses from individuals and groups. This often takes the form of a Knowledge, Attitude and Practice Survey (T.23), a Knowledge, Practice and Coverage survey (both can be done as baselines and endlines), quantitative Doer/Non-Doer Survey (T.32) or perception and/or Monitoring (M.2) surveys.

Question types primarily include categorical questions (e.g. 'yes/no'), numerical questions (e.g. number of people in the household that use the latrine) and interval/ratio questions (e.g. rating-scale, Likert-scale). They are used to gather information on behaviours, coverage, practices, characteristics, attitudes or demographic information. Surveys are completed using paper questionnaires or, more conveniently, tablets.

Depending on the methodology used, surveys can be a relatively quick, cost-effective and extensive data-gathering method. Short questionnaires with standardised questions and answers can provide a large data set involving large sample groups in a short amount of time.

Different types of surveys can be done before, during and after a WASH response, but surveys are commonly used to design (e.g. quantitative Doer/Non-Doer Survey T.32) and measure the effectiveness and impact of a WASH response (M.2 and M.4).

Process and Good Practice

Process Steps:

Step 1: Define the survey objectives. A well-executed and successful survey begins with well-defined survey goals and objectives. To write effective goals, start with an action verb (such as describe, explain, explore, identify, investigate, gauge, measure, assess or test) followed by the issue under enquiry. For example, 'to understand the knowledge of the displaced population in the province X regarding the prevention, diagnosis, care and treatment of diarrheal diseases in children under 5 years old'.

Step 2: Define how the survey will be implemented to ensure high quality and consistently collected data. Consider the sampling frame, method, the protocol for respondent selection, verification of data, ethical and safeguarding measures and a basic plan for data management and analysis. The timeframe and resource (administration, budget and logistics) requirements should be clearly defined at this stage of the process and coordinated with the support departments of implementing agencies, local authorities and/or camp management authorities.

Step 3: Design the survey questionnaire. No survey can succeed without a well-designed questionnaire. There are many good examples of survey questionnaires that can and should be adapted to the specific situation. In general, the questionnaire includes the questions to be asked, as well as a list of response choices which enumerators use to record the response. The wording of both of these items should be clear, precise and accurately translated into the language(s) spoken by the questionnaire respondents. Once the questionnaire tools have been developed, test each tool in the field to see how well the questions are understood by a small sample of respondents and identify any problems with the administration of the questionnaire. Where electronic devices are used, geo-data and time-stamps can be used to verify sampling and interview protocols.

Step 4: Conduct the survey using the appropriate protocol for the method chosen. Data quality control measures must be in place during fieldwork, e.g. Quality Improvement Verification Checklists that are performed daily by supervisors. Before field deployment, a clear strategy should be developed to support enumerators during collection to resolve problems that arise and to assess and maintain data quality as data is collected.

Step 5: Data analysis: survey results must be analysed. Ideally, data entry and cleaning start during or shortly after fieldwork. This saves time and enables data quality issues to be identified while there is still time to rectify them. Verification and validation of the data are important steps in survey quality control.

Step 6: Use of the data: the results of the survey must be presented in a final report (using visuals such as graphics where possible) according to the objectives of the survey. The report, however, is only the beginning. It is important to use the findings of the survey and to work as a team to address the challenges identified. The results and action plan should be disseminated to all stakeholders in the WASH sector who are likely to benefit from the information collected, as well as to the populations that participated in the survey.

- The survey team is generally made up of a programme manager, supervisors and teams of enumerators, including men and women who are fluent in the local language.
- The trained enumerators may be hired for between one and two weeks (maximum three) depending on the number of respondents and the number of interviewers recruited – if existing staff capacity is not available.
- The supervisors' role is to move from one team of interviewers to another to help resolve any difficulties encountered. Supervisors are the guarantors of the survey process, checking that the interviewers follow the correct respondent profiles and fill in the questionnaires correctly.
- The technical advisors and project managers may be too busy to manage detailed aspects of the survey: the support of a methodology assistant from the beginning and at key moments in the process can help. Collaboration with other individuals or organisations may be necessary to determine the sampling plan (the number of people and areas to be interviewed), create/adapt questionnaires, conduct interviews in the local language and enter or analyse data.
- Ensure that your questionnaire does not take longer than 45 minutes; test and improve the questions based on the feedback. Do not ask questions that will not be analysed and used.
- The major methodological errors in sampling include insufficient sample size or the number of clusters, failure to sample proportional to population size (for cluster surveys) and failure to weight the sample during analysis.
- Two key factors affect the representativeness of the sample for surveys: **(1)** accessibility of survey participants and **(2)** general inequalities which may prevent or reduce the participation of certain groups in surveys.
- Disaggregated data will often be an important component to identify people with a disability. The 6-item Washington Group Short Set of Disability Questions is recommended. The questions assess whether people have difficulty performing basic universal activities such as walking, seeing, hearing, cognition, self-care and communication.
- Accessibility may be restricted and undermine the survey. Restrictions on the movement of enumerators may be caused by insecurity, logistical challenges, transport problems, remoteness, weather, surveyors being refused access and natural disasters and make it impossible to reach all areas identified through the random sampling process.

→ **References and further reading materials can be found on page 290**

Planning Frameworks

Main Purpose

To use assessment data to identify the priority risks and needs and determine what needs to be done, how, by whom and when.

Important

- Programme plans should use assessment data to identify priorities, develop objectives and strategies and mobilise resources. The priorities should be selected in collaboration with the affected population and coordinated with government and other sectors, e.g. health, nutrition, food security and shelter **(P.9)**.
- Humanitarian organisations should support governments to fulfil their responsibility for the overall planning of the response. Plans should be aligned with pre-existing national strategies **(P.9)**.
- Programme plans provide a summary of the intended programme for donors, programme staff and communities, contributing to Accountability **(M.4)**, transparency and, because staff are clear about their role, programme quality.
- Programme planning should be collaborative. Engage all stakeholders **(P.9)** using, if appropriate, creative ways e.g. by inviting community representatives to planning meetings or using Drama **(T.6)** and Role-Play **(T.41)** to enable stakeholders to see different perspectives.
- Programme plans should adapt and change their designs and strategies in response to feedback, Monitoring **(M.2)** and a changing situation. Develop learning and adaptation processes **(M.6, M.7, M.8)** and identify revision milestones.
- Consider the longer-term impacts of planning decisions and promote sustainability and future resilience in affected populations.

Overview

The planning phase of an intervention involves analysing and prioritising the information gathered during the assessment. It is a vital first step in any hygiene promotion (HP) intervention – even when there is pressure to act immediately.

The planning process should involve as many representative stakeholders as possible. This does not, however, prevent immediate steps from being taken to address needs during the process – for example, soap can be provided at the same time as conducting an assessment of Menstrual Health and Hygiene **(P.7)** needs.

A WASH plan must include the objectives and indicators for HP as well as the specific activities required to achieve the objectives, the resources to implement the programme (e.g. funding, staffing, training, equipment and time) and the assumptions that need to be managed if the programme is to succeed.

A variety of tools and references exist to support the WASH planning process such as:

- Sphere Standards: provides minimum standards and indicators (including the Core Humanitarian Standard, Protection Principles and Community Engagement Framework).
- Stakeholder Analysis: examines who is interested and influential in the project **(T.49)**.
- Problem Analysis: identifies the main problems and solutions using a problem tree and is a basis for developing a Logical Framework **(T.25)**.
- Logical Framework Analysis **(T.25)** or Theory of Change or Behaviour Change models **(B.2)**: provide a planning matrix or summary of the programme.
- Human Resources Plan: assesses recruitment (staff and volunteers), management, training and support.
- Hygiene Promotion Strategy and Communication Plan: identifies trusted means of communication for different audiences and how they will be reached and supported **(C.10)**.
- Action Plans: can be done weekly or monthly and be drawn up for specific groups or teams. Community groups and staff teams can draw up action plans and this can form a basis for reporting.
- Monitoring and Reporting Framework: identifies key WASH indicators (including for participation and satisfaction), how they will be measured and what reports are required from whom and when **(M.2)**.
- Accountability Framework: identifies how feedback and complaints will be collected and acted upon **(M.4 and F.23)**.

Plans must also identify and manage potential risks that could prevent or undermine implementation, e.g. insecurity, logistics or community resistance. If insecurity limits access, arrangements may have to be made for remote programming (**E.10 and C.8**).

A baseline can refer to the situation before the disaster (**A.3**). For emergency programming, baseline data is drawn from the assessment data. The 'baseline' is the starting point for measuring the success of the programme. Indicators are developed to measure progress and impact, comparing the baseline with the 'endline' WASH situation when the programme ends. The indicators should include measures of community participation and satisfaction.

Process and Good Practice

- Aim to reduce public health risk and maintain people's dignity and give affected people a say in how the programme is designed and implemented. These aims are interrelated. A toilet that does not plan for accessibility, safety and privacy is not an adequate response.
- Consider a broad range of determinants that influence different people's health and behaviour in programme design, such as physical, environmental and social barriers and motivators as well as cognitive factors (i.e. how people think and feel). Hygiene promotion is not only about education and imparting information.
- Refer to the following questions to plan an HP response: what risk practices are most widespread and who engages in them and why? Which are having the biggest impact on public health? What can be done to enable change and overcome the barriers to change (e.g. access to facilities, hygiene items, information and communication based on behavioural determinants, **chapter P**, **chapter B** and **chapter C**)? Who can help to influence change and how can all sections of the population be reached effectively through multiple delivery channels (e.g. through trusted communicators, mass media and edutainment, **chapter B** and **chapter C**)? How can the affected community be involved in identifying and implementing appropriate solutions (**chapter E**)?
- Carry out organisational planning collaboratively with all staff engaged in WASH, including the engineers (**P.9**). The HP plan should be part of a holistic WASH response.
- Include local capacity in the plan (**A.6**), such as partner organisations, civil society networks and markets. Identify ways in which local markets can be supported e.g. locally available materials, or the provision of cash (**P.8**).
- Consider how the intervention can contribute to the longer-term resilience of affected communities, e.g. through training and capacity strengthening, earthquake and flood resistant structures and by avoiding parallel structures for community outreach or maintenance of WASH facilities (**E.7**).
- Use different media and methods (mass, social, interpersonal, **chapter C** and **chapter T**) whilst recognising that, at its heart, HP must encourage community dialogue and discussion (**chapter E**). Pay attention to the content of communications, not just the methods (e.g. some methods may be fun and engaging but fail to convey the content).
- Adapts plans in response to community feedback, Monitoring (**M.2**) and changing circumstances. For example, distributions in kind may later be halted in favour of market-based interventions (**P.8**). It may be helpful to pilot some initiatives and obtain feedback before large scale roll out.
- Recruitment procedures (including the provision of job descriptions and adherence to codes of conduct) must be followed in order to reduce the risk of misconduct and abuse of power and to ensure effective programmes.

→ **References and further reading materials can be found on page 290**



Communication

Information is a highly valued commodity during emergencies and communication is an important element of it. Communication facilitates hygiene promotion (HP) through active listening, information exchange and guidance and advice to target audiences, enabling them to develop positive hygiene behaviours and practices. Communicators need strategies and tactics to create effective messages which motivate the target audience to protect families, communities and nations in an emergency.

Diverse Communication Skills (C.2) are needed to create and deliver key messages and to build trust with the communities. Identifying different target audiences is important for tailor-made communication to ensure inclusivity and a high degree of participation and ownership (C.3).

Hygiene information can be communicated in different ways. Participatory communication (C.4) is based on dialogue, involvement and interaction; it aims to understand the perspective of the affected community and tailor interventions to their specific situation. It can also encourage communities to play an active and influential role in decisions that affect their lives. Mass communication (C.5) allows for the dissemination of information and key messages to large numbers of people rapidly and cost-effectively. No single method is guaranteed to be effective however; a mix of different methods tailored to different target groups (C.3) is advisable.

Constantly Monitoring (M.2) and Evaluating (M.3) the effectiveness of communication strategies, listening to and involving the affected community are vital elements of communication. Systematically collecting community perspectives, concerns, reactions and rumours is essential to improve and adapt the response (C.6).

Effective communication takes language and cultural factors into account (C.7). Information should be simple, clear, consistent in its meaning and responsive to audiences' needs. The content should respect and acknowledge cultural differences and context through the use of appropriate language. Remote communication strategies may be required (C.8) if access to the target population is reduced due, for example, to safety and security concerns.

Risk Communication and Community Engagement (C.9) is a response-wide strategy, often used in disease outbreaks. It aims to provide critical information to the affected community on how to stay safe and what actions they can take in response to the crisis.

An effective Communication Plan (C.10) assesses the needs of the target audience, selects appropriate hygiene messages, defines objectives, identifies appropriate communication methods and channels, prepares communication materials and communicates the messages in a timely and effective manner. It provides a sequenced framework for action, describes the content of the communication, how it will be communicated, through which media and to whom. Planning also identifies the available or required resources, helps to define roles and responsibilities and assigns financial and staffing resources.

Sub-Chapters

- C.1 Key Concepts and Good Practice
- C.2 Communication Skills
- C.3 Audience Profile and Inclusive Communication
- C.4 Participatory Communication
- C.5 Mass Communication
- C.6 Community Perspectives and Rumours
- C.7 Language and Cultural Considerations
- C.8 Remote Communication
- C.9 Risk Communication and Community Engagement (RCCE)
- C.10 Communication Plan

Key Concepts and Good Practice

Main Purpose

To engage all sections of the affected population through active listening and participatory interaction using communication channels and information that are adapted to the specific context and diverse groups.

Key Concepts

- Hygiene promotion (HP) is more than the provision of one-way information. It is a dialogue with communities about hygiene and related health problems to learn about their needs and encourage improved hygiene practices.
- Communication is relevant for all WASH actors and in all phases of an emergency. It may vary according to the situation but where 'messages' are used they must be specific, actionable and clearly articulated.
- The first step in the design of communication approaches is to first diagnose the situation, needs and preferences of the audience and then define the objectives and priority actions. The communication methods used must be mutually understood by both the audience and communicators.
- Communication 'channels' refer to the tools used to communicate (**C.4 and C.5**); they can be traditional or modern. Traditional and existing channels of communication are easier to use and are often more effective than newly introduced channels. Communication channels range from:
 - ▶ Oral interpersonal communication: community meetings, face to face communication, peer to peer exchange, word of mouth
 - ▶ Written interpersonal communication: guidance manuals, flipcharts, communication material for target audience groups like parent-child
 - ▶ Community or folk media: Community Drama and Puppet Theatre (**T.6**), Songs and Stories (**T.47**), Events (**T.11**), group discussion, mobile video unit/presentation, talk, workshop, Household Visits (**T.18**), Demonstration (**T.10**), community Radio (**T.38**)
 - ▶ Mass and mid-media: Radio and TV (**T.38**), Print Media such as brochures, booklets, flyers, newspapers, newsletters (**T.33**)
 - ▶ Social Media and Text Messaging: websites, e-tools, apps like Facebook, Twitter, WhatsApp, mobile and smart phones, videos, blogs, email (**T.44**)
- Effective communication differentiates between various target audiences, identifying what information is needed and which information is appropriate for each group. It addresses how individuals will best understand and obtain this information, based on their preferred communication channel, cultural context and language(s) (**C.7**). One size does not fit all in communication approaches.
- Effective communication is accessible to everyone (including people with hearing, visual, intellectual and physical disabilities), appropriate (using preferred communication channels and languages), actionable (moving audiences to specific actions), credible (accurate, trustworthy and transparent) and relevant (based on an understanding of public health and the needs of the population).
- The development of hygiene promoters' communication skills needs supporting and adapting to changing local and global communication trends to be effective. Communication should be as participatory as possible and actively involve and empower target audiences; this may be more time consuming but is more effective.
- Barriers to communication often exist in emergencies due to complex contexts and a lack of resources. Typical barriers include the physical breakdown or destruction of (or lack of access to) communication channels, trust issues due to myths and misinformation, lack of capacity to coordinate communication, lack of empowerment of communities to take action and distrust between stakeholders (such as government and communities) due to conflict or fragile contexts.
- During an emergency, situations change quickly. Communicators must adapt the information and messages in response to a rapidly changing health situation.
- Feedback is an important aspect of communication and accessible Feedback Mechanisms (**T.13**) must be put in place. Feedback can enable the participation of the target audience in joint decision-making processes that empower them to assess and prioritise issues and to take action. Feedback explains how the information is received, enabling a recalibration of content or form (**M.5**).
- Communication in HP is not solely about influencing behaviour. It also aims to develop trust with affected communities, empower them and assess risks and opportunities to promote social change.

Good Practice

- Use in-person communication methods where possible and active listening to ensure meaningful engagement with the affected population.
 - Increase the accessibility of information to different groups by providing it in multiple formats (including written, oral and pictorial).
 - Focus on the content of the communication as well as the methods. For example, some methods are fun and engaging but people may fail to grasp the content of the communication.
 - Use a mixture of channels. Digital channels can be effective, but each has its limitation and should be combined with other communication channels. Marginalised groups may not have access to technology. The use of Social Media (T.44) as a channel requires a strategy to be effective.
 - Ensure that group discussions and events are well facilitated and moderated and encourage active listening.
 - Use high-quality communication materials that are tailored to the target audience.
 - Create a suite of communication materials on the same topic to help target multiple audiences.
 - Consider the use of short, engaging and innovative communication materials (e.g. phone videos or humorous posters).
 - Use interactive communication materials if possible. They facilitate two-way communication and can help to deepen understanding and develop trust.
 - Create messages (where used) that are relevant and use simple and familiar language.
 - Assess people's knowledge, attitudes, beliefs and practices (T.24) and understand the risks they face to their health (A.2). Identify barriers to avoid or change. Identify key behaviours and target them one at a time. Follow the assessment with communications research to guide objectives, messages and monitoring activities.
 - Disaggregate large audiences into smaller groups or segments of people who have similar needs, values and/or characteristics (A.7 and C.3).
 - Ensure that the information provided is inclusive and does not discriminate against any one group
 - Involve influential community members (T.22) such as leaders and teachers as educators and promoters and familiarise them with participatory methods (if required).
 - Ensure that Feedback Mechanisms (T.13) are available and accessible to different audiences (M.5) and that the affected community can share their opinions or express their concerns about WASH communications.
 - Monitor (M.2) and Evaluate (M.3) to continually improve the effectiveness of communication. The process should be as participatory as possible (M.5).
- **References and further reading materials can be found on page 290**

Communication Skills

Main Purpose

To listen and communicate effectively with individuals, groups and communities to develop mutual understanding and trust between different WASH stakeholders.

Important

- Active listening is at the heart of effective communication.
- Diverse communication skills are needed for different forms of communication. Advocacy communication (P.10) and professional communication (such as for coordination) (P.9) differs from communications with communities.
- Fluency in the language of the target audience is an important skill for communicators. Sometimes fluency in multiple languages is required (e.g. the host and displaced communities may speak different languages).
- The use of culturally appropriate body language, attire and non-verbal communication is very important.
- Public information is not always trusted by the communities. Community Engagement (chapter E) is fundamental to gaining trust.
- Communication networks often become disrupted during emergencies. Alternatives will often be needed – flexibility and adaptability are required.

Overview

Communication skills are essential to hygiene promotion (HP) to build trust with the communities, enable their participation and promote behaviour change.

The following communication skills are important for HP:

Active listening: communication is not only about delivering information. It is also about listening carefully to what is being said.

Empathy: empathy is an important quality for understanding and sharing the emotions of another person; it informs the selection of an appropriate response.

Respect: respectful communication includes behaviours such as avoiding interruptions, knowing when to initiate communications, when to respond and when to stop talking.

Friendliness: friendly traits such as honesty and kindness can foster trust and understanding. It is important to maintain a positive attitude, keep an open mind and ask questions to help you understand the audience.

Being open to feedback: strong communicators accept critical feedback and give constructive input to others.

Specific language skills and working through interpreters: fluency in the languages of the affected population is important, or being able to work effectively with an interpreter.

Verbal communication: oral and written communications should be tailored to the audience and precise (e.g. identify a specific action that can be taken).

Non-verbal communication: this includes non-verbal signals, gestures, facial expressions, body language, tone of voice and even appearance. It is important to understand and respect the cultural sensitivities, gestures and dress code of communities with whom you are interacting.

Volume and clarity: being clear and audible is important when communicating. A valuable skill for effective communication is to adjust the voice in order to be heard in a variety of settings. Speaking too loudly may be disrespectful or awkward in certain communities.

Communication plans: communication specialists should be able to collect, analyse and record information about community needs and then design, execute and evaluate the intervention. Campaigns and media communications plans must be integrated with the overall emergency response.

Negotiation and conflict resolution: strong communicators have the skills to facilitate dialogue between different actors and to negotiate and resolve conflict if necessary.

Technical skills: it is important to be able to use the equipment identified in the media communication plan (e.g. phone lines, telephone banks, computers, walkie-talkies, personal digital assistants, cameras, copiers and radios)

Process and Good Practice

- Ensure that communication is two-way (C.4) and that community input and feedback is encouraged (C.6).
- Ask questions (chapter A). The initial communication role of the hygiene promoter is to try to understand the situation rather than to 'tell people what to do'.
- Listen carefully to what people say and try to reflect what you hear back to them, or summarise the main points that you have understood (Motivational Interviewing, T.27).
- Recognise that people may have experienced significant and traumatic events and be grieving for loved ones. Validate their experiences by allowing them to talk freely.
- Foster productive relationships with communities. Small gestures, such as asking someone how they are doing, nodding and smiling or offering praise can help build trust and relationships.
- Encourage the affected community to ask questions to clarify issues or learn about the WASH programme.
- Be as honest as possible with people; be prepared to admit that you do not know something and then return to them with an answer (if there is one).
- Share information as freely as possible in order to develop trust and open communication.
- Use the most appropriate methods and channels of communication for different target audiences (C.4 and C.5) selecting those that best fit a target audience's capacity to access and understand such information.
- Use pictures where possible and appropriate to clarify information and make communication more interesting.
- Use existing community networks (e.g. women's groups or community health networks) to support communication wherever available.
- Work with groups and use 'multi-way communication' to discuss an issue. This can yield benefits as a result of peer pressure and the influence of other community members.
- Ensure that information is accessible to audiences in diverse situations (including people living in remote and hard-to-reach areas (C.8), the socially and economically vulnerable and people displaced by the disaster). Avoid technical jargon and create messages (where used) which are simple and relevant.
- Provide information that helps individuals and communities make decisions about their future, supporting their self-recovery and behaviours.
- Avoid negative messages – they are not as effective as positive messages. For example, instead of 'diarrhoea can kill you' say 'wash your hands to protect your children from diarrhoea'.
- Reiterate key information and messages regularly as people may not have heard or understood them the first time. They may also need time to process new information and ask questions about it.
- Update information regularly in response to new knowledge and understanding: out-dated information can cause confusion and mistrust. Ensure that HP teams regularly share the information.
- Manage rumours and false information that may cause harm to the community (C.6).
- Take account of changing communication needs in different phases of emergency and be prepared to adapt materials and strategies in response.

→ **References and further reading materials can be found on page 290**

Audience Profile and Inclusive Communication

Main Purpose

To develop tailor-made communication strategies to increase ownership, inclusivity and the participation of multiple stakeholders.

Important

- Communities are composed of many types of people and each group or individual understands and perceives information differently. Hence, no one size fits all in communication design. Key messages should be tailored for specific audiences depending on their age, gender and sexual orientation, religion, origin and culture, language and disabilities (**A.7, E.3, E.4 and E.5**).
- Different audience groups may prefer different communication channels and understanding their preferences before communicating with them is important. For example, older people may prefer face to face communication while younger audiences may be more interested in Social Media (**T.44**).
- Some audiences have specific needs so multiple formats should be used to make communication accessible to all (e.g. persons with disabilities may require the use of sign language or pictures).
- Mass communications through digital platforms can create a space where everyone can find the information they need. However, information intended for wider consumption should be carefully presented. Social Media (**T.44**) can often be misused and the information may be misconstrued – unwittingly or intentionally.
- Focused programme objectives enable the target groups to be more easily identified and enable the risk to be communicated more specifically, e.g. if Menstrual Health and Hygiene (**P.7**) is the focus, then the communications can be designed for a target group of women and other people who menstruate.
- Important audiences to target are not exclusively those who are most affected by the situation, but also those who have influence, power and resources.

Overview

Audience profiling is the process of describing each audience segment, who and where they are, their needs, current behaviours, knowledge, values, aspirations and emotions. The purpose of audience profiling extends beyond collecting statistical data aiming to tailor communication to the needs of people in a community.

An understanding of the existing behaviours, knowledge, aspirations and emotional status of an audience can help to tailor approaches, key messages and activities that resonate and motivate behaviour change.

An assessment should be carried out to ensure inclusive communication and map the stakeholders. Assessments may include questions such as: who are the primary (priority) and secondary (influencing) audiences (include the range of different stakeholders in the given context)? What are their specific needs? What existing communications channels and processes can be used? What are the issues/problems confronting the audience? Are there existing geographic, cultural, socioeconomic and political barriers to engaging with the audience?

With the adoption of the 2030 Agenda, the 'leave no one behind' principle has been widely adopted in the WASH sector to ensure that the most vulnerable populations have access to basic needs. It is therefore seen as an important part of hygiene initiatives. Communication plays an important role in reaching out to vulnerable populations and programmes must plan for the dissemination and exchange of information with everyone affected.

Omitting a group from an audience profile can lead to implementation problems later on and reduce the effectiveness of a hygiene intervention. Two-way communication should always pay special attention to marginalised or disadvantaged groups in society. Gender issues (**E.3**) are always a primary concern in emergencies, as well as those related to the poor, or any other vulnerable group.

Process and Good Practice

- Identify the range of different WASH stakeholders in a specific context and consider their information and communication needs.
 - Use the community assessment data and analysis (**chapter A**) as a basis to identify:
 - Socio-demographic characteristics such as sex, age, language, disability and religion
 - Geographic characteristics such as where the audience lives and how that might impact behaviour
 - Psychographic characteristics such as needs, hopes, concerns and aspirations
 - Audience thoughts, beliefs, knowledge and current actions related to a health or social issue
 - Barriers and facilitators that prevent or encourage audience members to adopt the desired behaviour
 - Gender and how it impacts audience members' behaviour and ability to change
 - Effective communication approaches and channels for reaching the audience
 - Analyse and segment the different audiences to understand and determine the primary (priority) and secondary (influencing) audiences to inform the communication strategy.
 - Review and update the audience profiles regularly as new information becomes available to ensure they continue to be representative of the audience.
 - Tailor communication to the needs and preferences of children of different ages, older people, persons with disabilities (**E.5**) and vulnerable groups (e.g. people with underlying medical conditions).
 - Increase the accessibility of communications by using multiple formats. Consult the audience on their preferred methods of communication (e.g. audio messages, print media, braille, simplified language, pictorial or sign language).
 - Ensure that the facilities which are promoted in key messages are accessible to everyone (**chapter P**).
- **References and further reading materials can be found on page 291**

Participatory Communication

Main Purpose

To understand the perspective of the affected community, tailor interventions to their specific situation and encourage them to play an active and influential role in the decisions that affect their lives.

Important

- Participatory communication is a two-way process that requires listening, dialogue and interaction.
- Participatory communication helps to strengthen ownership and allows potential tensions and obstacles to be addressed quickly. WASH interventions are more likely to be successful if those affected by crisis are involved in decision making and feel that they can be a part of the response.
- Any communication intervention (even via the mass media) should be as interactive as possible.
- The use of participatory tools or methods does not guarantee participatory communication; it also requires empathy, listening skills, a respect for locally generated knowledge and the ability to empower others (C.2). The communication methodology should be adapted to the needs and capacities of different sub-groups of the community and be accessible and inclusive to reach vulnerable populations.
- Participatory communication should be part of a hygiene promotion (HP) communication strategy. Almost all – if not all – HP programmes use participatory communication.
- Participatory communication supports accountability to affected populations and enables rights-holders to claim their rights and have a voice.

Overview

Participatory communication is based on dialogue. It is an approach that involves people and facilitates interaction with the affected communities. It allows for a more direct sharing of information and the exchange of perceptions and feedback to empower people. It directly involves them as decision makers and as active users of water and sanitation facilities.

There is always space for some participatory communication – even in the acute phase of a response – and opportunities should be sought as the response progresses to promote community engagement and participatory communication (E.2).

Participatory communication does not depend on the use of defined tools or approaches, but many of them can facilitate its practice. The selection of participatory, two-way, communication tools and approaches relates to the reason they are being used and on the availability of resources, skills and time. Tools can range from participatory learning and action methods to the use of playful and engaging universal language tools such as music, arts and sports. Other tools and methods include Household Visits (T.18), Focus Group Discussions (T.14), Transect Walks (T.52), Community Mapping (T.7), Community Drama and Puppet Theatre (T.6), Songs and Stories (T.47), Role Play (T.41), Three-Pile Sorting (T.51), Pocket Chart Voting (T.31), Motivational Interviewing (T.27), Accessibility Audits (T.1) and many more. Approaches such as PHAST (F.6) and CLTS (F.2) also promote interactive communication. Although many approaches were designed for rural areas, participatory methods can be used in urban contexts. The advancement of affordable digital technology and Social Media (T.44) offers new ways to access and engage with people – even remotely (C.8).

Participatory communication encourages the sharing of opinions, experiences and ideas about local WASH-related issues and needs. It can help to mobilise individuals and provide space for people to exercise their rights and take action. It enables people to be actively involved in data collection, analysis, planning and decision making. The use of participatory communication facilitates a better understanding of people's different perceptions, priorities and needs. WASH-related information can then be tailored to specific situations, feedback can be used to improve the response and problems can be identified early on.

People have their own expert knowledge (e.g. of their community, community dynamics, or WASH-related practices and preferences). Accessing this knowledge supports WASH interventions that are more locally acceptable and appropriate. In each group or community there

are always different perspectives and realities; participatory communication methods can help to identify the differences and contribute to a more inclusive programme. It can also help to build self-confidence, ownership and trust and leverage community support for the intervention. For humanitarian responders it generates immediate feedback on their intervention, enabling them to be more accountable during a WASH response.

Participatory communication may be more challenging in isolated or remote areas or where insecurity or severe public health risk requires a remote response (C.8) but it can still be initiated quite quickly and easily.

Although participatory communication is relatively inexpensive it can require substantial numbers of staff and significant staff time. Staff and community workers need good communication skills and may need training and refreshing in participatory communication techniques. Trained community workers can become a lasting asset to the programme and the community. Participatory communication requires communities to remain engaged over time and, if carried out mechanistically, may start to feel like a burden to some communities.

Process and Good Practice

- Focus on the objectives of participation. Ask 'participation for what?' Select activities that are appropriate for a certain objective, rather than rolling out a standardised set of tools. Participatory communication requires relatively autonomous teams that can adapt their strategy for each community (including the time allocated). The approach requires the WASH team to evolve from using standardised approaches and to make room for a two-way process.
- Ensure that participatory activities are adapted to specific audience groups such as children, youth, elderly adults, or persons with disabilities. Specific needs should be assessed depending on the context and materials and communication methods adapted accordingly. Identify preferred communication channels for girls, boys, women and men including those with disabilities (who may have different requirements and preferences).
- Develop a communication strategy and plan (C.10) that employs both participatory and mass communication methods where appropriate. The need for mass communication will depend on the urgency of the situation, the size of the population and access, but two-way communication must be employed wherever possible.
- Recruit community mobilisers or outreach workers with good communication skills (including active listening), an ability to speak in the preferred language of the affected people and an understanding of the community they will be working in. Gender and age should be considered in the team's composition.
- Provide training and support for effective communication skills to all staff members (not just hygiene promoters) and encourage staff and volunteers to continuously develop them.
- Listen to what communities have to say and ask questions, rather than provide unasked-for information and advice.
- Share the information gathered through participatory communication methods and encourage discussion with the affected community.
- Endeavour to use visual aids wherever possible. The use of visualisation can be helpful in communications with people with limited literacy, but also benefits communication with almost anyone.
- Consider using participatory communication techniques that allow participants to express themselves more indirectly, particularly about sensitive subjects. It may be useful to reduce discomfort (e.g. using a third person perspective or more discreet voting tools).
- Assess why certain groups do not seek out or access information and identify how these barriers can be overcome.
- Use digital technologies and social networking to document, capture and create visual imagery, if appropriate, enabling people to easily access information and engage with each other. Photography and film (T.30) are key forms of documentation and expression in a networked environment.
- Ensure that a monitoring and feedback system is set up to adapt accordingly.
- Be creative.

→ **References and further reading materials can be found on page 291**

Mass Communication

Main Purpose

To enable the dissemination of key information to a large number of people in a comparatively fast and cost-effective way.

Important

- Mass communication is usually information transmitted in one direction, with limited opportunity for direct interaction and feedback. As a result, its use is preferable in conjunction with other, participatory, communication methods within a wider communication strategy.
- Mass information tools can be a powerful way to spread information and key messages quickly, particularly in the early stages of the response.
- Identifying the right mass communication channels and the information required should be based on a detailed assessment (**chapter A**) and, ideally, prior testing to ensure that the targeted audience has access to the chosen media and can understand the messages.
- The content of mass communication messages should be based on credible sources.

Overview

Mass communication refers to the dissemination of information using a means of communication that can quickly reach a large number of people. It includes tools and methods such as Public Announcements (**T.36**), Radio and TV (**T.38**), Text Messaging (**T.44**), Print Media (**T.33**) and various IEC Materials (**T.19**) e.g. posters, flyers or billboards. It is an important method for emergency risk communication (**C.9**).

Mass communication reaches a wider audience and can be done comparatively fast and at a relatively low cost (particularly in proportion to the number of people being reached). It can also reach people who are otherwise isolated by geography or conflict. Information can potentially be (audio-) visualised and reach target groups who have limited literacy. It is, however, mostly a one-way medium with little or no participatory elements, making interaction difficult. Feedback on whether the mass communication methods have been effective at influencing change is harder to obtain.

Mass communication, with its ability to reach a wide audience, may be useful to spread vital information, raise general awareness and help influence attitudes, behavioural norms and public opinion. It can create a demand for services. It makes issues or information more visible (or heard) and may lead to public pressure on local authorities and, indirectly, influence decision makers. It can also mobilise groups of people to take action (instead of only being focused on individual behaviour change). Mass communication is, however, rarely sufficient on its own and may require reinforcement by local hygiene promoters or health workers using more participatory communication means (**C.4**).

During the initial assessment and planning, it is important to identify which mass communication channels the anticipated audience/participant groups have access to. It is always advisable to focus on more than one communication channel, using a blended approach of different channels and including tools for both participatory and mass communication (**C.4 and C.5**). It is essential to be clear about the information that needs to be communicated and avoid conveying too many messages at once. Important questions to be answered include: what are the key messages to convey? Can they be understood by the target audience? Has the chosen message the right content, the right tone (light or heavy) and the right appeal (rational or emotional)? Would using humour or fear be appropriate and effective? When and for how long should the campaign be used and with what intensity? Mass communication messages should be pre-tested to ensure that they are interpreted as intended.

Messages should evolve during a crisis; there will be a need for new mass communication materials that respond to changes in context or a deeper understanding of the situation. It is important to provide timely information. Pre-designed mass communication materials may be available (e.g. IEC materials, **T.19**) as part of an agency's standard hygiene promotion tool kits). However, mass communication materials and interventions should be adapted as much as possible to the local context, through, for example, involving local artists or community members in the planning and design, or using locally produced or adapted images that can be understood and related to by the target audience.

To find out if a mass communication intervention has been effective, Monitoring (**M.2**) can track whether it has reached the anticipated audience (using process indicators) and whether it has contributed to changes in knowledge, attitudes and especially practices (using outcome indicators).

Process and Good Practice

- Integrate the use of mass communication into a wider communication strategy and plan (**C.10**) that typically includes various communication channels as well as participatory communication tools (**C.4**). If resources are limited, selected tools and methods may have to be prioritised and may only permit the targeting of key audiences or the use of a specific communication channel.
- Collaborate with others (**P.9**) to identify the available communication channels by contacting stakeholders such as the Ministry of Information, Ministry of Health, UNICEF's communication for development department, Communicating with Disaster Affected Communities Network and media landscape guides. Find out if there are existing materials that can be easily adapted and reproduced.
- Develop clear and memorable communications and short slogans that emphasise the main message. Succinctness is the most effective style for mass communications.
- Create positive messages and avoid reinforcing negative social norms.
- Check that all the messages chosen pass the tests of 'What?' (basic information being conveyed), 'So What?' (reasons or benefits for action) and 'Now What?' (defines desirable and productive action).
- Find out which mass communication tools are accessible (and 'used') by the anticipated target groups.

Consider literacy levels and the availability of the required media devices (e.g. mobile phones or Radio and TV, **T.38**).

- Assess whether Radio or TV (**T.38**) might be better in some areas for reaching people with limited literacy if messages cannot be conveyed in pictures such as posters or billboards (**T.19**). Ensure that communications are timely and in multiple formats to ensure that they reach a diverse audience. Consider Social Media (**T.44**) as a potential channel for mass communication.
- Vary the messages so that people do not become desensitised. Consider a series (e.g. of posters or radio jingles) with different, consecutive messages to attract continuous attention and build upon previous messages.
- Assess the potential benefits of using a familiar slogan, recognisable figure or Song (**T.47**).
- Make visual mass communication tools eye-catching, but avoid being sensational.
- Adapt the visuals to the local context (by e.g. employing local artists and using the local languages) so that people can relate to them more easily.
- Select communication channels (such as television and radio) that exert a high emotional impact, if appropriate. They can be more effective at influencing attitudes.
- Ensure that the content of educational materials includes a simple presentation of relevant facts and a clear statement of what the audience is supposed to do in response.
- Design mass communications interactively where possible. For example, it may be useful to involve the public in the design and production (e.g. through a workshop) or by providing contact details on a website, an email address on a poster or to encourage phone-ins as part of a radio programme.
- Think before you print. The decision to print posters and flyers (**T.19**) should be taken carefully as they are often thrown away immediately after use and create a lot of waste.
- Obtain the consent of the relevant local authorities if mass communication tools will be used in public spaces.

→ **References and further reading materials can be found on page 291**

Community Perspectives and Rumours

Main Purpose

To ensure that the concerns and reactions of the affected population are collected systematically and used to influence the WASH response.

Important

- Listening to the community and incorporating their perspectives into the WASH response is at the heart of Communication (**chapter C**) and Community Engagement (**chapter E**).
- Understanding different community views on the impact of the humanitarian crisis and response will ensure that humanitarian actors adapt the response to the expressed needs.
- Rumours, misinformation and disinformation can be dangerous and undermine the humanitarian response, yet often go unnoticed by humanitarian actors.
- Systematically collecting information from community members on their perceptions, concerns, questions, suggestions and rumours is important, but must result in the information being used constructively to adapt the programme, Communication Plan (**C.10**) and Community Engagement (**chapter E**) activities.
- Feeding back to communities about how their concerns have been addressed (**M.5**) is essential for building trust.
- Identifying community perspectives and concerns also supports community-based advocacy (**P.10**)

Overview

Listening to the affected community is a vital aspect of communication and community engagement. Using a systematic approach to collect community perspectives is more likely to result in their use to influence and adapt the response. Various approaches and tools can be used to do this, including day-to-day interactions with community members, regular documented meetings with different groups, listening exercises, accountability mechanisms (**M.4**), structured rapid or mobile perception surveys and listening to social media.

Rumour tracking and Community Perception Tracking (**F.24**) describe two new but different approaches used by organisations to 'listen' to the community, but there are a variety of ways of capturing community feedback and insights in a systematic way. There is often overlap between the different approaches.

Community Perspectives

Community feedback and perspectives can be understood as views, ideas or beliefs that are held individually or collectively within a particular community and which can translate into questions, concerns or practices about the emergency and the response to it. Understanding community perspectives is like taking the pulse of the community and making sure that communication remains useful, programmes stay relevant and issues are addressed. Listening, verifying, analysing and engaging are the main ways to understand community perspectives. At the core of community perspectives is active listening and asking questions to understand what people are thinking and feeling and to hear their views on how to improve and work together.

Systematically collecting community feedback about the response and their concerns can also highlight rumours (see below). It can also identify satisfaction or problems with the programme as well as adaptations that can improve effectiveness or address abuses of power. In recent years feedback collection and documentation has increasingly been done using mobile technology. It is important to triangulate and discuss findings with communities and other stakeholders so that action can be taken and so that communities know the purpose of the approach or tool used.

Communities' perceptions can rapidly change depending on the different stages of the emergency, the context and how the response is developing. As this information can vary widely across different groups of people and different locations, it is important to capture qualitative information, in real-time, on perceptions and beliefs related to the specific situation.

Rumours

A rumour is unverified information that passes from one person to the next; it can be true or false or a mixture of both. Misinformation is the result of misunderstanding and misconstruing information but without the intent to deceive. Disinformation is spread deliberately to influence, manipulate and deceive others. For example, people may be fearful of drinking water from a particular source because they have seen people adding chemicals to it – they have received some information but not the whole picture (the well is being chlorinated) and so they are misinformed. However, if they receive a WhatsApp message where someone purporting to be a scientist tells them that throwing salt in front of their door will prevent them from getting Ebola – that is disinformation.

Rumours, misinformation and disinformation often take place without humanitarian workers being aware of them,

but they can cause significant damage to health and wellbeing and to the capacity of agencies to implement programmes effectively. In times of crisis people may be more susceptible to rumours or persuasive disinformation messages. They want to know what to do in their changed circumstances and find critical thinking harder. They may be exhausted and stressed and their normal trusted sources of information disrupted. Rumours often flourish in situations of uncertainty where information is difficult to access. If various actors share confusing and inconsistent messages, as often happens during epidemics and pandemics, it can lead to the proliferation of rumours. This is one reason why interactive, clear and transparent communication is so important.

There are various ways to systematically identify and verify rumours in a planned and coordinated way through field and partner staff, local and social media and local groups and networks. Hygiene promotion outreach workers are also well placed to identify and respond to rumours.

Process and Good Practice

- Coordinate with governmental and non-governmental agencies (**P.9**) and devise a system for identifying, logging, jointly analysing and responding to community perspectives and feedback (including rumours) to harmonise communication with communities and share relevant information with different sectors. If this is not possible, establish an alternative system.
- Start listening to community perceptions as part of preparedness measures if possible; at the very least begin at the outset of an emergency.
- Explain to communities how their perspectives and insights have been used to improve the response, closing the feedback loop. Clarity of purpose and buy-in from the whole WASH team, especially managers, will be essential to make sure that the insights are acted upon.
- Train staff in active listening skills (**C.2**). Hygiene promoters need these skills for their routine work as do all staff dedicated to collating, analysing and acting upon the feedback. Those collecting the information must be trained, trusted and accessible to the community (consider gender, diversity and language). They should not be perceived simply as data collectors working in isolation – they are an important part of the hygiene promotion team.
- Map local media, groups and networks and, if appropriate, develop partnerships to support the process of engaging communities and establishing meaningful and effective two-way communication.
- Share and discuss triangulated data and the actions identified with all stakeholders. Prioritise the most harmful rumours that require immediate action. Feedback that may not be directly linked to WASH should still be acted upon to maintain the trust of the community in the response as a whole.
- Hold open, unstructured conversations with individuals and groups initially, to elicit feedback that may need more exploration.
- Counter rumours, where possible, by developing a new narrative to replace them as it may not be sufficient to simply deny the rumour. A new narrative may be a more positive message, or additional information tailored to different groups and coming from a trusted source such as a religious leader or someone respected as an expert.
- Avoid directly repeating and sharing a rumour; it is better to rephrase it as a question or immediately clarify that it is a false rumour.
- Monitor the impact of any efforts to counter rumours and monitor and identify new rumours.
- Establish open and transparent communication mechanisms with the community. Rumours often arise because of a misunderstanding or miscommunication, so communities must know how to contact the agency or make a complaint. Staff members who are new to the community should explain who they are and selection criteria must always be shared.
- Share the main concerns, questions and suggestions from community members with all WASH team members, especially hygiene promoters, who have significant interaction with different community members.
- Ensure that the process of data collection is supported by managers. The collection of rumours and perception data is challenging: language barriers, incomplete data and biases make the detection of trends difficult. Managers can mitigate the challenges, ensuring that sufficient data is collected, gaps identified and collection teams kept proactive and motivated through regular meetings to maintain morale and reduce collection fatigue.

→ **References and further reading materials can be found on page 291**

Language and Cultural Considerations

Main Purpose

To communicate effectively in a way that is accessible to everyone, respectful and considerate of cultural differences, context and specific needs.

Important

- A person's culture plays a very important role in the way they understand and talk about health and hygiene. Hence, the spiritual or cultural context of the person's behaviours should be taken into consideration.
- Do not assume that an acceptable way to communicate in one culture is universally applicable to all cultures. Being aware of one's own culture and biases is important.
- Actively incorporating an awareness of cultural practices into community interactions helps develop trust and makes the audience more willing to accept the content of the communication.
- Using appropriate language can help to avoid awkward situations and reduce mistrust and feelings of shame among targeted audiences.
- Different cultures understand and perceive a situation differently. Within each culture, gender, generational and socio-economic characteristics differ. Disabilities and special needs may be understood differently. Non-verbal communication can be interpreted in a variety of ways in each culture.
- Cultural considerations influence the choice of oral, written and visual communications. Images and virtual interfaces have different meanings in different languages and cultures (e.g. some languages are written and read from right to left and images may follow suit).

Overview

Culture is a way of identifying groups of people who share common characteristics and traditions such as language, social practices, attitudes and values. As communication styles are influenced by culture and may vary across communities, it is important to understand basic communication differences to be able to communicate effectively.

A respectful way of communicating with someone (including body language, seating position and use of certain words) may vary from community to community and region to region and, especially, between urban, rural and remote areas.

Social and cultural norms **(B.6)** also influence hygiene practices. Norms are rules, beliefs, expectations and behaviours that are supported by the community. Social norms can make the adaptation of hygiene practices easier, but most people find it difficult to adopt recommendations that are inconsistent with their social beliefs and expectations. In these cases, influencers from the community can act as champions for the desired behaviour **(T.22)**. Norms that support risky hygiene behaviours should be identified and discussed with groups of people so that individuals do not feel targeted or become defensive. The creation of positive hygiene messages by community leaders who set a positive example can be effective.

Language is often intertwined with culture. Hence phrases that may have different meanings in various cultural contexts must be used carefully. Communication material should be available in the local language and be translated with the support of community members. It is also important that communication materials use images and designs that are culturally appropriate.

It may be necessary to communicate through interpreters during an emergency response – responders may come from different parts of the world to the affected community or even other regions in countries that speak multiple languages. It is vital that interpreters are well trained and adequately briefed on WASH terminology and ways of working.

Process and Good Practice

Culture:

- Remember that a person's culture will shape how they understand hygiene and learn about the specific cultural beliefs that surround hygiene and health in the person's community.
- Learn how hygiene practices are understood in the affected community as well as the words used for or about WASH-related diseases.
- Find out which concepts, behaviours or languages are taboo or unacceptable and which practices are misunderstood or cause shame. For example, Menstrual Health and Hygiene (P.7) should always be treated sensitively and certain menstrual products, such as tampons or menstrual cups, may not always be acceptable.
- Use simple, clear language when expressing concern and avoid asking questions in a patronising or judgemental way.
- Be aware of the impact that cultural norms have on communication. For example, some cultures dislike eye contact during communication and become uncomfortable if it is maintained.
- Show sensitivity to non-verbal communication e.g. facial expressions, gestures, posture, or tone of voice as they play an important role in understanding the audience.

Language:

- Use the preferred language of the target audience wherever possible.
- Avoid technical jargon, abbreviations and complex words and provide a glossary of any unfamiliar terms used in written communications. Simple grammar, short sentences and an active voice should be used.
- Ensure that language is gender-sensitive and appropriate for people with specific needs, such as children, people with disabilities and older people (e.g. influencing the vocabulary used, size and colour of chosen fonts and background contrast).
- Ensure that trained and briefed interpreters are recruited and used whenever the preferred language of the affected population differs from that of the responders (even if they share a common language).
- Communicate a maximum of three ideas at one time. Complex messages may not be understood or might be overwhelming for the audience.
- Avoid communications and materials that reinforce cultural or gender stereotypes.

→ **References and further reading materials can be found on page 291**

Remote Communication

Main Purpose

To communicate with crisis-affected communities when access is prevented or limited.

Important

- Reduced access to the targeted population is usually the main reason to select remote communication channels. In many crises, safety and security concerns prevent humanitarian staff from undertaking regular in-person activities to promote hygiene behaviour. For this reason, all hygiene promotion programmes should incorporate some 'remote communication channels' to mitigate the impact of deteriorating circumstances.
- Behaviour change programmes are likely to be more successful if they utilise multiple delivery channels to reach populations repeatedly over time. This is because the behavioural messages are reinforced through multiple channels and, with repetition, the desired behaviour is perceived as normative **(B.6)**.
- Relying on a narrow set of delivery channels can exclude some of the affected population so that marginalised groups may not be able to engage with or participate in the programme. All delivery channels have strengths and limitations. It is therefore important to take time to learn about the best communication channels for reaching different sub-groups within the population.
- Remote communication does not have to be one-way; participatory **(C.4)** remote communication techniques are recommended.

Overview

Communication or delivery channels are the means by which organisations can reach, engage with and inform people within communities. Remote communication channels are those that do not involve in-person interactions with communities, such as mass media (e.g. radio, television, newspapers) or digital communications (e.g. phone-based messaging or calls and social media).

Remote communication channels work well when they are designed to complement in-person activities. This is because remote channels may not grab the full attention of audiences in the same way that in-person interactions can do. There is also typically a time lag between when people are exposed to a message via a remote communication channel and when they have the opportunity to practice the preventative behaviour. Strategies to overcome this include designing content that will stand out and resonate with local audiences and maximising the likelihood of exposure by repeating messages as frequently as possible at different times of the day.

There are benefits and limitations to all delivery channels. Mass media **(C.5)** has the potential benefit of reaching populations over a large area with standardised messages. It is often (but not always) seen as a trusted and legitimate source of information and can be cost-effective if well targeted. However, in many settings, populations do not have equitable access to Radio and TV **(T.38)**, or multiple networks are needed to reach people across a region. The use of mass media often requires the broadcasting of messages to a whole region or nation in a standardised way. Standardised messages can be less persuasive as they may seem less relevant to a particular individual's circumstances or context. One way to overcome this is to share the stories of individuals and make the content aspirational as well as practical. Additionally, previous learning or formative research **(M.7)** from the region can make the messaging more context-specific.

Several factors influence the selection of appropriate communication channels. The use of digital communication (such as social media or online group chats like WhatsApp, **T.44**) can be cheap but time-consuming as they have to be well moderated. Digital platforms have the benefit of enabling programmes to share a range of images, video, audio and links and to engage in a two-way discussion with populations. If done well, online platforms can create peer-to-peer learning **(T.29)** and sharing spaces that have considerable influence, although achieving this can be difficult as attention spans on social media are brief. As with mass media, access to online spaces may not be possible for everyone in the targeted community. Some social media sites make it easy to track

how people are engaging and sharing content; this can be useful for adapting messaging. Text or audio-based phone messages **(T.44)** can be effective in areas with high mobile coverage although the content needs to be short and typically only allows for one-way engagement. It can also be easy for users to become frustrated if they receive too many messages.

Process and Good Practice

- Focus on content more than on the selection of delivery channels. A delivery channel may be effective at reaching members of the target population but its capacity to change behaviour relies on well-designed content. Use behaviour change theories **(B.2)** to inform the content and consider the following: relevant knowledge **(B.3)**, utilising social influence, norms and group affiliation **(B.6)**, appealing to aspirations and addressing common behavioural barriers **(B.4, B.5 and B.7)**, helping people to make behavioural plans **(B.7)** and (potentially) rewarding people for doing the right thing **(T.40)**.
- Consider the following when selecting the most appropriate delivery channels for the context:
 - ▶ Access to the targeted population
 - ▶ The target behaviour to be changed
 - ▶ Population preferences for communication channels
 - ▶ Language **(C.7)**, literacy and inclusion **(C.3)**
 - ▶ Access to communication technologies
 - ▶ The time and cost of utilising each delivery channel
 - ▶ The communication channels used by other actors
 - ▶ Lessons learned **(M.6, M.7, M.8)** from previous uses of remote communication in the target area (or one that has similar characteristics)
- Assess common patterns and preferences in people's use of digital channels. This can be done using rapid formative research **(M.7)**, talking to other stakeholders and reviewing media surveys from the country. The Wash'Em approach **(F.22)** includes a 'Touchpoints tool' for rapidly mapping delivery channels.
- Develop a Communication Plan **(C.10)** which describes how frequently content will be shared and how this may be adapted.
- Find creative ways of involving populations. Didactic, one-way, information sharing is not normally effective at changing behaviour. Engage people in the design and use of remote communication channels by, for example:
 - ▶ Incorporating a range of 'voices' and perspectives
 - ▶ Designing content that realistically portrays the communities and their day-to-day realities
 - ▶ Identifying opportunities for participation such as radio call-in sessions, television interviews with community members or polls, discussions and photo sharing on social media

→ **References and further reading materials can be found on page 291**

C.6 Risk Communication and Community Engagement (RCCE)

Main Purpose

To provide critical information to the affected community on how they can stay safe and the actions they can take in response to a disease outbreak.

Important

- Effective outbreak response depends on the active participation of communities and cannot be addressed through the provision of health care alone.
- Hygiene promoters and WASH teams play a key communications role during outbreaks. Their work must fit into a response-wide plan for communicating with the affected population. The plan should incorporate their local knowledge from working with the communities.
- Information may be the only resource available in the early stages of an emergency – people need information about how to stay safe and the responses being planned. Giving people meaningful things to do can also help to calm anxiety and promote some sense of control.
- Communicating quickly using credible and trustworthy information is vital. So is expressing empathy and respect for those affected. Effective communication can have a positive impact on how the community responds to and recovers from the crisis. Conversely, it can make the situation worse and lead to discontent and sometimes disorder.
- Central to the concept of 'Risk Communication' are the key principles of engaging and empowering the affected community and monitoring, evaluating and adapting communications with them (C.6). Risk communication stresses the need for the exchange of information between those leading the emergency response and those affected by it, using different channels, messages and methodologies for different audiences.
- The communication strategy will evolve and must be constantly reviewed and updated.

Overview

Emergency Risk Communication is the process of providing critical information to help people stay safe, inform them of response plans and describe what actions they can take. It has become an important strategy, especially in emergency responses to outbreaks of disease. However, many of its principles can be applied to hygiene communication in all emergencies.

Risk communication aims to reduce both 'hazard' – the physical, structural and economic damage caused by an event – and 'outrage' – the level of emotion, concern, fear, anxiety or anger brought on by the event or threat. Effective risk communication aims to keep 'outrage' in proportion to 'hazard' so that people will have the appropriate level of concern to motivate them to act and mitigate the danger facing them.

People process information in a particular way during a crisis and this is the basis for risk communication principles. Under stress, people may not hear the information properly or cannot remember it. They may oversimplify what they have heard. They may hold onto current beliefs and find it difficult to do things differently – seeking evidence to confirm these beliefs rather than challenge them.

The advice being given can seem counterintuitive, e.g. that homes – normally places of safety – are in fact places of potential danger due to the spread of disease or an impending hurricane. If people are to believe the advice, the person giving it must be trusted. People may follow the advice of someone known and trusted even if they have no expertise and provide inaccurate information. Communication must be simple, credible, timely and consistent; it may need to be repeated and come from multiple sources. Communication must be specific to the context and provide clear actions that are relatively easy to follow.

People experience a wide range of emotions in response to a crisis. Communicators should expect fear and anxiety, uncertainty, hopelessness and helplessness and understand how these emotions can affect communication. Sometimes a perceived threat can motivate people to act, but fear of the unknown can be debilitating and make some people react inappropriately, or not at all. Risk communication aims to stop people from feeling that nothing can be done to change the situation or to reduce the threat. If people feel they have no power to influence the situation they may withdraw mentally and physically; enabling them to participate in the response can help to reduce their fears and helplessness.

Denial is also a common reaction to a crisis. It can occur because people lack information or because they have been deliberately targeted with disinformation. It can also occur when people feel overwhelmed by fear and powerless to counter a threat that is far outside their experience.

Contrary to popular belief people rarely act irrationally during a crisis. What can be erroneously described as 'panic' is an extreme 'fight or flight' reaction which is a

normal and rational survival response to threats. Accusing people of panic and of being irrational is usually counterproductive; when unwanted behaviours do occur (such as 'panic buying') it is preferable to acknowledge why this is happening and redirect people to more helpful actions. Criticising people for particular behaviours (such as breaking lockdowns or curfews) can also help to reinforce those behaviours amongst others by setting up negative social norms. Ongoing communication with people to understand why they are engaging in unhelpful actions and what motivates them should be at the heart of effective risk communication.

The stigmatisation of certain people or groups is very common in disease outbreaks; some people may be the victims of violence. Stigma should be challenged and care must be taken to avoid using communications or images that reinforce it. Mistrust of those responding – both government and aid organisations – can also be an issue and the affected community must be consulted on how to try and address this.

Process and Good Practice

- Coordinate and plan hygiene promotion communication during disease outbreaks within a response-wide risk communication strategy which should be outlined in Communication Plans **(C.10)**.
 - Develop partnerships and coordinate with others working in the response both within and between organisations to ensure consistency in communications with the affected community. For example, where possible, coordinate with an RCCE working group or coordination pillar.
 - Profile and segment **(A.7 and C.3)** the community and recognise their different concerns, information needs and communication preferences. Include different groups and adapt and pre-test communications **(C.3)**.
 - Describe clear and concrete actions that people can take, rather than just telling them about the threat. Present information as 'a call to action' instead of treating people as passive recipients e.g. wash hands with soap after using the toilet. However, make information practical – don't tell people to boil water if they have no fuel to do so.
 - Identify and work with trusted and credible sources of information and establish a system to track and address rumours, misinformation and disinformation **(C.6)**.
 - Encourage people to share information with their friends, families and communities, but ensure that contact points are available to provide additional information or clarify issues.
 - Encourage the identification of community-led and collaborative solutions to problems where possible e.g. how to monitor the arrival of outsiders visiting a community or support people to get to hospital.
 - Use a variety of methods and approaches. Focus on interpersonal communication, but collaborate with others to make use of public communication methods where possible e.g. Radio and TV **(T.38)** and mobile phones. If it is used locally, establish and maintain Social Media activity **(T.44)**. Find out about the national and local media and develop relationships with them to share timely and accurate information.
 - Be proactive and anticipate information needs. Try to communicate what is both known and not known (anticipating what people want to know). Avoid giving too much information all at once.
 - Avoid over-reassuring or making promises that cannot be kept – acknowledge uncertainty and be honest when you don't have the answers or the resources immediately e.g. 'I can't answer that question now but I will try to find out ...'
 - Recognise that people who have experienced traumatic events or sudden life changes may not easily retain information. Hygiene promoters and WASH teams may need to repeat information several times and in different ways. Acknowledge that people will be fearful, sad or angry; make time to listen to their experience.
 - Try not to reinforce 'negative norms' by talking about how many people are not following the advice or by blaming people for it. Instead, create a 'positive norm' that encourages people to use the WASH facilities because everyone else is doing so.
 - Be empathic, honest and open; these behaviours are fundamental to building trust with the affected community and are at the heart of effective risk communication. Active listening – paying close attention to what someone says and asking questions to deepen understanding – is also important for effective risk communication.
- **References and further reading materials can be found on page 291**

Communication Plan

Main Purpose

To provide a framework for action that identifies different community groups, their communication needs and preferences and how to communicate effectively with them.

Important

- A communication plan for a WASH response should be part of an overall hygiene promotion (HP) strategy. Communication plans should be adequately re-sourced and integrated into all preparedness and response plans.
- Timely information and communication are essential in any humanitarian response.
- A communication plan should be flexible enough to be adapted in response to community feedback **(C.6)**.
- Hygiene promoters are not responsible for the overall communication in an emergency but must coordinate with others **(P.9)** so that HP is consistent with and feeds into an overall communication strategy.
- Networks of outreach workers in the community can help to make communication more interactive. They can gather community perceptions about how well humanitarian workers are responding to their needs, as well as levels of engagement and satisfaction.
- Although people need information, they also need the opportunity to ask questions and clarify the information. Communication plans must stress active listening and seeking feedback rather than one-way messages alone.

Overview

A Communication Plan is a key part of an HP strategy and provides an overview of why, how and with whom communication is needed in an emergency WASH response. The plan should be structured, easy to read and regularly updated and shared with all key stakeholders.

All communications must recognise the significant change of circumstances, grief and stress that people have experienced. This means, amongst other things, being conscious of people's need for safety, to feel they have a voice, feel their culture is respected and that communications are trustworthy. It is also about being compassionate and non-judgemental.

A communication plan can be developed once it is understood:

1. How different groups are adapting their hygiene to the current situation
2. What the priority risks **(A.2)** to health are and how they can be minimised
3. Social norms, beliefs, practices **(B.4, B.5, B.6, B.7)** and structures related to WASH
4. Existing local capacity to respond **(A.6)**
5. The communication channels and networks used by different groups **(C.3)**

Well-designed hygiene communication activities can increase the knowledge of the target audience, influence their perceptions, beliefs and attitudes, change norms **(chapter B)**, motivate action, foster the development of skills, advocate for change **(P.10)**, promote demand for services and deepen understanding of community perceptions **(C.6)**. A communication plan should provide a framework to support the implementation of these activities.

The WASH cluster's HP technical working group should, ideally, compile a response-wide overall strategy and plan. Communication plans should be coordinated with the overall response and with representatives from other sectors and government departments e.g. a Ministry of Information (if one exists).

A communication plan must outline the following:

- **What:** aims, objectives, issues and concerns to be addressed
- **Who:** primary and secondary participant audiences (e.g. the primary audience for promoting infant feeding practices may be mothers with young children. The secondary audience may be other family members)
- **How:** channels of communication (C.4 and C.5) and strategies to make them interactive (listening and seeking feedback), accessible to all and adapted to different audiences (C.3 and chapter E). Communication methods and approaches (chapter T and chapter F) should be included, the human and other resources required (and over what time period) as well as indicators for monitoring and adapting communication and plans for collecting feedback and community perceptions (C.6 and chapter M).
 - The plan must also detail the concepts and ideas to be communicated for different elements of the intervention (e.g. for promoting engagement and participation (chapter E), involvement in the design of facilities (chapter P), supporting accountability (M.4), social and behaviour change (chapter B), countering misinformation (C.6 and C.9) and for different groups e.g. mothers with young children, teenage men and primary school children (chapter E).

A phased approach is often helpful so that the initial focus is on selected priority issues, subsequently adapted or broadened. Revisions may become necessary and alternative means of communication identified as the programme progresses and if Monitoring (M.2) identifies changes in public health risks and issues.

Pretesting communication concepts and ideas is always required for mass communication (such as text messages or radio adverts, C.5) and where it is difficult to discuss or clarify an issue immediately. Pre-testing is less important for Participatory Communication (C.4) than ensuring the consistency of communication, listening and giving people the chance to discuss and ask questions. It is critical to monitor communication plans and use the feedback to adapt them.

Process and Good Practice

- Update communication plans continuously; they are living documents that should be kept up to date by the hygiene promoters, communities and other relevant stakeholders.
- Assess the community (A.7) and the communication preferences of different subgroups (men, women, children, persons with disabilities and minorities).
- Consider local dialects and how the national language might be perceived in some parts of the country. Assess literacy rates and how communication methods may need to be adapted for people with disabilities (C.7).
- Map existing health and hygiene communication strategies and messages and find out how they resonate with the affected population – a familiar message may simply be ignored or need to be re-articulated in a more context-specific way.
- Design communications to reach different groups and ensure that all communications consider the mental health needs of the population.
- Coordinate, share and discuss rapid communication assessments with stakeholders and identify communication priorities as quickly as possible. Build on the initial messaging over time.
- Remember that assessments of communication needs are ongoing; initial information is usually incomplete and needs may change.
- Promote and encourage transparency by sharing assessment findings and plans with the affected community and involving them wherever possible in defining and refining objectives.
- Develop strategies for supporting the WASH team to actively listen and communicate effectively with affected communities rather than just convey one-way information.
- Collaborate with others (P.9) to develop a shared method for obtaining community feedback and perspectives and for tracking and responding to rumours and disinformation (C.6); include this in your communication plan.
- Make a budget for the implementation of the communication plan.
- Monitor and evaluate the communication plan to record feedback and learn lessons; use the information to take corrective measures during the programme (chapter M).

→ References and further reading materials can be found on page 292



Social and
Behaviour Change

The consistent practice of healthy, protective hygiene behaviours and the appropriate use of existing or newly created infrastructure are core outcomes of any WASH programme. Social and behaviour change aims to understand the barriers and motivators for change and to enable individuals and communities to practise safer hygiene. Strategies to trigger and motivate change draw on a variety of factors and focus both on the individual and the predisposing and enabling factors (chapter P).

Hygiene behaviour change can be defined as an adoption or increase in hygiene behaviours (such as handwashing with soap or the safe handling of drinking water) and a decrease in risky behaviours for a defined target population. The ideal outcome of hygiene behaviour change is that all individuals in the target population consistently and habitually practice the intended behaviours and thereby protect themselves against communicable diseases. The way that a programme achieves this must respect the autonomy of the individual and engage them in the change process (chapter E).

The brain responds to stimuli from the environment and ultimately controls behaviour. Hence hygiene behaviour change recognises the importance of human psychology and of understanding how people's minds work. This chapter provides an overview of the most relevant psychological motivators and barriers, the processes that influence people's hygiene behaviours and briefly introduces the theories that inform them. B.1 outlines the key concepts of social and behaviour change, B.2 describes some of the key models and theories of change. B.3 to B.7 provide additional information about motivators and barriers and how these behavioural factors can be employed to achieve hygiene behaviour change. The final sub chapter (B.8) presents an overview of existing behaviour change approaches.

Sub-Chapters

- B.1 Key Concepts and Good Practice
- B.2 Behaviour Change Models and Theories
- B.3 Motivators and Barriers: Knowledge
- B.4 Motivators and Barriers: Ability and Self-Efficacy
- B.5 Motivators and Barriers: Motivation, Attitude and Belief
- B.6 Motivators and Barriers: Social Influence, Norms and Group Affiliation
- B.7 Motivators and Barriers: Cues and Habit Formation
- B.8 Overview of Behaviour Change Approaches

Key Concepts and Good Practice

Main Purpose

To motivate and enable individuals, communities and societies to engage in specific hygiene behaviours to protect their own health and the health of others.

Key Concepts

- Social and behaviour change is complex and affected by a variety of factors that operate at several, intertwined levels: individual, interpersonal, community and societal. It is important to focus on all these levels in a WASH or outbreak control programme (**chapter A**, **chapter P** and **chapter E**).
- A variety of theories exist to explain what motivates behaviour and behaviour change. They include psychological theories that consider cognitive factors (such as attitudes, norms and self-efficacy) and models which look at change within the context of society (**B.2**).
- All the theories underline the importance of understanding the barriers and motivators (**T.3**) that influence people's behaviours by conducting a thorough assessment, rather than relying on assumptions about behaviour (**chapter A**).
- To change behaviour, the most influential motivators and barriers must be targeted through specific activities, often called behaviour change techniques (BCTs). A variety of BCTs form the active ingredients of behaviour change interventions.
- Behaviour change approaches (**B.8** and **chapter F**) generally explain how theories and formative research can be used to design an effective behaviour change programme. They may provide a menu of activities along with guidance for selecting the most appropriate approach in a specific context.

Good Practice

- Define which risky behaviours should be reduced and which protective behaviours should be adopted or increased (**A.2** and **A.7**) as a first step in designing behaviour change interventions.
- Define who needs to change. In diverse and mixed populations it is essential to describe specifically who needs to change as well as what needs to change (**chapter A**, **chapter E** and **chapter C**).
- Develop a theory of change that defines the programme's exact activities and behaviour change techniques and describes how these will change the motivators and barriers of each target behaviour. It should include quantifiable indicators of success.
- Use the theory of change (or Logical Framework, **T.25**) to plan the intervention, describing the chain of actions needed from planned activities through to the intended impact (**A.9**) and outlining how change will be monitored and evaluated (**M.2** and **M.3**).
- Assess each context and community (**A.7**) and avoid making uninformed assumptions about what will work. An intervention that works well in one specific context might not work in another. Formative research can be used to decide which motivators and barriers to address. This can strengthen the theory of change and enable the intervention to be further tailored to the specific needs and context of the target audience.
- Challenge misconceptions about the impact of 'hardware' on hygiene behaviour – for example, that hygiene infrastructure (**P.2**, **P.3**, **P.4**, **P.5**) or the supply of hygiene items (**P.6**) is all that is required to trigger and sustain behaviour change. Examples of deserted latrines and soap diverted to household purposes instead of handwashing are good illustrations of this misconception.
- Pilot hygiene behaviour change interventions during the design process. Behaviour change theories and models (**B.2**) are fallible and it is essential to adapt them if necessary to increase their feasibility and acceptability.
- Ensure that interventions are monitored and evaluated (**chapter M**) to identify what worked, what did not work (and why) and share the results with other stakeholders, including communities. Feedback Mechanisms (**T.13**) are also needed to understand the perspective of communities.

→ References and further reading materials can be found on page 292

Behaviour Change Models and Theories

Main Purpose

To provide a framework for how behaviour change occurs and the factors that influence change.

Important

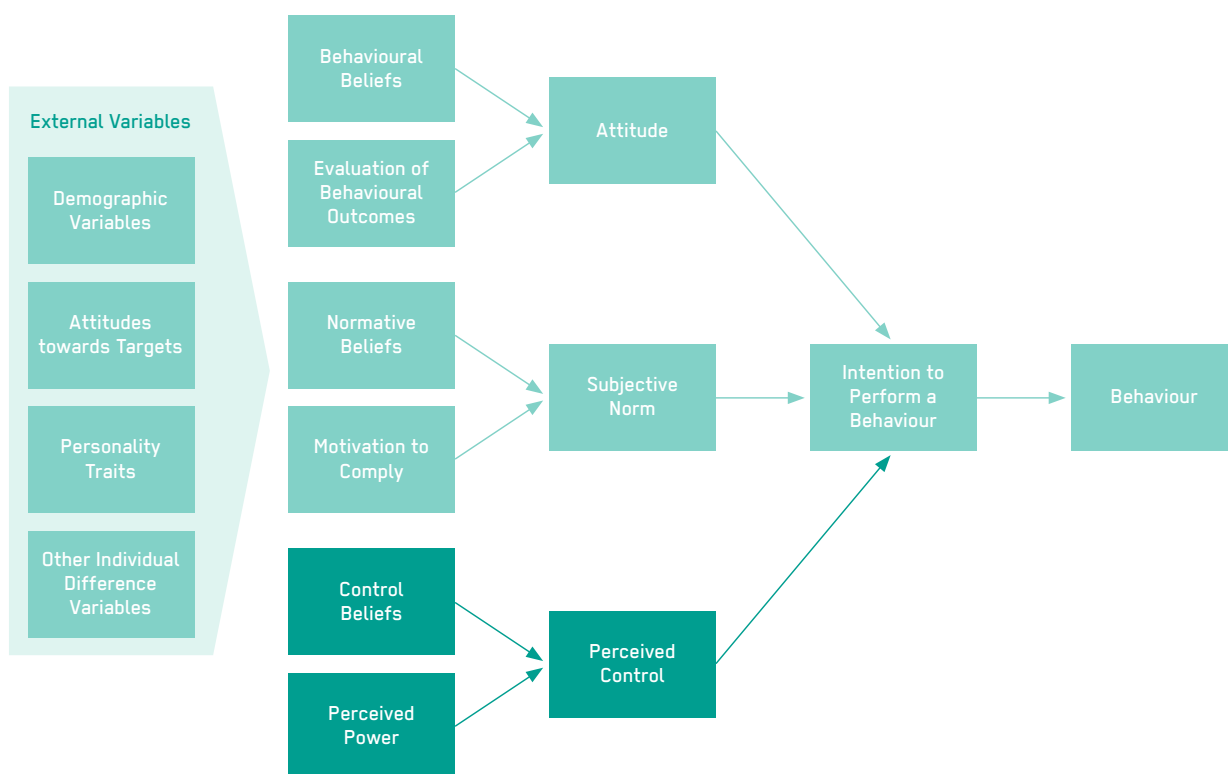
- Behaviour change models can simplify the complexity of behaviour change theory by identifying the different determinants that influence behaviour.
- There is a significant overlap between models and theories. Models have evolved (and will continue to do so). No single model is perfect or comprehensive.
- It is important to identify and explore the motivators and barriers identified in behaviour change models and theories and apply them to the design of hygiene promotion interventions.
- A behaviour change model can provide a useful point of reference throughout the project cycle to guide assessment, planning, implementation, monitoring and evaluation.

Overview

Behavioural models and theories explain why people act in certain ways, what influences behaviour and how it can be changed. Many different theories have developed over time as more is learned about human behaviour, but at the heart of most theories are social and behavioural factors (also called determinants) that motivate or act as a barrier to change.

Targeting these determinants can bring about change so it is useful to understand some of the behaviour change models and theories. The application of one model or theory does not preclude the use of another; there is often overlap.

1. The **Health Belief Model** proposes that the more a person feels vulnerable to a health threat and the more they perceive the threat as severe, the more likely they are to practise a protective behaviour. For example, if the fear of cholera is high, people are more likely to follow recommendations to protect their water sources. The actual choice of behaviour depends on the anticipated benefits of the behaviour and the associated costs/efforts.
2. The **Protection Motivation Theory** provides an explanation of why and how individuals manage and make decisions under stressful situations. It describes why individuals decide whether a situation is harmful to them (e.g. their perception of risk of contracting COVID-19 or Ebola). It considers the rewards of continuing with risky behaviour as well as the consequences and costs of performing a health-protective behaviour. Similar to the Health Belief Model, the perception of the health threat depends on the perceived vulnerability to and severity of a health threat.
3. The **Social Cognitive Theory** introduces the concept of self-efficacy, which can be described as a person's confidence in being able to perform a particular behaviour. Self-efficacy is thought to predict behavioural performance directly and indirectly through its influence on intention (B.4). For example, people may be aware of a water treatment method or of Oral Rehydration Solution to manage diarrhoea, but they may worry about getting the proportions wrong and lack the confidence to apply their knowledge.
4. The **Theory of Planned Behaviour** and the extended **Theory of Reasoned Action (figure 10)** describe people's behaviour as dependent on personal beliefs that affect their attitude (and subsequently intention, B.5) towards practising a particular behaviour. An intention to act is also affected by the 'perceived norms' of behaviour in a given context. For example, how a person feels about using a shared latrine and whether others approve or disapprove of this practice (B.6). It is also affected by 'perceived behavioural control' or the degree to which a person believes they are able to perform the behaviour (Ability and Self-Efficacy, B.4).
5. The **Theory of Normative Conduct** breaks down the construct of social norms into two components: (1) the individual's perception of the extent to which others perform the behaviour and (2) the extent to which others expect that individual to perform the behaviour (perceived and actual norms). Both can be strong drivers and barriers of hygiene behaviours (B.6).
6. The **Transtheoretical Model** (also known as the **Stages of Change Model, figure 11**) proposes that behaviour change (both positive and negative) occurs in six stages: Precontemplation, Contemplation, Preparation, Action, Maintenance and/or Cessation. People will be at different stages and need different information, support or interventions to move to the next stage. For example, a mother may already have considered (contemplated) using a potty to help manage her young child's excreta and she may decide to buy one (preparation) but she may not yet have found the time or motivation to change her routine and use it (action). For most stages, time criteria for completion are suggested. The model also includes social-cognitive variables such as self-efficacy and action-outcome expectancy, which describe whether the behaviour is expected to lead to the results.



Each behaviour is defined within: Action, Target, Context, Time
 Note: Upper light area shows the Theory of Reasoned Action;
 Entire figure shows the Theory of Planned Behaviour

Figure 10:
 Combined Theory of
 Reasoned Action and
 Theory of Planned Behaviour
 (adapted from Ajzen 1991
 and 2006)

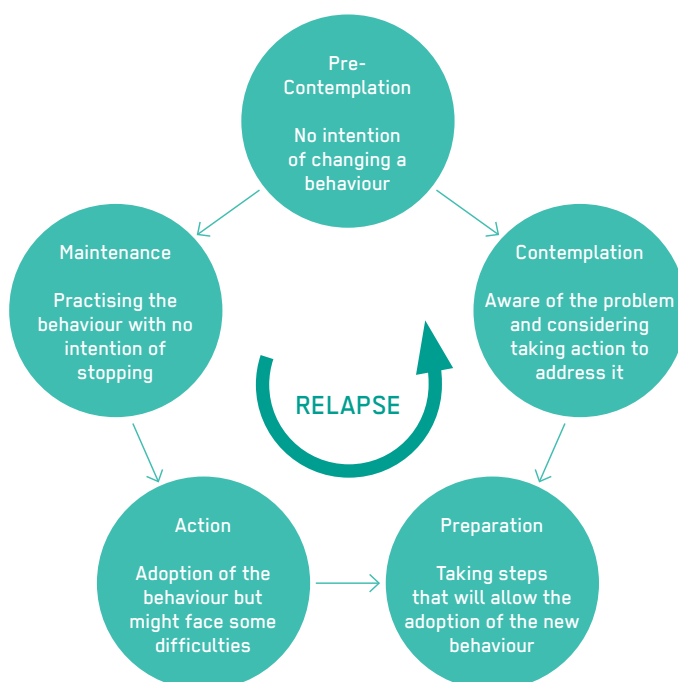
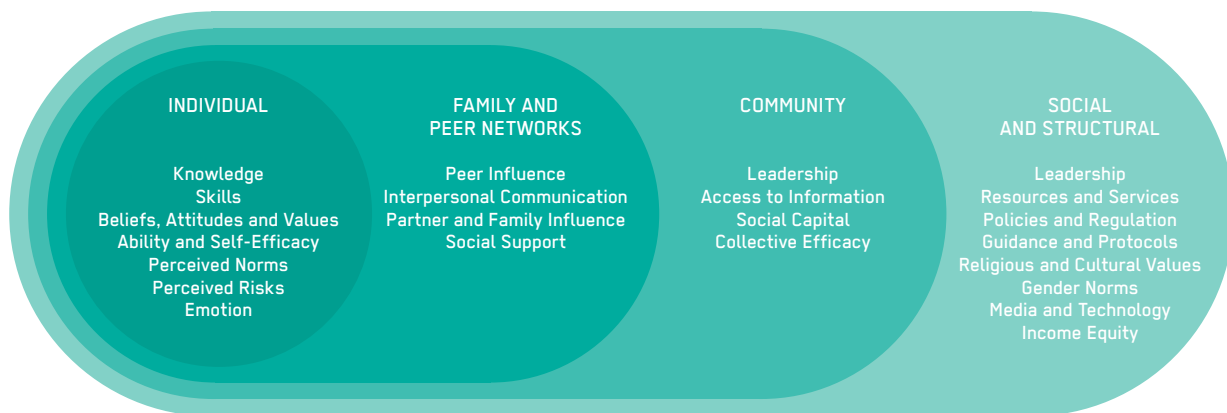


Figure 11:
 Stages of Change Model
 (adapted from Prochaska and
 DiClemente)

Figure 12:
The Social-Ecological Model
with Barriers and Drivers
at Different Levels
(adapted from McLeroy
et al. 1988)



Process and Good Practice

7. The **Socio-Ecological Model (figure 12)** suggests that health behaviours are influenced by drivers and barriers at different levels (individual, family, community and structural); hygiene promotion (HP) activities should be targeted at these different levels to effect change. For example, to introduce a new water treatment method, HP activities may aim to increase a person's confidence (or self-efficacy) and to make the method a 'new normal' in the community. Advocacy may also be necessary to promote the method in the WASH department. The theory provides a meta-model for social and behavioural change.
8. The **Behavioural Drivers Model** aims to build on the socio-ecological model and similarly clusters motivators and barriers of behaviour and behaviour change into psychological, sociological and environmental groups, but goes into significant detail about each factor. Psychological factors comprise, amongst others, interest and attitude (B.5) and self-efficacy and intent (B.4). Sociological factors include social influences and community dynamics. Environmental factors include the communication environment, defined as the information and opinions an individual is exposed to as well as emerging alternatives and structural barriers for behaviours.

Approaches such as FOAM (F.19), COMBI (F.18), RANAS (F.20), ABCD (F.16) and BCD (F.17) also describe behaviour change models that incorporate many of the determinants outlined above.

- Refer to social and behavioural models and theories to help identify the numerous factors that influence hygiene behaviour. They can be used to plan an assessment (chapter A), identify gaps in understanding, suggest and refine areas of intervention and monitor and evaluate (chapter M) the HP intervention.
- Use the socio-ecological and behavioural drivers model to explore the bigger picture of influences on hygiene and ensure that the programme identifies actions for each level.
- Understand an individual's position on the 'stages of change' model. When working with individuals or families (e.g. on Household Visits, T.18) ask how that person can move to the next stage and what support they need. It can be useful to ask the individual what would help and what is hindering their progress.
- Refer back to the models if change is slow or people seem resistant to better understand how change happens and how the programme could be modified to take account of different social and behavioural determinants.
- Coordinate with others (P.9) to jointly assess what is influencing behaviour in a given context and to expand the scope of actions that can be taken. No single agency can work on all of the determinants at any one time.

→ **References and further reading materials can be found on page 292**

Motivators and Barriers: Knowledge

Main Purpose

To understand the role that knowledge plays in social and behaviour change and how this can be applied to programming.

Important

- Knowledge of the causes and effects of disease, protective behaviours and how to practise them are often important pre-conditions for hygiene behaviours.
- Behaviour change interventions cannot rely exclusively on increasing people's hygiene knowledge and imparting knowledge about what to do and not to do. Hygiene behaviours are influenced by multiple motivators and barriers which need assessing prior to implementation.
- Having knowledge is not a prerequisite for behaviour change to occur – in many cases, social norms and the influence of others may be more significant.

Overview

To adopt and practise hygiene behaviours, such as hand-washing with soap, an individual usually needs three types of knowledge: **(1) health knowledge** (also called system knowledge or factual knowledge) is knowledge of how diseases spread from one person to another and their consequences **(2) action knowledge** refers to knowledge of actions that can block the spread of diseases, e.g. handwashing with soap and **(3) procedural knowledge** is knowledge of exactly how to execute these actions, such as when and how to wash hands.

All three types of knowledge (but in particular action and procedural knowledge) are typically important pre-conditions for individuals to adopt a behaviour. However, research has shown that knowledge is rarely enough to motivate and enable people to practise hygiene behaviours. Therefore, hygiene promotion (HP) that imparts knowledge to the target audiences should always be combined with other interventions. Knowledge-focused HP may have previously been implemented in the community, so the population's knowledge level should be assessed before implementation. A Knowledge, Attitude and Practice (T.24) or RANAS (F.20) survey may reveal if targeting knowledge or other motivators and barriers is the most promising way to promote hygiene behaviours, or indicate that other interventions should be given higher priority.

Process and Good Practice

- Assess people's knowledge levels in the three knowledge areas. Design different interventions to address any low-level areas of knowledge that are likely to be a barrier to improving hygiene practices.
- Consider using diagrams to increase health and action knowledge. For water-borne diseases, an F-diagram (T.53) graphically shows the faecal-oral transmission pathways and how to interrupt them. It can be explained to participants directly or distributed as a puzzle – participants put the pieces in the correct order – or serve as a starting point for group discussions. Similar diagrams can be produced for vector-borne diseases or airborne infections.
- Use depictions of potential events or scenarios to target health and action knowledge. Give scenarios to participants that show how situations in their everyday life lead to disease and which protective behaviours can prevent them. Storylines can be brought to life by, for example, showing the participants (anonymised) pictures of their peers' risky behaviour and subsequent contracting of the disease. Participants can then discuss the situations in which they may experience similar risks.
- Use visual aids: procedural knowledge can be supported effectively using visual aids showing, for example, when to wash hands, recommended hand-washing steps or the correct use of a latrine.
- Use the hygiene facilities themselves as prompts (if they are installed in a convenient location). A basin and soap, for example, may serve to remind the participants of the relevant procedural knowledge.
- Combine an intervention that targets procedural knowledge with one that targets practice, e.g. if possible, practise the recommended handwashing steps with participants and install a visual aid to depict the procedure.
- Combine knowledge-sharing interventions with approaches that address motivators and barriers. Avoid the common pitfall of designing and implementing knowledge interventions that rely exclusively on knowledge to trigger behaviour change. Knowledge is an important pre-condition for behaviour change but rarely works on its own.

→ **References and further reading materials can be found on page 292**

Motivators and Barriers: Ability and Self-Efficacy

Main Purpose

To determine and influence the likelihood that an individual will change their practices or adopt new behaviours, with a particular focus on ability and self-efficacy.

Important

- Self-efficacy describes a person's subjective perception of their capacity to perform a specific hygiene behaviour in a given circumstance.
- Self-efficacy is often a crucial motivator or barrier for hygiene behaviour change, but is frequently ignored in hygiene promotion (HP) programming.
- Self-efficacy can be strengthened using behaviour change techniques, such as modelling the behaviour, guiding practice, breaking the task down into smaller tasks and examining past successes and failures.

Overview

The ability to perform a behaviour is an important precondition for engaging in it. Ability may depend on access to critical infrastructure (P.2, P.3, P.4, P.5 and P.6) or knowledge (B.3) and skills. In contrast, self-efficacy relates to confidence in the ability to perform a behaviour. It is a subjective perception and may differ drastically from actual ability.

In HP programmes, people's actual ability can be improved through access to WASH facilities and services (chapter P). In addition, HP can provide the knowledge and skills to increase ability and overcome internal barriers to change. However, improved knowledge and access does not necessarily increase a person's subjectively perceived ability to perform a behaviour – known as self-efficacy. For example, despite having all the required knowledge, skills and access to WASH facilities, an individual may still feel unable to perform a critical behaviour because of a previous experience of failure when e.g. using an Oral Rehydration Solution (ORS) to manage diarrhoea, or because they lack the physical capacity to dig a latrine. In such cases, interventions that aim to develop confidence in the behaviour, or that identify community support mechanisms, can effect much more significant behaviour change than infrastructure and education.

Emotional wellbeing can also significantly affect self-efficacy. Tiredness and hunger, or high levels of stress can impair a person's ability to make choices or perceive themselves in a positive light. Trauma can be a significant barrier to action.

Process and Good Practice

- Demonstrate and model behaviour and impart skills through peer-to-peer learning: by observing peers demonstrating a behaviour such as hygienic food preparation individuals realise that they can do it too.
- Provide direct guidance: participants are encouraged to practise the behaviour under the direct guidance of a hygiene promoter to directly experience their ability to perform the behaviour.
- Encourage behavioural practice: participants are encouraged to practise the behaviour during their daily life. They can then meet again with the hygiene promoter to discuss how it went.
- Use feedback to strengthen self-efficacy: providing people with encouragement and positive feedback about their ability to perform the behaviour increases self-efficacy.
- Set graded tasks or goals: some complex behaviours might seem impossible to adopt in a single step. Self-efficacy can be increased by breaking down the new behaviour into smaller, easier tasks (e.g. collecting the items needed to make ORS, making the solution, administering it to a sick child) and providing support at each stage.
- Re-attribute previous successes and failures: a failure in the past to change or maintain a behaviour may negatively affect self-efficacy. Identifying and discussing what went well, what went wrong and why can bolster self-efficacy.
- Support people to cope with relapse: relapses of behaviour may discourage individuals from continuing with the new behaviour. Informing them that relapse is normal motivates people to try again.
- Enhance ability by ensuring that essential WASH needs are met for all members of the affected population (chapter A and chapter C). Self-efficacy can depend on contextual factors, in particular, access to WASH facilities and services (P.2, P.3, P.4, P.5 and P.6), as well as the provision of other services.
- Identify community support mechanisms (T.46) where required, to support self-efficacy e.g. to help collect water.
- Encourage community hygiene promoters to coach and support others through Household Visits (T.18) and discussion (T.14).

→ References and further reading materials can be found on page 292

Motivators and Barriers: Motivation, Attitudes and Beliefs

Main Purpose

To determine and influence the likelihood that an individual will change their practices or adopt new behaviours, with a particular focus on motivation, attitudes and beliefs.

Important

- Hygiene promotion (HP) uses behavioural determinants such as attitudes, beliefs, misconceptions and feelings to better understand how to influence change.
- Motivation is a pre-condition for any behaviour.
- Attitudes are made up of different beliefs; attitude is the basis of the motivation for behaviour change.
- Positive or negative attitudes can be very powerful barriers or motivators for behaviour change.
- Assessing these motivators and barriers helps to plan health and hygiene promotion activities accordingly.

Overview

Motivation is the reason that a person acts or behaves in a certain way; it is a pre-condition of behaviour change. The motivation to change behaviour is based on a particular attitude, which itself is formed by a wide range of beliefs. The beliefs may be about how beneficial the new behaviour would be, or how good or bad it would feel to perform it. Beliefs can be 'false' and might include elements that are inconsistent with the facts. Perception is highly selective and people often favour 'evidence' that confirms their beliefs and reaffirms their actions. All the beliefs that form an attitude need to be in favour of the desired behaviour for a person to act. Attitudes are developed individually, but originate in the culture, traditions or values considered to be acceptable or normal in a given context. Attitudes can change over time or they can persist, even if they prove to be misconceptions.

Attitudes and beliefs can contain emotional and cognitive aspects. For example, an attitude towards toilet use consists of feelings or emotions about using or not using a toilet (such as comfort, shame or disgust) as well as cognitive beliefs about how safe the toilet is for women or children to use and how costly it would be to construct. An attitude might also be formed by beliefs, such as women and men should not use the same toilet or that using a toilet will lead to infertility. To plan successful HP activities, a good understanding should be developed of existing beliefs (both emotional and cognitive); useful methods include Focus Group Discussions (T.14), KAP Surveys

(T.24) or RANAS (F.20) surveys.

Past experience, such as poor treatment from an agency can also shape attitudes to WASH and therefore what people are prepared to engage with. The way that a programme is carried out is often as important as the programme itself.

Process and Good Practice

- Assess people's current attitudes and beliefs; address them if they do not support the desired behaviour.
- Target emotional beliefs or attitudes through:
 - ▶ Framing the desired behaviour as enjoyable or something that can make people feel happy or better
 - ▶ Describing the consequences of not performing the desired behaviour as unpleasant or something that causes people to feel bad
 - ▶ Starting a discussion about how much participants would actually like to perform the desired behaviour and how much they would regret not doing so
- Target cognitive beliefs or attitudes:
 - ▶ Discuss how much each participant would need to invest to comply with the desired behaviour and weigh up those costs with the benefits he/she would receive.
 - ▶ Discuss what the future costs or benefits might be if the desired behaviour was not performed. Include non-monetary costs (labour, time, effort) and benefits (social status, health protection, safety)
 - ▶ Discuss with participants how they could reward themselves each time they practice the desired behaviour or include rewards as part of the HP plan.
- Design culturally appropriate methods of making attitudes visible with the use of drawings, Role Plays (T.41), pictures or even Songs (T.47) and discuss the different beliefs and feelings connected to the behaviour as described above.

→ **References and further reading materials can be found on page 292**

Motivators and Barriers: Social Influence, Norms and Group Affiliation

Main Purpose

To influence and shape individual and group hygiene behaviour, with a particular focus on social influence, norms and group affiliation as potential barriers and motivators for change.

Important

- People have a strong desire to belong to a social group (e.g. family, religious, political or cultural groups) and to be accepted by the group. To be accepted, they are prepared to adhere to so-called social 'norms' – the general understanding within the group of what is 'good' and 'bad' behaviour. Hygiene promoters need to understand how to use social norms to design effective programmes.
- Targeting social norms through hygiene promotion (HP) can create a shift in a group's understanding of 'good' or 'bad' and generate a fruitful basis for successful behaviour change. It can increase social pressure and support individuals to comply with the new norm of performing a safe behaviour.

Overview

'Social norms' are the common understanding within a society of what is acceptable or 'good' behaviour. These norms also describe an individual's beliefs about how they and others should behave within that society or group. They represent the values and traditions of a particular society or group and therefore vary between groups, within society and over time. 'Gender norms' relate to the understanding of how men, women, girls and boys should behave in a given context (E.3).

There are three dimensions of social norms:

Descriptive norm: individuals naturally observe the behaviour of others in their surroundings. Usually, individuals want to belong to their social group and therefore will comply with the behaviour of the majority (e.g. people will wear facemasks in public or wash their hands after using the toilet if the majority of their peer group are doing this).

Injunctive norm: individuals will observe and listen to influential people or to those whom they perceive as trustworthy about specific issues (such as hygiene promoters or religious leaders) e.g. if a mother tells her daughter to use reusable menstrual cloths, she will be more likely to do so.

Personal norm: every individual has their own values and convictions about what is good or bad; these beliefs might be based on their society's shared understanding, or be the result of personal reflection. For example, a person will consistently dispose of her child's faeces safely, if she believes that protecting her family's health is very important to her.

Scientific research has shown that HP activities targeting social norms can be very successful at influencing behaviour change. A well-known example is the Community-Led Total Sanitation (CLTS, F.2) approach which uses different activities to shift the prevailing norm of open defecation to a new social norm of everyone using a toilet. Through the CLTS activities, the whole community comes to perceive open defecation as 'undesirable' and toilet use as 'desirable', creating a new social norm that subsequently exerts pressure on everyone else to follow it.

A variety of behaviour change tools and approaches can be used to influence and strengthen social norms (chapter T and chapter F).

Process and Good Practice

- Assess and analyse the current social norms relating to WASH (including gender norms) using a variety of assessment techniques (**chapter A**), as soon as time permits. Assess descriptive, injunctive and personal norms.
 - Use the analysis and understanding from an assessment to shape the HP implementation and communication plans (**C.10**).
 - Provide people with opportunities to observe others' behaviour (**T.10, T.12 or T.32**): by observing the behaviour of their peers or family members, participants are induced to perform the same behaviour and follow the new norm.
 - Encourage people to talk to others: prompt participant groups to talk to others about the desired behaviour in question. This increases awareness of what others are doing and of what might be healthy or detrimental.
 - Encourage Public Commitment (**T.37**): participant groups are asked to pledge their commitment to practise the desired behaviour publicly, thus showing others that they accept and value the behaviour.
 - Highlight the (dis)approval of others: influential people are requested to show their approval of the desired behaviour or their disapproval of the unhealthy behaviour and this can influence the behaviour of others who respect them.
 - Encourage people to resist social pressure: participants are prompted to anticipate and prepare for negative comments from others or to resist pressure to continue the undesired behaviour.
 - Identify role models: participants are prompted to set a good example (e.g. for children) by engaging in the desired behaviour, setting themselves up as representatives of the new social norm and encouraging others to follow.
 - Identify and use normative Nudges (**T.9**) where participants are asked to reflect on values that are important to them. Reminders of these values (e.g. protection of family health) are placed at the main locations where the decision to perform the desired behaviour should be taken. For example visual images can be used, such as a picture located at the latrine of a healthy family or a famous footballer washing their hands, to remind the participant of her/his values.
 - Highlight the alignment of personal norms and benefits: participants are invited to reflect on the kinds of benefits (e.g. health or financial) they can receive for themselves or their loved ones if they perform the desired behaviour and recognise how these benefits are connected to their own personal values.
- **References and further reading materials can be found on page 292**

Motivators and Barriers: Cues and Habit Formation

Main Purpose

To use the concepts of cues and habit formation to encourage successful and sustainable behaviour change.

Important

- The formation of habits is important if behaviour change is to be sustained over time. Although this may not be the primary aim in the acute phase of an emergency, behaviour change communication must support people to create habitual hygiene behaviours.
- The establishment of habits requires behavioural performance to be linked to specific environmental cues; these are situations or sensations in an individual's daily routines.
- Cues, such as footsteps on the ground between a latrine and a visible handwashing station, may trigger hygiene behaviours even if they have not yet become routine. Such cues are often called 'Nudges' (T.9).
- Existing habits from older behaviours can conflict with the new habits, jeopardising the success of behaviour change interventions if not addressed.

Overview

Habits are behaviours that are performed frequently and automatically in response to cues.

Many researchers have proposed that automatic performance in response to environmental or situational cues is the active ingredient of habit formation. Taking the example of handwashing with soap, potential cues could be the perception that hands are dirty (environmental cue) or an association with a particular action (situational cue) such as feeding a baby or exiting the toilet after defecation. A handwashing habit is formed when a person automatically washes their hands in response to these cues. A hygiene promotion (HP) assessment should try to identify the cues that can be used to support sustained behaviour change.

There are two main challenges faced by HP in promoting habit formation. Firstly, there may be existing habits that conflict with the new habits, for example, a person might return directly to household work after using the toilet – without washing their hands. Or a person might wash their hands whenever it is time to feed the baby – but without soap. In such situations, it is essential to remove or change the cues that trigger the old, undesired habit. Small modifications to the environment, such as a reminder to wash hands when exiting the toilet or a soap dish or mirror above a basin, may serve as cues for the desired new behaviour and help to encourage it. Major disruptions in the environment during an emergency can remove existing cues; so can constructing a new latrine, moving house or the changes associated with the seasons.

The second challenge is that habit formation requires a stable environment and sufficient time (up to several weeks for a behaviour that is executed daily). A stable environment is needed because the cues must be the same over time to automatically trigger the desired behaviour. Time is necessary because the execution of the behaviour in response to the cue needs many repetitions to become automatic. It is not therefore always possible to alter existing cues or to establish new ones. In such situations, self-control, which requires substantial effort, might be the only strategy available to create a new habit. Facilitating support from others (T.46) can be an important way of supporting an individual's self-control in such situations. Rewards and Incentives (T.40) may also be effective, compensating the participants for the additional cognitive effort required for self-control.

Emergencies provide opportunities as well as threats for habit formation. On the one hand, existing habits are already disrupted: individuals have been displaced, live in a new social setting and are obliged to change or modify their usual everyday activities. This can make the formation of new habits much easier. On the other hand, the environment might continue to be volatile, preventing new habits from being established.

Process and Good Practice

- **Use changes in the context to support behaviour change:** context changes such as seasonal changes, marriage, illness and the construction of major infrastructure or displacement are likely to have disrupted existing habits. Aligning behaviour change interventions with these disruptions can make it easier for individuals to establish new habits.
 - **Piggyback on existing behaviours:** the newly promoted behaviour can be absorbed as an add-on to activities that are already performed. For example, if individuals already store designated drinking water in a particular place, storing chlorine tablets in a nearby visible location can prompt people to chlorinate water directly after collection.
 - **Add friction to the undesired behaviour:** weaken existing habits by restructuring the environment to disrupt the smooth performance of the undesired behaviours, making them more difficult to do and creating an opportunity to establish new ones. For example, removing drinking vessels from the location where unsafe water is stored and locating them exclusively where safe water is stored may disrupt the existing habit of consuming unsafe drinking water and foster a new habit of safe water consumption.
 - **Target and plan specific activities to change behaviour:** the desired behaviour must be performed repeatedly in response to the same situation to become a habit. Planning should specify the exact situation (for example, household water treatment), when it occurs and where and how to perform the desired behaviour. For example, a type of planning called daily Routine Planning (**T.42**) could be used to promote household chlorination. The person would be asked to plan exactly when (how long before drinking?), where (what water container?) and how (dosage?) they would take the specific steps to chlorinate water in the course of their daily life.
 - **Encourage (self) monitoring of behaviour:** to successfully change behaviour and avoid falling back into old, conflicting habits, participants may need to monitor themselves. This is particularly relevant if cues for conflicting habits cannot be removed. Self-monitoring can be achieved by inviting participants to record their behaviour. For example, participants could tick on a chart each time they chlorinate their water.
 - **Use memory aids and environmental prompts:** memory aids can remind individuals of the desired behaviour in situations when they are at risk of relapsing into old habits. A reminder poster placed where the water collection containers are stored could, for example, remind participants to collect water from the safe source. Similarly, posting an action plan for chlorination on the wall could serve as an effective environmental prompt.
- **References and further reading materials can be found on page 292**

Overview of Behaviour Change Approaches

Main Purpose

To select an appropriate and structured process for applying the principles of behaviour change to hygiene promotion (HP) interventions.

Important

- Ensure that interventions to influence behaviour are set within a broader understanding of how change happens and take account of Preconditions and Enabling Factors (**chapter P**).
- Enable the participation and involvement at all levels and of all stakeholders, especially HP participants, when planning WASH programmes (**chapter E**).
- Maintain a flexible, adaptable approach. The selection of a particular behaviour change approach does not prevent innovation and adaptation to the local context. Neither does it change the need to keep listening to community voices and feedback (**C.9**).
- Ensure that, where possible, HP interventions take account of national guidelines.
- Collaborate and coordinate with other stakeholders working in WASH, communication and behaviour change (**P.9**).

Overview

Chapter F provides an overview of different frameworks and approaches that aim to promote safe WASH behaviours. Some of them are ready-to-use; others need adapting to the given conditions.

Some approaches are designed for specific target groups such as children, e.g. Fit for School (**F.10**) or School Health Clubs (**F.1**), or for specific target behaviours such as sanitation or handwashing with soap, e.g. Wash'Em (**F.22**). A few of the approaches are more suited to implementation in rural communities, e.g. Community-Led Total Sanitation (**F.2**) or Participatory Hygiene and Sanitation Transformation (**F.6**), while others have been developed for institutions or the urban context, e.g. Social Marketing (**F.21**). Some approaches may be easier to implement in acute emergency contexts; others are more suited to chronic situations. The selection of approaches will also be influenced by the level of public health risk and the availability of funding and resources. Most will need adaptation to the specific socio-ecological context.

In general, behaviour change approaches aim at promoting one or more safe or healthy behaviours within a specific target group. Ideally, the activities used are directly linked to the barriers, motivators and needs of the audience (**B.3, B.4, B.5, B.6, B.7**) and include interactive and engaging components (**chapter C** and **chapter E**). Most of the approaches have been developed from theoretical behaviour change models (**B.2**) which stem from social and health psychology.

It is important to know whether the selected approach is successful in changing behaviour and the related attitudes and norms. Monitoring (**M.2**) and Evaluation (**M.3**) can identify the results and impact and be used to modify the approach, improve activities and interventions and save resources in the longer term. Some of the approaches described integrate evaluation tools and strategies with their programme activities.

Process and Good Practice

The following questions can guide the selection of a specific behaviour change approach. The list is not exhaustive but can stimulate further reflection and lead to an informed decision about which approach best fits the specific context.

- What are the national guidelines and recommendations? Before selecting a behaviour change approach, check the national guidelines to find out which procedures or approaches are already used and which approaches are mandatory. Many countries have national WASH policies; they may already define the targets, coordination mechanisms, monitoring and evaluation frameworks and standards to be used. Identify which Ministry or department is responsible for which sector and learn about their approaches or recommendations.
- What resources are available for programme development? If material already exists and is validated for the specific context, consider using it. This can save resources, such as the time required for adaptation and money for producing new material.
- When is it advisable to select an approach and prepare for implementation? Ideally, select an appropriate potential approach for your context during preparedness planning or when making longer-term plans. The selection can then be made according to the available resources, the staff can be trained and material developed in advance.
- Which approach should I use? This depends greatly on different contextual aspects. Rather than providing participants with an incoherent set of messages and activities drawn from different approaches, it is more effective to use a limited number of approaches systematically, so that the process and activities can be fully implemented. In an emergency, more than one approach may be needed to target different groups in the affected community.
- How will I know the intervention has made a difference? Evaluate the impact and get feedback from the community: adapt, improve and implement again.

→ **References and further reading materials can be found on page 293**





Monitoring, Evaluation,
Accountability
and Learning (MEAL)

Monitoring, Evaluation, Accountability and Learning (MEAL) are key components of all humanitarian programmes. Together, they support the WASH programme to achieve its objectives to promote healthy behaviours and prevent illness. One of the key concepts (M.1) for MEAL is to guide the programme so that it continues to be appropriate and responsive to the needs and vulnerabilities of the affected population.

Monitoring (M.2) systematically and continuously checks that a WASH-hygiene promotion (HP) programme is doing what it intended, identifying necessary changes and guiding revisions in a timely way. In an emergency, the monitoring system needs to be simple, fast and flexible.

Evaluation (M.3) can be defined as the systematic and objective examination of humanitarian action to determine the worth or significance of an activity, policy or programme. It is intended to draw lessons to improve policy and practice and to enhance accountability. Accountability (M.4) plays an important role in contributing to the quality of the response, checking that resources are used appropriately and transparently and requiring that responders take responsibility for their work and meet certain standards.

Participatory MEAL (M.5) describes the importance of men, women, boys and girls affected by the emergency being able to voice their opinions, providing input for WASH project design and process.

Learning (M.6) draws lessons from previous or ongoing interventions that may lead to the adaptation and improvement of future plans, approaches and activities. Research and Evidence (M.7) emphasises the need to guide and strengthen evidence-based decision making. Knowledge Management (M.8) discusses the need to gather, process and share learning to improve the quality of HP activities.

Sub-Chapters

- M.1 Key Concepts and Good Practice
- M.2 Monitoring
- M.3 Evaluation
- M.4 Accountability
- M.5 Participatory Monitoring, Evaluation, Accountability and Learning (MEAL)
- M.6 Learning: Process and Key Elements
- M.7 Learning: Research and Evidence
- M.8 Learning: Knowledge Management

Key Concepts and Good Practice

Main Purpose

To ensure the WASH programme is going according to plan, achieving its stated goal, meaningfully involving all the key stakeholders and acting on lessons learned throughout the process so that the programme is relevant to needs and its quality improved.

Key Concepts

- Monitoring, Evaluation, Accountability and Learning (MEAL) are all essential components of WASH programmes. All team members, including hygiene promoters, must ensure that MEAL is incorporated into the response and implemented in coordination with others working in WASH.
- MEAL should guide the programme, ensuring that it continues to be appropriate and responsive to the needs and vulnerabilities of the affected population.
- Monitoring (**M.2**) is an ongoing process to check whether the programme is going to plan and to allow changes to be made quickly. It complements periodic needs assessments to identify the most vulnerable population and their needs.
- The purpose of an Evaluation (**M.3**) is to examine what the project has achieved, whether it has achieved its stated goal and what changes have occurred as a result of the intervention. It can be carried out at various points in the project cycle.
- Accountability (**M.4**) aims to ensure that resources are used appropriately and transparently, WASH responders take responsibility for their work and communities benefit from efficient and effective programming.
- Affected people have the right to be involved in planning, implementing, monitoring and giving feedback. They are the best judges of the emergency response.
- Participatory MEAL (**M.5**) aims to engage men, women and children affected by a humanitarian crisis, ensuring that they are kept informed in a timely way and able to take decisions regarding the WASH programme.
- Drawing lessons learned from past and current hygiene promotion (HP) interventions in humanitarian settings can improve the quality of WASH interventions over time. It is important to capture and document best practices in HP, identify new challenges, disseminate information about innovative approaches and use the findings to improve future responses (**M.6, M.7 and M.8**).

Good Practice

- Include a budget and resources for MEAL in all HP programme plans.
- Train and support capacity strengthening, if necessary, to ensure a good quality monitoring system and to support local authorities and service providers.
- Develop a WASH Monitoring (**M.2**) and Evaluation (**M.3**) framework at the beginning of the programme with all stakeholders. The framework should clarify the information required, the methods needed to provide comparable evidence of change and describe who will be collecting the data, when, how and how often.
- Develop the indicators required to measure the programme objectives as early as possible. Monitoring (**M.2**) should be planned and systematic.
- Use national or internationally recognised standards (such as Sphere) to support the identification of key actions and indicators that contribute to programme quality and Accountability (**M.4**). Depending on the focus of the programme, key indicators are likely to cover hygiene practices, WASH facilities (**P.2, P.3, P.4 and P.5**), community satisfaction and participation, market-based WASH programming (**P.8**) and WASH-related health data (**T.17**).
- Define a clear purpose for the data to be collected and the type of information required. Collecting quality data requires time and resources. It should be collected in the least intrusive way, ensuring that only information that will be used is collected. Irrelevant or poor-quality data is of little or no use; collecting too much information can contribute to population survey fatigue.
- Collect qualitative and quantitative data from a variety of sources (triangulation) and analyse it using appropriate methods.
- Disaggregate Monitoring (**M.2**) and Evaluation (**M.3**) data by age, gender and disability.
- Establish an inclusive, accessible, open and transparent system for the timely collection of feedback and complaints (**T.13**) about the programme.
- Ensure that hygiene promoters have skills in active listening (**C.2**). Hygiene promoters are the frontline workers with communities; active listening skills are essential for collecting data, showing an interest and being non-judgemental. Active listening reflects back what has been said to demonstrate that the listener has understood how people feel and what they have said: 'ask, listen, communicate!'

- Capture and document best practices in HP to fill the existing gaps in knowledge and evidence **(M.7 and M.8)** in the humanitarian WASH sector. Research, identifying new challenges and using innovative approaches is important, even in a complex humanitarian response, to learn lessons for subsequent responses.
 - Collaborate and coordinate with others **(P.9)** so that MEAL resources are used efficiently. An HP technical working group and/or community of practice are the main fora in a humanitarian response where technical and contextual knowledge exchange can take place between all the stakeholders.
- **References and further reading materials can be found on page 293**

Monitoring

Main Purpose

To measure progress and check whether the programme is working according to plan.

Important

- Monitoring should be planned and systematic; indicators for monitoring the objectives should be developed as early as possible in the programme.
- Information should be recorded, analysed and shared with people in a timely manner and used to ensure a high-quality, effective programme.
- Different aspects of the programme need to be monitored: the processes (e.g. whether latrines are constructed with the involvement of the community), the activities and outputs (e.g. the number of latrines and whether they are being used), the outcomes (e.g. whether excreta is being safely disposed of) and, if possible, the impact (e.g. changes in public health).
- Monitoring is not a one-off activity, but a continuous process that compares progress with the project or programme design, tracks changes in the context and people's needs and identifies appropriate corrections during the response to increase the programme's effectiveness. Monitoring data should feed into the Evaluation (**M.3**).
- In an emergency, the monitoring system needs to be simple, fast and flexible.
- Data collection and storage must adhere to common ethical standards. Confidential, identifiable information should not be shared without the respondents' permission.
- Hygiene promoters, engineers and the affected community should all be involved in the monitoring process from start to finish.

Overview

Monitoring is the systematic and continuous checking of a hygiene promotion (HP) intervention to ensure that it is doing what was intended, allocated funds are being used effectively, feedback is heard and acted upon and strengths, weaknesses and gaps are identified so that changes can be made as needed.

Indicators are the 'signals' that enable measurement of the progress or targets and therefore of change, e.g. changes in the frequency of safe disposal of babies' excreta or washing hands before eating. There are different levels of programme intervention (with corresponding indicators) that together deliver the overall goal of the response. A goal is a complex overall aim that in WASH is usually about protecting public health. The activities, such as constructing toilets or handwashing facilities, contribute to the outputs, e.g. people using these facilities, which in turn contribute to outcomes, e.g. reducing disease risks. Each level is measured with its own indicators.

The five essential 'output' indicators for monitoring HP (as part of a WASH response) relate to: **1)** safe excreta disposal, **2)** handwashing with soap at key times, **3)** the use of safe drinking water, **4)** the practice of these target hygiene behaviours amongst all sectors of the community (including vulnerable groups) and **5)** enabling women to manage menstruation with privacy and dignity. However, the selection of indicators will be dependent on the context and whether the programme is responding to WASH health risks or the outbreak of a specific disease.

The initial assessment and analysis (**chapter A**) identifies the needs as well as what and how change can be achieved. Assessment findings inform the design of the objectives and indicators for the WASH intervention. This initial information can help to establish a baseline for each indicator so that monitoring can track any changes by the end ('endline') of an intervention. Additional specific information may be needed to fill in gaps in the baseline or to better understand the determinants of specific behaviours. In an emergency, there may be constant changes in the context and monitoring is essential to measure progress and to adapt the programme.

Monitoring is about identifying the things that are going well and the things that need changing. It should also track the effective and efficient use of funds and whether the programme is having the intended impact. However, it is difficult to attribute an impact on health to WASH interventions alone, as public health is influenced by the response as a whole rather than by a single sector intervention. Proxy indicators (measuring change indirectly, using a substitute indicator) are often used to support

Process and Good Practice

monitoring, e.g. handwashing with soap is known to reduce diarrhoeal diseases and it can therefore be assumed that if people are washing their hands at key times there will be an impact on their health – so handwashing with soap is a proxy indicator for the impact on health.

Different methods and tools can be used to collect monitoring data; they are similar to those used for assessments. Examples are: Transect Walks **(T.52)**, Pocket Chart Voting **(T.31)**, (Community) Mapping **(T.7)**, community meetings, team meetings, Observation **(T.28)**, Focus Group Discussions **(T.14)** and post-distribution monitoring. In some circumstances remote programming **(E.10)** and data collection may be necessary.

Using different methods helps to capture different perspectives and to triangulate and cross-check information, e.g. Observation **(T.28)** addresses how drinking water is stored at household level and Pocket-Chart Voting **(T.31)** addresses the sources of drinking water. Monitoring data should not simply be about numbers (such as how many latrines have been built) but about whether the community is satisfied with them and whether the latrines are in good condition and being used. Both quantitative and qualitative data is usually required.

It is also important to monitor community engagement and participation **(chapter E)** – ensuring that all sectors of the community, including vulnerable groups, are consulted and represented in all aspects of the programme. Data should be disaggregated by age, gender and disability as a minimum.

The WASH cluster plays a key role in the coordination of monitoring systems. The Global WASH Cluster Coordination Toolkit provides guidance on how to establish a WASH response monitoring plan, with information compiled from different sources across the sector.

- Use existing national standards if available, or internationally recognised standards, such as Sphere, to support the identification of key actions and indicators and contribute to quality and accountability.
- Draw up a specific monitoring plan at the beginning of the programme with a timeframe, budget and a clear indication of staffing and responsibilities.
- Clarify the purpose of collecting the information: who will use it, how, when and why.
- Track each indicator using monitoring methods and tools. A monitoring plan should describe who will use the methods and tools, how and when.
- Involve the community in the monitoring process **(M.5)** instead of treating them solely as the objects of monitoring.
- Consider using visual tools such as a Spidergram **(T.48)** to rate 'hard to measure' indicators like the level of community satisfaction or participation.
- Share the monitoring plan with different stakeholders, e.g. the community, partners, donors and other organisations, in a format that is accessible and easy to understand so that it can be used for decision making.
- Employ visual methods of presenting information, such as pictures, graphs, bar and pie charts, to help explain the monitoring findings to different audiences.
- Focus on collecting data that is essential or useful to know, rather than nice to know. Plan according to the available resources for monitoring and only collect data that will be analysed and used.
- Advocate to the Coordination Platform or WASH cluster to establish a monitoring system that tracks key HP interventions, not just the distribution of hygiene kits.

→ **References and further reading materials can be found on page 293**

Evaluation

Main Purpose

To examine what the project achieved, whether it achieved its stated goal and what changes occurred as a result of the intervention in order to be accountable to stakeholders and learn lessons to improve subsequent programming.

Important

- An evaluation looks at the overall changes which can be attributed to a WASH programme and examines the outcomes achieved, the relevance, efficiency and wider impact on people's lives.
- Evaluations can produce recommendations to improve the programme (including capacity strengthening if needed) and capture learning to inform future policy and practice.
- Evaluations are an important aspect of Accountability (M.4) and sharing and using evaluation findings encourages transparency and learning (M.6, M.7, M.8) in the sector.
- Evaluations must be carefully planned and as systematic and objective as possible.
- As with any data collection, the safety of participants and data collectors needs to be protected, such as ensuring data is anonymous, collecting data remotely, or taking protective measures during epidemics such as COVID-19 (e.g. maintaining physical distance, open-air interviews, or using masks).
- A monitoring and evaluation framework identifies the specific information required to provide evidence of change. It is good practice to include all partners and other actors when developing the framework and, where possible, carry out joint monitoring.
- The results of the evaluation must be shared in an appropriate format with all key stakeholders so that the findings can be discussed and applied, e.g. through workshops, reports, presentations and community meetings.

Overview

Evaluation can be defined as the systematic and objective examination of humanitarian action to determine the worth or significance of an activity, policy or programme. It is intended to draw lessons to improve policy and practice and enhance accountability. Key evaluation criteria are:

Relevance: asks whether the programme is doing the right things, e.g. is the hygiene promotion (HP) programme meeting the needs according to the context? Does the programme target the right people in terms of geographical areas as well as vulnerabilities to WASH-related health risks?

Effectiveness: analyses whether the programme has achieved its objectives and intended results and examines the factors influencing the achievement of those objectives, e.g. has the HP programme achieved its behavioural objectives of increasing handwashing with soap at critical times? To what extent can these changes be attributed to the programme? If intended results did not occur – why not?

Efficiency: measures both quantitative and qualitative outputs in relation to the inputs, e.g. how efficient is the distribution method for hygiene items? Does this method make the best use of the resources available? Were there alternative options to improve access to hygiene items?

Impact: examines whether there were significant or lasting changes resulting from the programme and whether they were intended or unintended, positive or negative, e.g. has the goal of the programme been achieved? Have there been any changes in public health? Has the programme made a real difference to the affected population?

Sustainability: evaluates the extent to which the net benefits of the intervention will continue or are likely to continue, e.g. have people been supported to continue using, maintaining and repairing the water facilities? What behaviours have changed as a result of the intervention and how likely are these changes to last? Has local capacity strengthened?

Coherence: considers how well the intervention fits with existing country plans and local priorities, e.g. does the programme align with Government policies such as with Ministry of Health community outreach systems?

There are numerous reasons for undertaking evaluations including to review innovations, gain evidence, demonstrate success or challenges as part of a learning process (M.6), assess value for money and to be accountable (M.4) to key stakeholders such as donors and, especially, to the affected population.

There are different types of evaluations depending on the objectives. Some evaluations are carried out at, or after,

the end of the programme and aim to provide Accountability (M.4) and influence future policy and practice. Real-time evaluations are carried out during the programme, are interactive and involve multiple stakeholders; the evaluator acts as a facilitator to generate an overview of the programme and provide immediate feedback so that issues can be addressed during the response. All types of evaluation can be external and independent or conducted by an agency with the support of an external evaluator or by staff members. It may be appropriate to do joint evaluations in collaboration with other programme staff, partners and other organisations (e.g. within the WASH cluster) to minimise the duplication of resources (P.9). Some evaluations have a strong focus on accountability to the affected population (M.4 and F.23), empowering them to play a key role in carrying out and contributing to the process in order to strengthen ownership of the programme and ensure that they are in a position to make use of the findings (M.5).

Existing national standards, Sphere standards, the Core Humanitarian Standard and the Code of Conduct can be used as references to assess the quality of the programme in conjunction with the programme objectives and indicators.

Process and Good Practice

- Budget for an evaluation in the HP programme. Calculate costs such as the evaluators, interpreters, logistics (e.g. transport and accommodation) and dissemination (e.g. printing, community meetings and workshops).
- Clarify the purpose of the evaluation, the type of information needed and develop a Terms of Reference with a timeline and budget.
- Establish a formal baseline at the start of the programme to identify gaps in data and understanding and to serve as a comparison with the end of the project. Baselines can also feed into a broader programme evaluation.
- Develop a Logframe (A.9 and T.25) with indicators to enable an evaluation of the inputs (resources used), activities (what was done), outputs (what was delivered), outcomes (what was achieved) and impact (long term changes).
- Match the evaluation methods to the requirements of the evaluation and be accessible to and inclusive of marginalised groups. Examples include: Key Informant Interviews (T.23), Observation (T.28) and Transect Walks (T.52), Pocket Chart Voting (T.31),

questionnaire-based surveys (T.24 and A.8) and Community Mapping (T.7).

- Develop indicators which are disaggregated by age, gender and disability. Depending on the objectives of the programme, they are likely to include:
 - ▶ Hygiene practices: e.g. hand washing, disposal of excreta, water handling and storage and indicators to assess whether there have been any changes in behaviour, community perceptions and motivators
 - ▶ WASH facilities: access, use of and acceptability of water supplies, latrines/toilets for different groups
 - ▶ Community satisfaction, engagement and participation
 - ▶ Hygiene promotion methods: monitoring the effectiveness, appropriateness and acceptability of community mobilisation methods such as community meetings, Theatre (T.6), Household Visit (T.18) or posters (IEC, T.19)
 - ▶ Health data: e.g. trends in diarrhoea morbidity (such data is influenced by numerous factors – not just WASH and should be used with care)
- Collect qualitative and quantitative data (A.4) from different sources (triangulation), analyse it using appropriate methods and compile the findings into a report.
- Avoid the common pitfalls of evaluations, including:
 - ▶ Focusing on easy to reach geographic areas
 - ▶ Not collecting baseline ('before intervening') data
 - ▶ Not respecting data protection and or putting participants at risk, e.g. in insecure areas
 - ▶ Neglecting consultation with less visible groups, e.g. women, older people and persons with disabilities
 - ▶ Ignoring seasonal or geographical WASH differences
 - ▶ Collecting too much or unnecessary information, which consumes time and resources and does not answer the evaluation questions
 - ▶ Focusing the evaluation merely on outputs, not considering outcomes, behaviour change and impact
 - ▶ Not widely sharing the results, so the information is lost and not used to adapt programming
 - ▶ Not informing the target group about the results of the evaluation

→ References and further reading materials can be found on page 293

Accountability

Main Purpose

To ensure that WASH responders take responsibility for their work, use programme resources appropriately and for humanitarian purposes and that communities benefit from efficient and effective programming.

Important

- Hygiene promoters and other WASH personnel control the aid resources; they are in a powerful position in relation to the affected community and they must use this power responsibly.
- Affected people have the right to be involved in planning, implementing, monitoring and giving feedback on the emergency response. They are best judges of the response **(M.5)**.
- Standards such as Sphere and the Core Humanitarian Standard (CHS) provide a framework for accountability, supporting the programme to respond to the needs of the affected community and engage without endangering it.
- An accountable humanitarian response is based on communication, participation and feedback; WASH staff should establish mechanisms for sharing information with the affected community including about the organisation, its principles and what assistance they are providing, when and how.
- Hygiene promoters play a key role in ensuring an accessible and safe WASH feedback and complaints mechanism. This must be established with the input of the affected community and the feedback acted upon in a systematic and timely manner.
- Data collection requires informed consent and might require ethical approval. Any data collected must adhere to data protection standards and ensure confidentiality.
- Knowledge, skills, behaviours and attitudes are important aspects of being accountable; hygiene promoters must be competent, respectful and enabled to do their job well.
- Programme planners should assess whether the response is necessary, useful and feasible before its implementation, as well as assessing how the community can maintain the project's benefits in the long run. The design and implementation should be sensitive to the cultural, socioeconomic, environmental and political context.

Overview

Accountability is defined by the Organisation for Economic Co-operation and Development as the obligation to demonstrate that work has been conducted in compliance with agreed rules and standards. Sphere describes accountability as the process of using power responsibly, taking account of and being held accountable by different stakeholders, primarily those who are affected by the exercise of such power.

Sphere and the CHS aim to improve the quality of humanitarian response in situations of disaster and conflict and to enhance the accountability of humanitarian action to crisis-affected people. Sphere's WASH technical chapter describes the critical need for community engagement, linking communities with response teams to maximise their influence on reducing public health risks. The WASH Community Engagement model in Sphere **(chapter E)** emphasises accountability, including welcoming and addressing complaints and using power responsibly.

One of the principles of the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs seeks to guide behavioural standards, stating the need to 'hold ourselves accountable to both those we seek to assist and those from whom we accept resources'.

There are different forms of accountability: upwards accountability (e.g. to donors) lateral accountability (e.g. to governments) and downward or forward accountability (e.g. to those affected by the disaster). As service providers, hygiene promoters are accountable to the affected population – they are the best judges of the programme's impact and have a right to a say in decisions that affect their lives (see also Accountability to Affected Population, **F.23**).

WASH accountability comprises five dimensions of change: **(1)** participation, **(2)** transparency, **(3)** feedback and complaints, **(4)** monitoring, evaluation and learning and **(5)** staff competencies and attitudes. These five dimensions complement and link with the CHS, particularly commitment 4: 'Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them' and commitment 5: 'Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.'

WASH personnel should take responsibility for their actions, particularly in an emergency situation when communities are more vulnerable to exploitation and where aid workers often think they already know what people need. Wherever data is collected, efforts must be made to keep both communities and staff safe, including adhering to data protection standards. In highly insecure

environments, it may be necessary to conduct remote interviews (via phone or digital means) or provide personal protection.

Even in an acute emergency, it is essential to involve the affected population as far as possible in programme planning, implementation, monitoring and feedback **(M.5)**. Being accountable includes building trust, being respectful and developing collaborative relationships with affected communities. WASH personnel can and should support people's capacity to overcome adversity by listening, providing clear and accurate information and the opportunity to provide feedback on the programme.

The advantages of accountability are many. Listening to people, empowering and involving them in decisions that affect them and understanding their needs will lead to an appropriately designed, implemented and more sustainable programme.

Process and Good Practice

- ▶ Ensure that all sectors of the community (including men, women, boys and girls, persons with disabilities and older people) can participate fully in the programme and have the opportunity to voice their concerns and express their preferences e.g. on the type of toilets, hygiene items or means of communication.
- ▶ Share information about the organisation and the programme with the community in a format and language they understand. For example, they should be informed about the content of hygiene kits and when they will be received in an accessible language and medium suited to the population.
- ▶ Establish open, transparent and participatory mechanisms for feedback and complaints **(T.13)**. All stakeholders, particularly the users, must be able to provide feedback or complain about the programme and be informed about the

organisation's intended response. Acknowledge receipt of the feedback, analyse it, use the findings and respond to the feedback, closing the feedback loop: 'consult, modify and consult!'

- ▶ Monitor **(M.2)** the progress of the programme against its goals and objectives. This feeds into the learning process **(M.6, M.7 and M.8)** and should involve the affected population, e.g. the users of the latrines monitor their satisfaction and use.
- ▶ Train and support staff to demonstrate behaviours that support accountability, such as respect for the people they are working with, being open and transparent and relating to community members as partners rather than helpless victims. A trusted relationship with the community can also increase acceptance of the programme.
- ▶ Demonstrate active listening skills: hygiene promoters play an essential role by showing an interest, being neutral and reflective and demonstrating an understanding of what people say and feel. 'Ask, listen, communicate!' **(C.2)**.
- ▶ Establish a feedback system that is simple, accessible, safe, appropriate and effective **(T.13)**. Take into account people's age, gender, disability, language and context and design the system with the involvement of a diverse range of community members. Adapt the system according to the context (a suggestion box may work in one community but not in another with limited literacy).
- ▶ Include vulnerable groups in the community and listen to them. The marginalised, older people, persons with disabilities, those with special health needs and children may be less visible, but must not be forgotten.

→ **References and further reading materials can be found on page 293**

Participatory Monitoring, Evaluation, Accountability and Learning (MEAL)

Main Purpose

To ensure that men, women, boys and girls affected by a humanitarian crisis are engaged, informed and equipped to take decisions and actions relating to WASH to decrease the risks to their health and dignity.

Important

- Participatory Monitoring, Evaluation, Accountability and Learning follows on from participatory assessment and planning (**chapter A**) in the project cycle and fits into the broader scope of community engagement (**chapter E**). It is not restricted to the humanitarian WASH sector and should be designed in collaboration with other agencies and sectors.
- Participatory MEAL ensures that women, men and children affected by the emergency have opportunities to voice their opinions, influence project design, state what results they want to see and are informed about and can judge the project's achievements.
- Hygiene promoters are the front-line workers in the communities and play a key role in participatory monitoring and accountability processes. They need to be skilled and trained to ensure that everyone in the community understands the process and is equally involved.
- Participatory monitoring is about involving communities in collecting and recording information as well as involving them in discussing, analysing and using this information as a basis for decision making.
- People can still participate, even if access is difficult or unsafe. Steps can still be taken to ensure that communities are not endangered, e.g. protective measures, remote data collection (**E.10**) and appropriate communication strategies (**chapter C**).
- Involving the communities in Monitoring (**M.2**) and Evaluation (**M.3**) increases their ownership of the programme and the reliability of the information. It is also an opportunity for them to provide feedback and suggestions on how to improve the programme.

Overview

Participatory MEAL does not necessarily use different Assessment (**chapter A**), Monitoring (**M.2**) and Evaluation (**M.3**) tools to traditional MEAL. The main difference is that it aims to give communities greater control over the use of the tools and decision making.

Participatory monitoring is the systematic recording and periodic analysis of information collected and recorded by the target population with the help of humanitarian organisations. Its main objective is to provide information to the population so that adjustments and/or modifications can be made jointly between the community and the organisation. The approach has the advantage of allowing the community to react immediately, based on predetermined indicators. For example, a community can monitor the quality of their water source and, based on the results, prioritise corrective actions, undertake simple maintenance and repair work or report problems that require attention. Before engaging in participatory monitoring, the participants should have a clear understanding of why they are doing the monitoring. The information collected should allow everyone to be informed about the progress (or lack of progress) towards planned activities and goals. Participatory monitoring can also feed into participatory evaluation.

Participatory evaluation is an approach that involves the stakeholders of a programme or policy in the evaluation process. People can participate at any stage of the evaluation process, from evaluation design to data collection and analysis and reporting. Participatory evaluation allows the affected populations to understand the factors of success and to identify the barriers to achieving the desired change. The main advantages of participatory evaluation are: **(1)** access to information that may otherwise be unavailable to communities, **(2)** participants gain a new understanding of why something did or did not work, facilitating learning for responders and communities, **(3)** providing an example to people of how to take more control of their lives and **(4)** encouraging collaborative working. The Most Significant Change (**T.26**) tool is a method for involving stakeholders in 'searching' for project impact by identifying stories about change. People meet and hold regular and often in-depth discussions about the value they attribute to the changes and why. Participatory accountability refers to a shared understanding of the humanitarian principles, standards and responsibilities underpinning the programme. It also refers to the monitoring and enforcement of appropriate action when agency responsibilities are not met. The community should have a clear understanding of their rights and entitlements from the beginning of the WASH

programme, before the feedback and complaints mechanisms **(T.13)** are jointly developed. Solutions should be agreed jointly with all stakeholders wherever possible. Participatory learning is an approach in which all stakeholders, including the affected population, are actively involved in the learning process through a series of activities (which could include a community learning event). Participatory MEAL is not possible without mutual trust and respect. These develop over time, but it is important to begin with an understanding of the local culture and customs, ensuring that outreach workers have the right skills (and are actively listening) to engage communities within the process.

Process and Good Practice

- Begin the participatory evaluation process with an interactive process, such as a facilitated workshop. Aim to reach an agreement on the Terms of Reference and discuss the reasons for Community Engagement **(chapter E)** in the Monitoring **(M.2)** and Evaluation **(M.3)** process, reviewing the benefits and purpose of working together.
- Collaborate with different groups in the community to tailor Communication **(chapter C)**. For example, consider specific needs such as the monitoring tools and processes for working with children or with marginalised groups to ensure that their views and voices are not left out.
- Decide on the level of participation of different stakeholders. Which groups will be involved and what roles will they play? The scope of participation can be broad and include programme staff, community groups and partners, or it can focus on a small number of key groups, depending on the objectives and context.
- Develop key questions and, where possible, involve women, men, boys and girls in defining the changes they want to see. Ask community members what they hope for when the project is completed.
- Establish a range of indicators with the community, asking people to define their interpretation of success. For example, 'Imagine that the project is finished. How will it affect your life? What will be happening around you?' Indicators of change developed by a community may not seem logical or compatible with other programme indicators. However, they offer a means for staff to see the project through the eyes of the affected population and take their experiences and wishes into account.
- Decide which information-gathering tools are needed (and feasible with the available resources) and explore how the process can be conducted jointly. It may be necessary at this stage to reduce the number of indicators to avoid over-burdening the community. Resources and equipment may be needed, as well as training for some community members.
- Decide who will do the monitoring and evaluation jointly with the community. Who is responsible for collecting and analysing data and how often?
- Review the objectives and activities. This can be carried out as part of a community action plan (i.e. a roadmap that identifies what will be done, who will do it and how). The community action plan becomes a framework for the implementation of WASH activities, the progress of which can then be monitored.
- Analyse the information collected collaboratively and regularly at pre-arranged times during the programme. The time needed for the analysis will vary according to the context and/or seasonality of activities. Discuss the results jointly and present them to the whole community for further discussion. Different communication methods and tools may be needed in order to reach everyone.

→ **References and further reading materials can be found on page 294**

Learning: Process and Key Elements

Main Purpose

To improve the quality of hygiene promotion (HP) interventions in emergencies by drawing on lessons learned from past and current HP interventions.

Important

- Sharing knowledge and building on lessons learned in HP is important both within humanitarian (and development) organisations and between them.
- The establishment of learning systems for the humanitarian WASH sector at organisational, national and international levels will help to improve the overall quality and effectiveness of HP interventions.
- Organisations must drive the process and provide an enabling culture for learning and knowledge sharing. Hygiene promotion managers need to make it their responsibility.
- Learning and knowledge-sharing require a culture of behaviour change in individuals, organisations and systems so that initiatives to improve learning, knowledge sharing and communication are given greater support and investment. Investment in good information management is required at all levels as well as its promotion. The production and dissemination of guidance and recommendations is important as well as its inclusion in inductions, handovers and training.
- Learning is weaker if learning-focused systems for Monitoring (M.2) and Evaluation (M.3) have not been established.
- Research (M.7) and Knowledge Management (M.8) are two important components of any learning system to ensure that learning is rigorous and shared across the sector.

Overview

Learning involves the exchange of information, knowledge and views. It takes place at different levels and for different purposes such as participatory learning (M.5), project-based learning and learning that informs policy and advocacy.

The Active Learning Network for Accountability and Performance in Humanitarian Action defines learning as the capacity for continuous, collective, interactive and inquisitive review by knowledgeable and trained staff. Organisations implementing WASH programmes must therefore create this capacity by establishing a learning strategy that includes HP.

Collective learning in the sector is derived from collective experience. This is an implicit basis of Sphere, where standards, indicators and key actions are derived from learning in the humanitarian WASH sector. WASH coordination mechanisms are also important contributors to the learning process at the national and global level, as are research initiatives that carry out research and learning for the humanitarian sector.

Learning processes can be difficult to establish in humanitarian contexts, particularly during the acute response phase. However, it may be possible to gain knowledge through Monitoring (M.2) and Evaluation (M.3), but with additional or more focused analyses. In addition, specific Research (M.7) can be undertaken to complement the monitoring and evaluation findings. The main goal is to learn what works or does not work and why. Being able to acknowledge mistakes and failures can contribute significantly to learning and building trust. For example, identifying why the affected population has not successfully adopted handwashing with soap at critical times is essential learning with which to adapt the HP programme. The assumption however that learning is universal and can be applied in the same way in every community is a mistake, as learning must be contextualised.

Knowledge Management (M.8) is a crucial element of learning and includes the documentation, centralisation, comparison, synthesis and sharing of information and guidance. There are various ways of disseminating knowledge and experience – not just through the written word but also through interaction such as personal communication, meetings, videos or workshops.

Learning within the humanitarian sector is difficult without individual learning by practitioners. Investment in continuously developing the HP capacity of WASH professionals at every level is essential. Organisations need to develop learning strategies and provide adequate resources for the learning and knowledge needs of all staff.

Process and Good Practice

- Plan learning strategically. Key questions to ask for each project include:
 - What do we need to know about this area?
 - Why is this a priority?
 - What are we curious about and why?
 - How will we document, share and use the evidence and information generated?
 - What are the best approaches to use?
 - How can we best communicate with populations to reduce WASH-related risks?
 - How can we learn and use the knowledge generated by communities to improve our response?
 - Budget for learning as part of the planning process of an HP programme. Include both individual and organisational learning in the budget.
- Use a Monitoring, Evaluation, Accountability and Learning framework to ensure that the knowledge generated at an individual, programme and organisational level is integrated and coherent.
- Consider and adhere to ethical standards wherever learning requires data collection.
- Integrate learning into the capacity strengthening plan of the HP team to ensure that staff apply current sectoral learning.

→ **References and further reading materials can be found on page 294**

Learning: Research and Evidence

Main Purpose

To ensure that WASH and hygiene promotion (HP) is evidence based and that practitioners continue to learn from experience and enquiry to improve their practice.

Important

- There are significant gaps in knowledge and evidence in the humanitarian WASH sector, including in HP and a lack of good quality research in emergencies. Conducting research in the context of a humanitarian response is challenging but creative ways can be found to address the difficulties.
- Research is important to guide and strengthen evidence based decision making in the design, implementation and evaluation of humanitarian WASH programmes and helps to understand the risks, benefits and consequences of HP.
- Strengthening collaborative research with national and international scientific or academic partners is key to designing rigorous and effective research protocols that will produce relevant and reliable evidence.
- Research helps to develop and test innovative HP interventions in humanitarian settings. Trying out new and innovative approaches is important to broaden current knowledge and to improve HP effectiveness.
- Research must adhere to strict ethical standards and ensure that participants are not negatively affected or endangered by it. Research with vulnerable participants often raises particular questions about their protection, which need to be taken into account when planning data collection.
- Evidence generated on HP will equip the humanitarian community with knowledge of what works so that people affected by crises get the right help when they need it most.
- The use of electronic devices such as tablets and phones facilitates data collection. Such technologies, if appropriate, enable teams to reduce local travel while making the collation, analysis and sharing of information quicker.

Overview

The Global WASH Cluster defines research as pursuing ‘a systematic approach to better understand water, sanitation or hygiene interventions that aim to improve the health of populations affected by humanitarian crises’. Research in the field of humanitarian aid (including WASH) remains insufficient in both quantity and quality (see introduction). Recent studies have described the need to improve quantitative and qualitative data, measure health and behavioural outcomes and strengthen research on affected populations and their safety and access to WASH facilities.

There are many ways to generate evidence, such as case studies, reviews, field research, action research, Monitoring (M.2) and Evaluation (M.3) and anthropological studies. Evidence can be generated at a local level and used locally or more widely. What is important is the dissemination of findings to the humanitarian and academic community to continuously improve the WASH response to affected populations. Findings may be disseminated through scientific articles, published technical guides, external communication and joint local or international learning events, each of which may suit different purposes or audiences:

- A case study is a descriptive and exploratory analysis of a person, group, or event and is commonly used in the social sciences to understand and document what works and how.
- A scientific article presents research findings written by researchers and scientists. They are generally considered primary sources and are written primarily for other researchers; they may need reworking to be accessible to practitioners.
- Documents like technical manuals are written primarily for practitioners and often draw on case studies and collective experience.
- Hygiene promotion can draw on a range of disciplines and expertise in social sciences or public health. However, the balance between scientific rigour and the challenges of conducting studies whilst also responding to a humanitarian crisis must be continually weighed up. Consequently, the means for implementing robust studies that support the implementation of effective HP programmes must be an integral part of the response strategy of organisations and the sector. Implementation modalities, including the ‘when’ of conducting these studies, should be identified at the onset of the crisis or during strategy development. Below is a list of criteria for framing the studies:

- A study can be implemented to address short, medium, or long-term needs as part of more comprehensive future planning.
- Research can be 'retrospective', in cases where the research project consists of analysing data already collected during previous operational missions (e.g. from needs assessments, monitoring, programme evaluations and final reports) – or 'prospective', if the research activity has been specifically implemented to answer a given research question.
- A study can lead to the production of tools or methods that may differ according to its objectives, such as recommendations, protocols, guidelines, information and education documents, new materials or training tools.
- Depending on the subject, partners from different organisations (scientific, institutional, operational and technical) may be involved in the study.
- Involve humanitarian practitioners during all stages of study development and implementation when working with them to design and conduct research. Research institutions rarely have the same local capacity as humanitarian organisations in terms of staffing, logistics and local networks.
- Work closely with local researchers to improve contextual insights, provide mutual support and guidance and to strengthen local capacities. Such collaboration may involve working with local researchers throughout the study, from data collection through to the publication of study findings. Building a trusting relationship with local researchers is central to the pursuit of high-quality research.
- Employ a variety of methods and strategies to manage the impact of a changing context (e.g. use quantitative and qualitative methods **(A.4)** and delayed interventions instead of control groups). Changes the methods during a study may be necessary due to a variety of factors, such as security issues, or large-scale population movements. It can affect the study sample size, choice of study group, choice of data collection tools (changing from face-to-face to remote means), data sources (switching from primary to secondary), the ability to follow cohorts over time and, potentially, the ability to continue the study at all.
- Avoid presumptions of generalisability. For any research study conducted in a specific context, it is unlikely that its findings will be directly applicable to another. In instances where knowledge may have applicability elsewhere, researchers should demonstrate how – if at all – their results are relevant to other settings and crises, to facilitate the uptake of knowledge.

Process and Good Practice

- Collaborate with national or international research organisations and/or other WASH NGOs to minimise or overcome some of the challenges faced when conducting research in humanitarian settings, such as insecurity, an inability to access affected people, the limited availability of adequately trained research staff or a lack of resources.
- Adhere to research ethics; this is crucial in emergencies where crisis-affected people may have lived through traumatic experiences and be very vulnerable. Methods for gaining informed consent must be clearly articulated and studies must incorporate a risk benefit analysis.
- Consider the ethical implications of using control groups carefully – particularly where needs are high.

→ **References and further reading materials can be found on page 294**

Learning: Knowledge Management

Main Purpose

To systematically collect, collate and share knowledge, lessons learned and evidence to improve the quality of hygiene promotion (HP) programming.

Important

- There are significant gaps in knowledge and evidence in the humanitarian WASH sector. Capturing and documenting best practice in HP, identifying new challenges and disseminating innovative approaches is essential to address the emerging challenges in emergencies.
- The 'localisation of humanitarian aid' is an approach that builds on existing local and national knowledge and uses it to design humanitarian WASH responses – the international response complements (rather than replaces) local knowledge. Localisation is very important for HP because it can lead to more effective programmes.
- Better knowledge management systems for HP in emergencies are required at national and local levels to enhance the overall quality of the response and take account of the knowledge and needs of the targeted audiences. A knowledge management system should be included in all preparedness plans.
- Organisational knowledge management is the responsibility of each organisation to fill gaps in knowledge and strengthen institutional capacity in HP.
- Hygiene promotion technical working groups and/or communities of practice are the main fora at response level, where technical and contextual knowledge exchange is encouraged between organisations.
- Briefing papers and conversations with colleagues are the best two sources for accessing humanitarian research, according to a study conducted by the Humanitarian Evidence Programme.
- The integration and implementation of new knowledge and policies in emergency responses often occur slowly and reluctantly, reducing the expected impact of research and evaluations.

Overview

Knowledge management is the process of identifying, capturing, structuring, developing, validating, sharing and using organisational knowledge effectively. It refers to a multi-disciplinary approach to achieve organisational or sectoral objectives by making the best use of knowledge.

Sharing knowledge outside their organisation is an important responsibility for humanitarian organisations. Sharing fosters continuous learning from experience in the sector, encourages a search for evidence and promotes the adoption of learning by key WASH stakeholders. Knowledge management fosters a culture of innovation and reduces the repetition of mistakes in the sector. For example, the Global WASH Cluster's (GWC) Technical Working Group on Hygiene Promotion aims to help the GWC share tools and good practice through existing channels and new platforms. Various approaches also exist to improve the timely, large-scale dissemination of knowledge at a global level including: communities of practices (e.g. in HP, WASH and Nutrition), knowledge exchange and support platforms such as the Sustainable Sanitation Alliance, the Emergency WASH Knowledge Portal, the COVID-19 Hygiene Hub, the International Federation of Red Cross and Red Crescent Watsan Mission Assistant, or the GWC Resource Centre and its planned WASH Knowledge Hub.

At the operational level, the creation of technical working groups is an opportunity to ensure that lessons learned from previous responses and ongoing Monitoring **(M.2)** of the current response lead to real-time knowledge exchange to improve programme quality. The leadership of such a group is critical to its success and depends on the mobilisation of adequate resources (in some cases, a dedicated coordinator may be funded externally) and the willingness of expert organisations to involve their staff in the coordination mechanisms **(P.9)**. Leadership is essential, but the active and inclusive participation of organisations involved in HP is also important. Ensuring accessibility to such meetings and groups is a mandatory requirement; therefore, accessible and appropriate communication channels and technologies must be used.

Regardless of whether the products are oral or written, language and format are important factors to promote their assimilation. Hygiene promotion that encourages and promotes the participation of local communities and stakeholders must be tailored to cultural needs and ensure that learning is accessible to affected communities (though unfortunately, it is not yet common practice to translate all documents into local languages). Finding the right communication channels and networks for the

transmission and transfer of knowledge is essential.

There is no common repository where humanitarian knowledge can be exchanged and shared at local, national or international levels. It is therefore important (depending on the knowledge to be shared) to identify in advance who will be interested in the information and how they will access and integrate it into their programme. Disseminating learning requires dedicated time and resources.

Systematically sharing lessons learned from project monitoring systems, feedback mechanisms and evaluations within and outside the organisation stimulates a culture of exchange. This can take the form of workshops involving local stakeholders, community-based organisations and national and international humanitarian actors. Social Media (**T.44**) can also be a powerful tool for disseminating key findings, testimonials and demonstrations.

Case studies, fact sheets and summaries remain the best tools for sharing knowledge among humanitarian professionals.

For the sector to fully benefit from knowledge gained through earlier interventions, a complete change of mindset is needed amongst HP practitioners. From the outset, HP programme designers need to identify and apply lessons learned from previous interventions to current responses. They should also allocate the time and resources needed to capture and generate new knowledge systematically over the course of their project, enabling other individuals, organisations and ultimately the sector to benefit from their experience.

Process and Good Practice

- Use existing HP knowledge management systems or platforms to identify relevant evidence and learning or to share and promote new learning within an organisation.
- Be actively engaged in the HP technical working group, or similar, to share learning and learn from others.
- Ensure that all key HP materials are translated into the appropriate languages (English, French, Arabic and Spanish are the most commonly spoken in the sector).
- Consider the different levels at which knowledge management is required and make provision for this (e.g. funding and time).
- Encourage an acceptance in the sector to acknowledge failure and success and to use both to improve programming.
- Find ways to share and discuss the outcome of evaluations or research with practitioners at all levels (e.g. operational, policy-makers, local and international).
- Make use of national or international emergency WASH exchange fora, like conferences (e.g. the annual Emergency Environmental Health Forum) or local exchange workshops to continuously learn and share knowledge with other WASH and HP practitioners and researchers.

→ **References and further reading materials can be found on page 294**





PART 2:
Hygiene Promotion
Tools and Methods

This section is a compilation of commonly used hygiene promotion (HP) tools and methods, arranged in alphabetic order. Many tools and methods – especially those that are interactive and stimulate discussion – can be used throughout the programme cycle and for all components of HP. Several tools – even those that are not always interactive – can be adapted and made more so. A key aim of an HP intervention is to influence WASH practices. Most tools support Social and Behaviour Change (chapter B). Some have been developed from specific behavioural change models (B.2) and approaches (chapter F). Not all existing tools are included; the selection is of the current most commonly used tools for a variety of situations. As tools are adapted or developed, they will be added to the online version of the Compendium.

Some tools are suited to specific situations. Others can be used for different phases of the emergency and at various stages in the project cycle (e.g. for assessment, implementation and monitoring). With minimal adaptation, the tools can be used in a variety of settings and with different groups of people. Most of the tools provide a method for investigating and learning about the WASH (or health/hygiene) situation. Many describe ways of engaging the affected population, promoting discussion about the situation and motivating people to address the issues.

The use of the tools and methods must respect the autonomy and dignity of participants. Consent must always be obtained and people given information about the process and how their data will be used and stored. Knowledge and information should be gathered to address the community's needs, not for its own sake. The tools must be used to build people's confidence and self-esteem rather than to make them feel small or inadequate. Participatory tools and methods are underpinned by a particular philosophy and set of values. They aim to provide a voice to people from diverse backgrounds and identities and involve the affected community in identifying collective solutions to the specific problems faced. People are not passive information providers; they are active investigators of solutions to improve their situation.

Many of the tools facilitate participation and accountability in a WASH programme because they emphasise the importance of listening to affected communities and of using dialogue and discussion to understand the particular issues faced by that community. All the tools should be implemented using the essential considerations and practices that underpin accountability, safeguarding and working with children, outlined on the following pages.

Accountability and Safeguarding Good Practice

- Consider the risks and benefits of participation and only use a specific tool or method where it has the potential to be relevant and useful.
- Seek the informed consent of those participating and explain who you are and why they are being invited to participate – use language that is clear and easy to understand and allow people to ask questions.
- Make sure participants are clear about the process and intention of the discussion or activity and what will happen to the information gathered.
- Treat people with respect – start by introducing yourselves and end with an overview of what has been discussed. Thank participants for their time and inputs.
- Obtain permission to record any session (whether through video, photograph, sound recording or written notes) before starting and explain to participants how this data will be used and stored.
- Respect people's wishes about visual recording, e.g. if people are reluctant to have their photograph taken.
- Take care when and if obtaining people's names and explain how names might be used, e.g. as a caption for a photograph, used anonymously or as a community record.
- Clearly explain the implications of participation and manage expectations (people sometimes feel that giving their names will involve some benefit in cash or kind).
- Consider the protection of participants and especially of vulnerable persons (such as minors and persons with illness or disability). Giving people who are often marginalised a voice can cause tensions and challenge patterns of dominance and power and it is important to be aware of this.
- Ensure the confidentiality of the information collected.
- Ensure that people with disabilities are not excluded and that the location is accessible. They (and others) may feel more comfortable with a support person or need interpreters (e.g. if they have trouble with vision and/or hearing). They may also need separate sessions/activities due to discrimination and community perceptions or biases.
- Check if permission from local authorities is required and, in the case of more formal surveys, check if the survey protocol has to be submitted to the relevant review board to ensure the proposed data collection meets international ethical standards for research involving human subjects.

- Provide adequate training and support (including debriefs and periods of reflection) on the use of the tools for new staff, volunteers and interpreters.
- Be aware that people's experience of participation is often varied; some may mistrust the process. Some activities may be more successful if there is an ongoing relationship with community members and when trust is established.
- Consider gender specific consultations (e.g. use of female staff for Menstrual Health and Hygiene (P.7) and related topics) or the use of private, safe places when addressing gender sensitive issues or working with marginalised groups.
- Be aware that in some situations, e.g. densely populated urban areas, the sense of community may be non-existent. In many situations effective use of the tools may involve navigating community dynamics of power and vulnerability.
- Ensure that people working with the community know where to refer people for additional support or services if needed (e.g. if someone discloses sexual or gender based violence, or a breach of the Code of Conduct) and where and how to complain or provide feedback.

Working with Children

- Consider the appropriate minimum age of the children who are participating.
- Obtain informed consent from a parent or primary caregiver.
- Ensure the confidentiality of the child's information.
- Be aware of procedures, including the responsibility to report if a child discloses abuse during an interview or activity. This is a priority safe-guarding issue and must be carefully planned for, in advance, when working with children.
- Consider how to manage children's and parents' expectations of support after the activity has been completed.

To support the context-specific selection of appropriate tools and methods the matrix on page 168 and 169 provides an overview of all tools and methods covered in this publication classified in relation to some key selection criteria. It can provide an initial indication of which tools and methods may be suitable for a particular context. The matrix is divided into four categories: HP Component, Response Phase, Target Group and Application Level.

The **HP Component** category refers to the six key HP components described in the first section of this Compendium. This category indicates whether the tools and methods are commonly used in relation to the components in the six chapters of Preconditions and Enabling Factors (P), Community Engagement and Participation (E), Assessment, Analysis and Planning (A), Communication (C), Social and Behaviour Change (B) and Monitoring, Evaluation, Accountability and Learning (MEAL) (M). An indication of whether a tool or method is linked to any of the HP components is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

The **Response Phase** category indicates which specific tool or method is appropriate and suitable in which phase of the response. It is subdivided into the phases of acute response, stabilisation, recovery, protracted crisis and development. An indication of a tool or method's suitability for each phase is provided using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable). The level of appropriateness is selected through a comparison between the different tools and methods, mainly based on the criteria of applicability and speed of implementation.

The **Target Group** refers to different population groups whose participation could be enhanced through using a specific tool or method. It is subdivided into children, adults, older people, people with disabilities, local leaders and/or the society as a whole. An indication of whether a tool or method is suitable at targeting a specific segment of the population is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

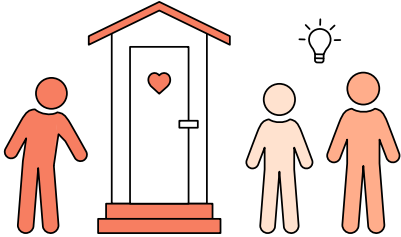
The **Application Level** refers to the different environments and scale for which the tools and methods are most appropriate. It is subdivided into individual/household, community/municipality, institution, camp, rural and urban contexts. An indication of whether a tool or method is suitable at a specific spatial level is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

Tools and Methods Matrix

**** Two asterisks: suitable**
*** One asterisk: less suitable**
No asterisk: rarely suitable or unsuitable

		HP COMPONENT						RESPONSE PHASE				
		Preconditions and Enabling Factors	Community Engagement and Participation	Assessment, Analysis and Planning	Communication	Social and Behaviour Change	Monitoring, Evaluation, Accountability and Learning	Acute Response	Stabilisation	Recovery	Protracted Crisis	Development
T.1	Accessibility and Safety Audit	*	**	**	**	*	*	**	**	**	**	**
T.2	Assessment Checklist	*	*	**	*	*	*	**	**	**	**	**
T.3	Barrier and Motivator Analysis	*	*	**	**	**	*	*	**	**	**	**
T.4	Beautification	*	**		*	*		*	*	**	**	**
T.5	Care Groups		**		**	**		*	**	**	**	**
T.6	Community Drama, Cinema and Puppets	*	**	*	**	*		*	**	**	**	**
T.7	Community Mapping	*	**	**	**	*	**	*	**	**	**	**
T.8	Competition	*	**	*	**	**	*		*	**	*	**
T.9	Cues and Nudges	*	*	*	*	**	*	*	**	**	**	**
T.10	Demonstration, Show and Tell	*	*		**	*	*	**	**	**	**	**
T.11	Events		**		**	*			*	**	*	**
T.12	Exchange Visit	*	**		**	*	*		*	**	*	**
T.13	Feedback Mechanism	**	**	*	**	*	**	**	**	**	**	**
T.14	Focus Group Discussion (FGD)	**	**	**	**	*	**	**	**	**	**	**
T.15	Games and Toys		**	*	**	*	*	*	**	**	**	**
T.16	Gender Analysis	*	**	**	**	*	*	**	**	**	**	**
T.17	Health Surveillance Data	*	*	**	*	*	**	**	**	**	**	**
T.18	Household Visit	*	**	**	**	**	**	**	**	**	**	**
T.19	Information, Education and Communication (IEC)		*	*	**	*	*	**	**	**	**	**
T.20	Institutional Checklist	*	*	**	*	*	**	*	**	**	**	**
T.21	Integrated Behavioural Model (IBM) for WASH	**	*	**	*	**	**	*	**	**	**	**
T.22	Involvement of Local Champions		**		**	**		**	**	**	**	**
T.23	Key Informant Interview	**	*	**	**	*	**	**	**	**	**	**
T.24	Knowledge, Attitude and Practice (KAP) Survey	*	*	**		*	**	*	**	**	**	**
T.25	Logical Framework Analysis and Problem Tree	**	*	**	*	*	**	**	**	**	**	**
T.26	Most Significant Change (MSC)	*	**	*	**	*	**	*	**	**	**	**
T.27	Motivational Interviewing		**		**	**		**	**	**	**	**
T.28	Observation	**	*	**		*	**	**	**	**	**	**
T.29	Peer Education (Child-to-Child)		**	*	**	**	**	*	**	**	**	**
T.30	Photo Voice and Participatory Video	*	**	**	**	**	**	*	**	**	**	**
T.31	Pocket Chart Voting		**	**	**	*	**	*	**	**	**	**
T.32	Positive Deviancy and Doer / Non-Doer Analysis	*	*	**	**	**	*	*	**	**	**	**
T.33	Print Media		*		**	*		**	**	**	**	**
T.34	Proportional Piling	*	**	**	**	*	**	*	**	**	**	**
T.35	Protection Mainstreaming	**	**	**	*	*	**	**	**	**	**	**
T.36	Public Announcement		*		**	*		**	**	**	**	**
T.37	Public Commitment		*		*	**			**	**	**	**
T.38	Radio and Television (TV)		*		**	*		**	**	**	**	**
T.39	Ranking	*	**	**	**	*	**	*	**	**	**	**
T.40	Rewards and Incentives	*	*		*	**		**	**	**	**	**
T.41	Role Play	*	**	*	**	*	*	*	**	**	**	**
T.42	Routine Planning and Self-Regulation		*	*	*	**	*		**	**	**	**
T.43	Seasonal Calendar	*	**	**	*	*	*	*	**	**	**	**
T.44	Social Media and Text Messaging		**	*	**	*	*	**	**	**	**	**
T.45	Social Norms and the Use of Shame and Disgust	*	*		*	**			*	**	**	**
T.46	Social Support	*	**		*	**		**	**	**	**	**
T.47	Songs and Stories		**		**	*		*	**	**	**	**
T.48	Spidergram	*	**	**	**		**	*	**	**	**	**
T.49	Stakeholder Mapping	**	*	**	*	*	**	**	**	**	**	**
T.50	Supervised Handwashing		*		**	**	*	*	**	**	**	**
T.51	Three-Pile Sorting	*	**	**	**	*	**	*	**	**	**	**
T.52	Transect Walk	*	**	**	*	*	**	**	**	**	**	**
T.53	Transmission Routes and Barriers (F-Diagram)	*	*	**	**	*	*	**	**	**	**	**
T.54	Venn Diagram	*	*	**	**		*	**	**	**	**	**
T.55	WASH Committee	**	**	*	**	*	**		**	**	**	**

Accessibility and Safety Audit

<p>Purpose To assess how to improve the access and safety of WASH facilities</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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An Accessibility and Safety Audit is carried out on-site through a small group discussion about safety and access to identify problems and make design improvements. Discussions held at the location where people collect water or go to the toilet can be more practical and effective than relying on recall.

Issues are explored by walking around the water or sanitation site and engaging people in discussion about how they use it and how it might be improved. Discussion points include ‘can people with mobility problems access the facilities comfortably? Does it offer enough privacy? Do people feel safe using it during the day and night? Is there enough space for carers to take children to the toilet? Are the handwashing facilities accessible and easy to use? What solutions can be suggested for the current problems?’ The audit can be carried out in different ways, with different groups and at different WASH sites. It takes between 10 minutes and one hour. Checklists (T.2) can help ensure that all the key issues are covered and can be filled in by a facilitator or participants. It is preferable to work with small groups who are comfortable with each other, but it is possible to work with only one or two people who happen to be at the site at the time of the visit. Women or men-only groups (including the facilitator) might elicit more open responses. Adolescent girls may prefer to try it on their own and give feedback to a facilitator or teacher they know. For shared facilities it can be useful to share the results with other similar groups to reach a consensus. For households, changes can be initiated by members of the household if they have the resources.

Applicability: It can be used in all phases of the emergency and in most contexts with WASH facilities. It can also be used in areas where people go to defecate. To draw out people’s suggestions and get the best from the tool, people will need to feel comfortable with each other and with the facilitator.

😊 Do

- Where possible, involve WASH engineers and all those constructing the facilities
- Compile a Checklist (T.2) to remind and guide facilitators. Train facilitators by repeating the exercise several times
- Include people with a variety of disabilities
- Explain why some suggestions for improvements might not be possible or realistic and encourage practical suggestions

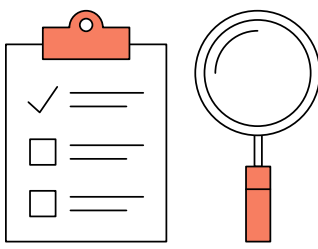
😞 Don’t

- Do not work with larger groups (five to eight people maximum)
- Do not raise people’s expectations for changes that are not feasible

Practical Example: The Women’s Refugee Commission completed a research mission to the Jijiga Somali refugee camps in Ethiopia to listen to Somali refugees and learn what measures would enable refugee adolescent girls to safely become resilient, self-reliant and leaders in their families and communities. Among other approaches, they used Safety Audits to understand the situation. The young Somali women said they feared harassment and attack by, ‘hyenas, lions snakes ... and men’, particularly when collecting water and firewood. Amongst various recommendations they identified the importance of locating water points closer to girls’ housing (not only at male-dominated areas such as mosques and sports fields) and sturdy doors and locks for latrines.

→ **References and further reading material for this tool/method can be found on page 294**

Assessment Checklist

<p>Purpose To help gather assessment information</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

An Assessment Checklist acts as a guide for appropriate data collection in an assessment (chapter [A](#)). Generic checklists, such as the Assessment Checklist in the WASH chapter of the Sphere handbook, need adapting to the specific context. Checklists are also recommended for collecting data during Observation (T.28) and Transect Walks (T.52).

Assessment Checklists help ensure that all the key points are covered. They act as a focus, springboard and aide-memoire for more specific questions. Not all the points in the checklist may be relevant; it is important to discuss and agree on the most appropriate issues and specific questions according to the context. A checklist is more than a list of questions; it should link with other assessment methods, both qualitative and quantitative ([A.4](#)). An Assessment Checklist can help to prioritise whether an intervention is needed and the likely scale of the response. It is useful to assess WASH needs, identify available resources, describe local conditions and collect information on demographics, hygiene behaviour and public health. The checklist should encourage the assessors to consider all the groups in the community including men, women, children, older and vulnerable people, engaging with them and understanding their views and preferences. Checklists are also a useful tool for coordinating with others ([P.9](#)). The Sphere WASH assessment checklist helps plan joint assessments and the findings can then be shared and used for decision making. Care should be taken to select only those questions that are necessary, to avoid wasting respondents' time and raising expectations. Checklists will need to be translated, copied and printed; assessment teams will need training in their use.

Applicability: Assessment Checklists are important in all emergencies, but especially during the acute response. The advantage of a checklist is that it guides the assessments. The checklist can be prepared during emergency preparedness and quickly adapted when needed.

In a rapid assessment, the checklist will need shortening to prioritise the most urgent and important assessment points. As the situation changes, ongoing assessment will be needed and the checklist may need adapting. It is useful to coordinate assessments and share, discuss and combine checklists.

☺ Do

- Adapt generic checklists to the context
- Be open to new emerging information and update the checklist as needed
- Attach the Assessment Checklist to the assessment report

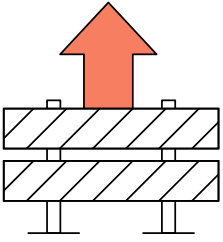
☹ Don't

- Do not raise community expectations by asking a long list of questions about issues beyond the programme's scope or resources
- Do not use the checklist as you would a questionnaire: remember to listen, consult and engage with people

Practical Example: After the earthquake in Nepal, several WASH teams were doing rapid assessments in different areas. One sanitation team was focusing on hygiene promotion and sanitation. They used a standard checklist from their organisation and the Sphere checklist. They took the most critical points from the two lists and shared the checklist with teams in other areas to aid comparison and decide priorities. After the programme began further points were added to the checklist. This enabled the team to gather more information, build on the initial rapid assessment and deepen their understanding of the situation.

→ **References and further reading material for this tool/method can be found on page 294**

Barrier and Motivator Analysis

Purpose To identify and understand behavioural determinants 	HP Component <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★ MEAL 	Target Group <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	Response Phase <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	Application Level <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Barrier and Motivator Analysis will help to understand people's behaviour and what motivates their behaviours by assessing the factors that help or hinder behaviour change. This in-depth analysis can be done in a variety of ways.

Behaviours are influenced by numerous factors including context, beliefs, values and social pressure (**chapter B**). Most human beings, regardless of their physical, cultural and social context, share key drivers and emotions that are good for their survival. Such universal drivers include affiliation to a certain group; attraction (a tendency to be attracted to and want to attract, high-value mates); nurture (a tendency to want to care for offspring); comfort (a tendency to place oneself in optimal physical conditions) and fear (a tendency to avoid objects and situations that risk injury or death). Motivators are positive drivers that motivate people to practise healthy hygiene behaviours and barriers are factors that prevent people from doing so. Barriers can be physical (access to facilities such as soap, water, suitable toilets), social (norms and customs, lack of trust in health workers and health information) and biological (mental state). The analyses usually require the collection of both qualitative and quantitative data (**A.4**) but, in the acute response phase, there may not be time to conduct a quantitative survey. Assessment techniques such as Focus Group Discussions (**T.14**) and Key Informant Interviews (**T.23**) can provide insights about existing barriers and motivators. It can also be helpful to conduct a Doer/Non-Doer Analysis (**T.32**) using both qualitative and quantitative data (**A.4**). Findings may influence the selection of promotional activities and the formulation of hygiene messages in a behaviour change plan. The analysis of barriers and motivators for hygiene promotion (HP) should be part of the general assessment and not a separate exercise.

Applicability: Barriers and Motivator Analysis is applicable in all contexts and should be used in the initial phase of an assessment before implementing any HP activity. However, a more structured Doer/Non-Doer Analysis (**T.32**) will usually require more time and may not be possible in the acute phase.

😊 Do

- Listen carefully to a variety of stakeholders
- Do consider both the priority groups that you want to work with (e.g. mothers of young children) and those who might influence them (e.g. grandmothers)

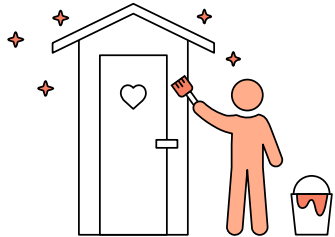
☹ Don't

- Do not make assumptions about what will motivate or hinder behaviour based on your own perspective
- Do not focus on one single barrier (e.g. lack of knowledge) but consider all socio-cultural, environmental and physical barriers to change

Practical Example: WaterAid carried out formative research in five countries in Southern Africa to identify drivers and barriers for key hygiene behaviours such as handwashing with soap, food hygiene or latrine use. Common barriers identified included a lack of facilities, poor construction quality, limited privacy, soap considered to be an expensive commodity and the time, distance and queues when collecting water. Motivations ranged from disgust at having something dirty or disease-causing on your hands, to affiliation and the wish to be judged positively by peers. Other drivers found to motivate construction and the use of latrines included by-laws or sanctions established at a local level with penalties such as fines and livestock confiscation for non-compliance.

→ **References and further reading material for this tool/method can be found on page 294**

Beautification

<p>Purpose To encourage the sustainable use and care of WASH facilities and promotional material</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Beautification aims to enhance the look, appeal and usability of WASH facilities, such as toilets and handwashing systems, hygiene promotion (HP) materials and products and to create a sense of ownership of the facilities and the products. It requires Community Engagement (chapter [E](#)) so that community members are part of the process.

Beautification can be applied to facilities such as drinking water stations, pumps, handwashing stations, shared or public toilets and HP materials like print media. Beautification makes the landscape around facilities or displays more attractive by e.g. adding colour and lighting to make the product visually appealing. It also aims to spark the interest of the target audience to use, own and maintain the facility or to read and use the HP materials. The appearance of a healthcare facility, public space or school can make it become a source of pride and a valued feature in the community. Beautification can be done by painting the facility or putting artwork or promotional material on the walls. Plants, gardens and lighting around the facility can also enhance its visual appeal and make it more attractive to use. It is essential to use culturally appropriate materials, colour and design, hence discussion with community members is important. Beautification of facilities can be done quickly and the community often initiates, leads and manages the process with minimal support. Although Beautification does not directly influence behaviour, it can lay the foundation for the target audience to appreciate, use and maintain the facility or to read the promotional material.

Applicability: Beautification of WASH facilities can be done in all settings but is usually most appropriate during the stabilisation and recovery phases and where facilities are more permanent. The Beautification of HP communication materials can be done in all phases of the response. If materials are not available, Beautification may require funding and innovation may be needed to make it cost-effective. For example, by using traditional methods of home decoration for latrines or recycling and adapting local materials.

☺ Do

- Use locally available materials, plants etc. and make use of the skills of local artists
- Involve the local leadership ([T.22](#)), community and children of different ages, especially at the beginning
- Conduct Beautification Competitions ([T.8](#)) among communities or schools

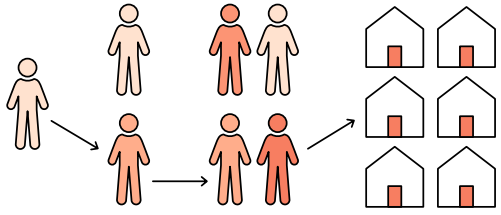
☹ Don't

- Do not design Beautification using expensive or imported materials or expertise
- Do not take over the process and make all the decisions; put those using the facility in charge
- Use long-lasting materials

Practical Example: The first lady of Malawi launched colourful handwashing stations as part of a beautifying Malawi campaign and as a COVID-19 pandemic response. Handwashing facilities were placed in public spaces with colourful boards and awareness pictures.

→ **References and further reading material for this tool/method can be found on page 295**

Care Groups

<p>Purpose To facilitate peer-to-peer outreach in the community on relevant hygiene issues</p> 	<p>HP Component</p> <ul style="list-style-type: none"> Preconditions & Enabling Factors ★★ Community Engagement & Participation Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> Children ★★ Adults ★ Older People ★ Persons with Disabilities Local Leaders Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality Institution ★★ Camp ★★ Rural ★ Urban
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A Care Group is a group of 10–15 community-based volunteer promoters who agree to regularly visit 10–15 of their neighbours and share behaviour change communication about health and hygiene.

A Care Group meets regularly with a trained extension or project worker for support, training and supervision and to discuss problems or successes encountered in their neighbourhood household visits. This is a cascade model based on Peer Education (T.29). The model can be used with a variety of groups but is usually associated with mothers of young children with a focus on maternal and child health. Some programmes stipulate at least one pregnant or lactating mother as a criterion for the visited households. Others may include a household with children under two or five years. The trained mothers are role models in their community. They are chosen by neighbours based on various criteria, usually including basic literacy and numeracy to ensure accurate reporting and record-keeping. The number of households that they cover is kept low (10–15 households) so that volunteering does not become too time-consuming; it is expected that members will visit each of their assigned households twice monthly. The Care Group is also limited in size to facilitate effective interactive and participatory learning. The groups are usually provided with visual aids (such as flipcharts) to support their work. Care Group meetings should follow a specific structure and include objectives, Games (T.15) or Songs (T.47), trouble-shooting, learning about and trying out a new behaviour, exploring barriers and solutions and making a commitment to practise. The Household Visits (T.18) can then follow a similar structure. Supportive supervision observing household visits and giving feedback should also be carried out.

Applicability: This method is used in development settings but can be adapted to acute settings in which more frequent visits may be needed and members may cover fewer households.

Do

- Work closely with the community to design and implement the Care Group approach
- Identify Care Group volunteers with the community, based on agreed criteria
- Meet regularly with the Care Group and provide supportive supervision

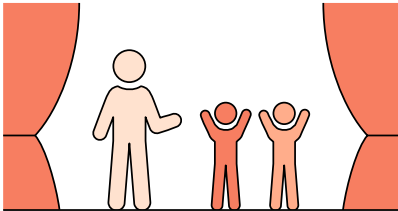
Don't

- Do not have too many volunteers in each Care Group
- Do not give each Care Group volunteer too many households to visit
- Do not neglect accurate record-keeping to monitor and evaluate the outcomes of the Care Group Programme

Practical Example: The Care Group approach has been used in over 28 countries in development and emergency contexts by different organisations and some governments. World Vision began piloting the Nurturing Care Groups (NCGs) approach with a WASH focus in Ghana in 2019. In two districts 108 NCGs were established reaching 75,000 people. The behaviours targeted through the leader mothers included ending open defecation and handwashing with soap at critical times. A 2021 evaluation revealed that the NCGs had a significant impact on indicators such as reducing detectable E. coli in drinking water from 32 % to 8 % and increasing the availability of soap from 34 % to 84 %. Access to basic sanitation only increased slightly (7 percentage points more than the control group), but there was evidence of improvements in animal penning and reduced stigma toward menstrual hygiene management.

→ **References and further reading material for this tool/method can be found on page 295**

Community Drama, Cinema and Puppet Theatre

<p>Purpose To disseminate information and promote discussion in a fun way</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Community entertainments such as Drama, Puppet Theatre or Cinema are lively entertaining methods that can be used in WASH programmes to share information and promote healthy hygienic behaviour. Used with other hygiene promotion (HP) methods, these entertainments can be very effective for all ages, especially children.

Community Drama can be done by professional actors, hygiene promoters or community members with some training and basic props, e.g. relevant local costumes and hygiene items such as soap. Puppets can be made easily from locally available materials and they can be animals or human characters. A sheet or curtain can be used for the performers to hide behind. Community cinema can involve the showing of locally produced films shot on mobile phones (T.30) and projected onto a building wall or, with appropriate permission, commercially produced films. Shows should have simple context-based easily-followed plots, a few actors or puppets and lots of action using a few simple key messages. Frequent repetition of the messages using loud and slow speech is useful. Puppets should be as active as possible, e.g. nodding and moving when talking. The dramas can include comic stereotypes, with exaggerated characterisation and local references to keep the audience interested. When showing a film it is sometimes useful to stop the action at key points and discuss it with the audience. Films can be made engaging with music and Songs (T.47). All shows should be short (about 15 minutes) to keep the audience engaged. They can take time to prepare and rehearse. Community members can be involved in the plot and prop decisions and as well as acting. Discussion following the show is encouraged to ensure that the audience has grasped the main points; key actions can also be agreed upon.

Applicability: Community entertainment is appropriate in many contexts – camps, towns and villages. Shows can be performed in the street or at a specific venue. They can be used at any time in the programme after the initial assessment. Shows can also be used as a learning tool for training hygiene promoters. Unlike Role Plays (T.41) which can be done quickly, shows take time to prepare and rehearse. Care must be taken that they are not only fun, but effective at promoting healthy hygiene behaviour.

☺ Do

- Encourage audience participation
- Focus on a few simple messages, with short plots that are relevant to the context
- Use comic sound effects, e.g. a young child going to the toilet

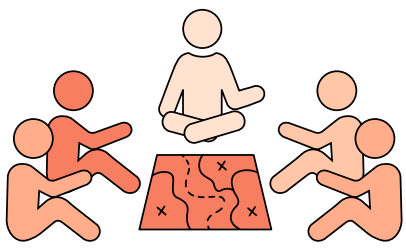
☹ Don't

- Do not talk too quickly or use complicated terms – keep it simple and easy to understand
- Do not have several characters talking at the same time

Practical Example: Puppet Shows were popular as part of an HP programme in a camp in Greece. Two Syrians in the camps were given some cloth and thread and they made a variety of puppets – some animals and some depicting themselves and the HP volunteers. The team of volunteers from the camp made up stories based on relevant topics such as rubbish disposal and handwashing. They then performed the puppet shows with small groups of children and followed up with them afterwards to reinforce appropriate behaviour change.

→ **References and further reading material for this tool/method can be found on page 295**

Community Mapping

<p>Purpose To jointly visualise a local situation and encourage community discussion about how to improve hygiene</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Community Mapping is a participatory learning and action tool used with groups to visualise and provoke discussion about their community and identify actions on health or social issues such as inadequate hygiene.

Community Mapping is a tool that enables a community group to visualise their situation more objectively. The tool can provoke discussion between community members about community issues. It can be a one-off activity or a longer-term progress monitoring process. A group of community members is invited by a facilitator to draw a map of their community, or section of the community, on a large sheet of paper or the ground and to mark the main roads and landmarks. The group should be in charge of drawing the map. If it is being drawn on the ground, sticks, stones, leaves or waste material can be used to construct it. The facilitator's role is to guide the process, help to provoke discussion and encourage the group to identify areas of high hygiene risk e.g. of open defecation, households without latrines, mosquito breeding sites or accumulated solid waste. Maps can be drawn with different groups and in different locations and should remain the property of the group that drew them. Photographs or copies should be made with their permission for programme records. Before and after maps can be used as monitoring and evaluation tools. A community map can take some time (up to three hours) but the progression from discussion to action can take a lot longer. It is important to be aware of the demand the exercise can make on community members' time. Mapping usually works better with a small group of between 15–20 people and therefore needs to be repeated several times to ensure adequate triangulation.

Applicability: This tool can be used in any setting but works best with a group that shares something in common and trusts each other. The process can take time and may not be appropriate during an acute response. It requires a trained facilitator, but the technique can be learned quickly, improved through use and therefore be quickly scaled up. An additional facilitator is useful for recording notes and observations.

☺ Do

- Be aware of who is participating and who may find it difficult to contribute and why
- Consider gender differences and work with women and men separately and together
- 'Hand over the stick' and allow community members to control the process and drawing of the map
- 'Interview' the map by asking questions to confirm, clarify or identify WASH issues


☹ Don't

- Do not stick rigidly to the rules but be flexible about the process and allow people to be creative
- Do not teach but encourage people to discuss between themselves

Practical Example: Community Mapping was used in a Southern Gobi programme to map the availability of water resources, understand the problems faced by communities to access them and generate community solutions. The map provided a spatial overview of the quality and availability of water in the region (e.g. the number and functionality of wells, water collection methods and routes and livestock and vegetation levels around the wells). The exercise enabled community members to express their concerns visually and discuss potential solutions.

→ **References and further reading material for this tool/method can be found on page 295**

Competition

<p>Purpose To provide incentives and a framework to initiate joint action</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★ Older People ★★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> Acute Response ★ Stabilisation ★★ Recovery ★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Competitions aim to initiate group or individual action towards a common goal by providing incentives to win a WASH-related challenge. Competitions are commonly held in school settings, but can also be carried out at a community level e.g. in hygiene, health or WASH clubs.

Competitions utilise the creativity, motivation and collaboration of and between participants to encourage individual or collective behaviours and actions. They make positive use of the competitive element of peer pressure (e.g. between schools) and the prizes/incentives offered. Through their participation in a shared process, teams or individuals own the results and are more likely to implement them and adapt their behaviours. Potential themes include handwashing, the use and design of toilets, practical hygiene actions or preventing water wastage. Incentives do not have to be financial rewards. They can be non-cash prizes such as certificates or recognition (e.g. participation and honouring at public events like an award ceremony). In many cases, simply participating is beneficial (regardless of winning a prize) through gains in knowledge, the enjoyment of group activities or from a positive group dynamic and shared achievements. Publicly advertised Competitions can spread key messages to a wider range of stakeholders. Competition judges can learn a significant amount during the process by analysing specific evaluation criteria. The implementation process includes conceptualisation and material development, identification of context-specific prizes, communication with target groups, selection of judges, development of evaluation criteria and the planning of the launch and award ceremony. Competition has to be considered sensitively to avoid creating tension between different groups. Depending on the scale, implementation can take several days/weeks to months; it also depends on the availability of the target group. Seasonal aspects may also affect active participation (e.g. exam periods, school holidays or harvesting time).

Applicability: Simple Competitions may be feasible during the stabilisation phase. Bigger contests requiring the use of existing institutional and communication structures may only be possible in recovery or development. Competitions can be conducted in schools, communities or camps. They are often conducted with children, who can be more receptive to playful interactions and may also involve their families in the process.

☺ Do

- Ensure sufficient resources to prepare the Competition and support participants
- Use public events or involve celebrities to motivate participants and gain public attention
- Provide easy-to-read and visual guidance materials

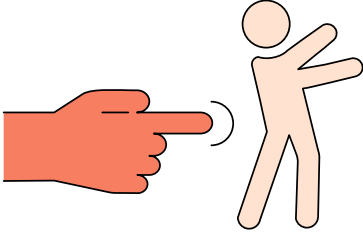
☹ Don't

- Do not let the Competition focus only on e.g. dance, poetry or paintings, but ensure a WASH-related focus and outcomes
- Do not favour certain groups through better access to materials or a lack of transparency in the evaluation
- Do not only honour winners but also recognise the efforts of all other participants

Practical Example: Toilets Making the Grade (TMG, F.12) is a school sanitation and hygiene Competition developed by the German Toilet Organization that triggers teamwork between school management, administration, parents, learners and maintenance staff to jointly develop context-specific solutions that schools can implement based on a guided self-assessment. TMG aims for school-led WASH improvements, capacity strengthening for local government and extended public and policy advocacy. It was piloted in Germany and is currently being implemented in Uganda, Pakistan and Jordan.

→ **References and further reading material for this tool/method can be found on page 295**

Cues and Nudges

<p>Purpose To encourage the desired behaviours by making them easier, more accessible and attractive</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Cues and Nudges are used to encourage behaviour change (B.7), facilitating rapid and improved individual decision-making through small changes to the environment. They make use of mental shortcuts so that the desired behaviour is actively supported or encouraged by the environment itself.

Cues and Nudges are based on the assumption that there are two main systems of thinking. System 1 represents fast, auto-pilot, intuitive thinking and decision making and system 2 represents slow, complex and rational thought. System 1's quick-thinking quality makes it highly receptive to social and environmental cues. Hence focusing behavioural change efforts on Cues and Nudges can encourage rapid behaviour change as well as improve the speed and efficiency of system 2. Specific types of Cues and Nudges vary; their design can be creative. Three main types can be planned **(1)** Default – the process of setting up a particular choice or behaviour as the default, so that people must consciously choose to opt-out, **(2)** Salience – to increase the availability or prominence of the prompts to behave in the desired way and **(3)** Social proof – utilising the tendency to follow what others, particularly peers, do (Social Norms, **B.6** and **T.45**). WASH programmes have mainly drawn on 'salience and social proof'; examples include installing mirrors at washbasins (to encourage use of the washbasin), using a path of brightly coloured floor tiles or painted footsteps leading to the handwashing area in schools (also turning it into a game), using other visual Cues such as arrows on the ground, or the use of the fly or bottle top 'target' in men's urinals. Cues and Nudges can be implemented quickly and at a relatively low cost.

Applicability: The tool is appropriate in most contexts and phases but may not be a priority in the initial phase of an emergency. The evidence supporting Cues and Nudges in humanitarian settings is limited but encouraging. The approach is inexpensive and can be rapidly implemented.

☺ Do

- Conduct an assessment of the target group, behaviours and available or required resources (e.g. hardware, enabling products) to develop tailored, context-specific Cues and Nudges
- Listen carefully to different community members to help identify potential Cues and Nudges

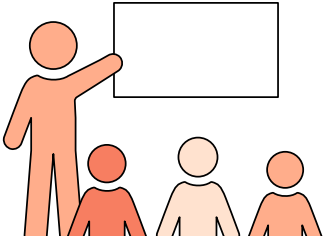
☹ Don't

- Do not use Cues and Nudges as a single approach. The method should be used alongside other interventions
- Do not confuse the tool with mandatory laws e.g. for vaccination. Cues and Nudges are 'carrots' not 'sticks'

Practical Example: Splash in Nepal incorporated Nudges into a comprehensive behaviour change strategy. Handwashing rates increased from around 9% to more than 65% after using a combination of infrastructure, education and Nudges. Students showed a significant preference for using sinks with mirrors, even when those sinks were further from a latrine. A study of Save the Children, Bangladesh looked at a set of Nudges implemented to encourage handwashing with soap after toilet use in two schools. Handwashing with soap among school children was low at baseline (4%), increasing to 68% the day after the Nudges were completed and 74% at both two and six weeks after intervention.

→ **References and further reading material for this tool/method can be found on page 295**

Demonstration, Show and Tell

<p>Purpose To support the adoption of a new behaviour or the correct use of new/innovative items</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Demonstration is a useful tool for working with priority or influencer groups. It can support an individual's belief in their capacity to execute the targeted behaviour effectively or use and maintain an item appropriately (B.4).

Through demonstration, visual and verbal explanation, the target audience can learn to use and maintain an item or perform something effectively and correctly. It could be used to introduce new technology such as household water treatment (P.3), a handwashing station (P.2), menstrual products (P.7), mosquito nets (P.5) or for a behaviour such as handwashing with soap. Practising and explaining each step is effective, as people tend to believe what they see and feel comfortable if they are able to do it themselves. Demonstrations can address common problems people may face when performing the required behaviour and provide tips and tricks to overcome them. Demonstrations can take place at distribution points, small local meetings or gatherings or in institutions such as schools or health facilities. Volunteers can be trained to conduct demonstrations in their communities. In some cases, Demonstration by specialists may be more convincing; the choice should be based on a preceding analysis of the motivations for behaviour change and the influential groups. Demonstrations are also useful in training because they allow for the practice of skills learned. The more interactive the demonstration, the more effective it will be. It must therefore be conducted in local languages and in living situations to make it as real as possible for participants. Demonstrations are not effective on their own; they must be part of a wider behaviour change strategy (chapter B). They are often accompanied by information, education and communication materials (T.19) which can increase the effectiveness of a Demonstration by illustrating the target behaviour.

Applicability: Demonstration is a universal tool and can be used in any situation and with different target groups. They are more effective in smaller groups and should be adapted to the needs and level of understanding of each specific group. Increasing the coverage of demonstrations, therefore, requires the identification, training and support of outreach networks; Demonstration kits should be provided.

😊 Do

- Demonstrate in real-life contexts using the same equipment that the audience expects to use
- Make time to answer questions posed by the audience and be prepared to repeat the demonstration
- Budget to train and equip outreach workers to perform demonstrations

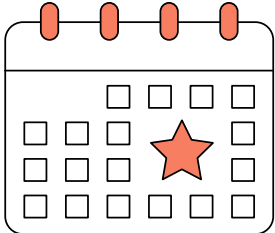
😞 Don't

- Do not use alternative similar items (e.g. a different water treatment product to the one being distributed) or modify the target behaviour for the purpose of the demonstration
- Do not cut corners or speed up the Demonstration as you become familiar with doing it

Practical Example: In 2011, during a cholera outbreak in Haiti, Oxfam trained community volunteers in affected communities on household water treatment before, during and after the distribution of chlorine tablets to ensure their correct use. Chlorine tablets were new to the communities and some people believed that they were medical pills and were scared to use them. Demonstrating at a community level and practising with the communities using their own water sources helped to build trust in the household water treatment.

→ **References and further reading material for this tool/method can be found on page 295**

Events

Purpose To benefit from the energy and commitment of all stakeholders and create momentum to galvanise action 	HP Component Preconditions & Enabling Factors ** Community Engagement & Participation Assessment, Analysis & Planning ** Communication * Social & Behaviour Change MEAL	Target Group ** Children ** Adults ** Older People ** Persons with Disabilities ** Local Leaders ** Society as a Whole
	Response Phase Acute Response * Stabilisation ** Recovery * Protracted Crisis ** Development	Application Level Individual/Household ** Community/Municipality ** Institution ** Camp * Rural ** Urban

Many WASH issues hold dedicated days of celebration that are recognised worldwide. They aim to raise awareness and advocate for improved access and the use or funding of facilities such as toilets or menstrual hygiene. Campaigns often have a specific overall theme each year. These Events provide an opportunity for leaders and governments to pledge their commitment to water, sanitation and hygiene and to influence others.

Globally recognised days for hygiene, such as Global Handwashing Day, play an important role in creating awareness about worldwide campaigns and provide an opportunity for stakeholders such as governments, international agencies and NGOs to show their commitment towards achieving a common goal. During these Events, new and creative campaigns are launched, tested and replicated worldwide to encourage the target audience to take up practices such as handwashing or to gain more knowledge on topics such as Menstrual Health and Hygiene (P.7). Hygiene promotion programmes can customise the celebration for their context and often guidance is provided about how to do this. The length of preparation may vary from a few weeks to months, depending on the scale of the activity. The Events often target specific behaviours related to that year's theme, leading to increased awareness and participation to address the issue. For example, men's involvement might be encouraged in celebrating Menstrual Hygiene Day and they might become champions who can influence others. Politicians, religious leaders, stars and influencers can also be engaged in activities (T.22). Holding local Events on these days can attract media coverage of healthy hygiene practices or innovative methods of improving hygiene, reaching a wider audience as a result.

Applicability: Celebrations of important WASH days are global Events. Country-level activities are often planned, especially in schools, but the day may also be marked in other locations and venues by a variety of stakeholders. As a one day Event it is not appropriate during the acute phase of an emergency and is more relevant in the stabilisation and recovery stages. It is important to adhere to the global theme and align with global efforts to show solidarity and support to the topic. As the aim of the Events is to create a unified momentum to action, they are more effective when celebrated at scale. Hence, it is important to mobilise local groups and organisations to plan activities or campaigns together.

😊 Do

- Develop messages tailored to the local context
- Focus on motivating the target audience and mobilise other public and private stakeholders
- Work with mainstream and social media
- Assess the impact of your efforts

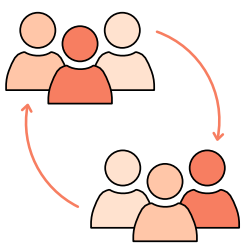
😞 Don't

- Do not try to address too many behaviours at one time
- Do not focus on disseminating only one-way messages

Practical Example: In South Sudan, Global Handwashing Day reinforced the habit of washing hands to prevent the outbreak of diseases like hepatitis and cholera in the refugee camps. Refugees, including children, performed catchy Songs (T.47) containing core messages on hygiene and combating water-borne diseases. Local TV stations aired handwashing videos with the theme 'Handwashing keeps cholera away from you and your family'.

→ References and further reading material for this tool/method can be found on page 295

Exchange Visits

<p>Purpose To exchange with and learn from others</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> Acute Response ★ Stabilisation ★★ Recovery ★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Exchange Visits seek to improve the knowledge and practices of visiting communities or organisations and to integrate the experience gained from the visit into their daily lives or work.

Exchange Visits are a practical and effective tool to foster learning between communities (and organisations). They are intended to benefit all participants (both hosts and visitors) through an open exchange of ideas, knowledge and sound practices. An exchange can be appropriate for communities or organisations of any size, geographic reach, mission, or programme. The aim is to exchange experiences and discover new viewpoints and approaches for specific themes (such as hygiene-related behaviour or community outreach techniques). For capacity strengthening, Exchange Visits offer considerable scope for all target groups. Learning experiences facilitated through Exchange Visits can take place at different levels. They can lead to an increase in knowledge due to practical demonstrations that make it easier to understand an idea or a concept and stimulate willingness to take action. Additionally, an Exchange Visit can lead to changes in attitudes and encourage open-mindedness. This is particularly relevant in relation to hygiene-related behaviour change when communities with a similar cultural and social background meet and discuss the applicability and advantages of the desired hygiene practices. Exchange Visits between organisations that do the same work can be an effective way of strengthening team spirit, networking and knowledge-sharing as well as scale up methodologies that promote good hygiene practices. Organisers should promote an atmosphere in which visitors and hosts feel comfortable to exchange, including adequate logistics such as transport, safe accommodation and translation services if required.

Applicability: Exchange Visits are feasible after the acute emergency phase and when visits can be made in a sufficiently safe environment. They are appropriate for any size of community and programme type. They are most applicable for exchanges between peer groups as visiting groups can more easily relate new experiences to their own context.

😊 Do

- Ensure the visiting group is inclusive so that a representative variety of key stakeholders are exposed to new learning that they can apply in their own community
- Prepare participants in advance and encourage them to share their experiences on their return home
- Define the objectives of the Exchange Visit jointly with the visitors and hosts

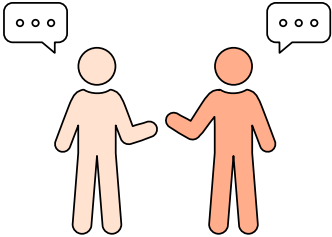
😞 Don't

- Do not forget to give feedback to the host group
- Do not focus only on information-sharing, but also identify lessons and ideas to use and adapt after the visit
- Do not select participants who are unlikely to use the experience to influence others.

Practical Example: In a cross-border project between India and Nepal, supported by Malteser International, Exchange Visits between communities on both sides of the border raised awareness of the application of improved WASH strategies in flood-prone areas. Nepali communities learned about using raised platforms for handpumps and the Indian visitors to Nepal picked up skills about more gender-sensitive WASH programming.

→ **References and further reading material for this tool/method can be found on page 296**

Feedback Mechanism

<p>Purpose To listen and act upon people's positive or negative feedback about the WASH interventions</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

A Feedback Mechanism is a formal, systematic, inclusive and planned system to listen to and act upon the positive or negative opinions of the recipient of a humanitarian WASH intervention. When feedback is received from individuals or communities, the organisation must respond, act or refer to other sectors or organisations.

Feedback Mechanisms are an essential element of Accountability (M.4), transparency and the rights of the affected population. They contribute to building trust and empowering people. As an integral part of Monitoring (M.2) and Evaluation (M.3) they can provide an early-warning system and help improve the overall WASH response. The design and establishment of a complete Feedback Mechanism include (1) the involvement of all the stakeholders in the design so that it is appropriate to their needs, (2) listening, collecting and acknowledging the feedback through selected feedback channels and engagement with the communities, (3) categorising the feedback, including recording and validating where necessary, (4) responding to the feedback by taking appropriate action to address feedback and (5) closing the feedback loop by informing people about the actions taken. Feedback Mechanisms must be designed with the users using Participatory Communication (C.4) and established at the beginning of the intervention. They must be transparent, safe and accessible to all, including the most vulnerable. Examples of Feedback Mechanisms include complaint boxes, regular consultations with different segments of the population, or through hygiene promoters actively seeking feedback as part of their day-to-day work with the community.

Applicability: Feedback Mechanisms are applicable throughout the project cycle and in all contexts and phases. They are an integral part of monitoring, evaluation, accountability and learning (MEAL, chapter M) and demonstrate a commitment by the humanitarian community to be held accountable by the affected population.

☺ Do

- Ensure that different segments of the population have access to the feedback channels. Use the Community Profile (A.7) and Communications Channel (C.4 and C.5) to identify preferences and how best to collect and respond to feedback
- Establish Feedback Mechanisms from the outset. The mechanisms can develop over time
- Coordinate with others, monitor the use of the feedback channels and adapt the system if required

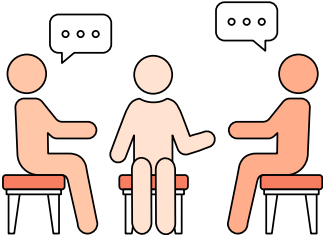
☹ Don't

- Do not forget to mobilise resources (skilled staff, a budget) to establish and implement the Feedback Mechanism
- Do not manage the Feedback Mechanism in isolation. It must be designed in conjunction with the MEAL component of the humanitarian response (chapter M)
- Do not collect feedback without responding to it

Practical Example: In the Darfur IDP camps, World Vision used a variety of feedback methods. Community Help Desks were supplemented by suggestion boxes and regular monitoring – including the use of Checklists (T.2), Focus Group Discussions (T.14) and community meetings. Community representatives and leaders were provided with managers' phone numbers so that urgent issues could be addressed. Feedback was recorded and followed up as soon as possible. The progress and resolution of issues was reported on and discussed in community meetings.

→ **References and further reading material for this tool/method can be found on page 296**

Focus Group Discussion (FGD)

<p>Purpose To understand different perspectives and factors which influence behaviour</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

A Focus Group Discussion (FGD) is a facilitated discussion with a small group of people who share certain characteristics (e.g. a group of women) enabling them to share different views and opinions on a specific topic. FGDs can be useful in WASH programmes to discuss sensitive topics such as hygiene and sanitation practices.

An FGD is a participatory tool aiming to involve affected people, listen to their views and better understand the perspectives of different groups within the community. An FGD works best in groups of 8–12 people, with separate groups for men, women, elders or marginalised people and with a focus on a specific topic such as Menstrual Health and Hygiene (P.7). It is important to be clear about the purpose, the population of interest and the issues to be explored. A supportive environment is also important so that the group feels relaxed enough to exchange views and ideas with others. It is a useful method for listening to the views of marginalised groups, as they may be reluctant to talk in larger mixed groups. The discussion can reveal helpful in-depth information or deeper insights into the context, adding to the more general information collected by surveys. The data collected from an FGD is always qualitative – what people think and feel rather than the number of people practising a specific behaviour. Preparing a Checklist (T.2) with key discussion points can help to facilitate the discussion. If there are specific issues or problems, the group can generate suggestions for addressing them. The facilitation team (and notetaker) should discuss, analyse, document, compile and share the results with other stakeholders, including participants.

Applicability: FGDs can be used in all situations, response phases and stages of the programme cycle: (1) during an assessment to understand people's views, problems and needs (2) as a monitoring tool (3) for feedback about the community's level of satisfaction and views on the effectiveness of the programme. FGDs are easy to replicate; the same method can be used with different groups at different times. They can take time to organise and carry out and should be used with other methods.

☺ Do

- Provide space for interaction and discussion
- Enable the exploration of more information on topics as they arise
- Use a good facilitator and a separate notetaker so that the flow of discussion is not interrupted

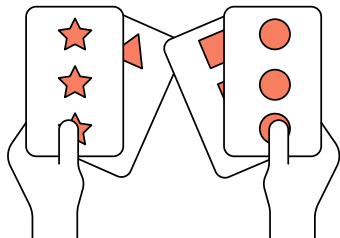
☹ Don't

- Do not rely on FGDs alone, but use them with other methods
- Do not use the FGD as a 'question and answer' session; ensure that it is a genuine discussion
- Do not invite a large group; it is difficult to manage and becomes more like a meeting than a discussion

Practical Example: FGDs were used in a WASH response in Bangladesh with groups of women discussing how they felt about using the latrines. Questions included whether they felt safe using them, including at night, and how they managed menstruation? Many women said they did not use them at night and preferred to go to the toilet in the corner of their shelter. They also requested somewhere to wash and dry menstrual cloth.

→ **References and further reading material for this tool/ method can be found on page 296**

Games and Toys

<p>Purpose To impart knowledge through playful learning, mobilise collective action and trigger positive hygiene behaviours</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Games and Toys can inspire children (and adults) to improve hygiene and sanitation practices, mobilise them to get involved in activities and support behaviour change. The aim is to impart knowledge and trigger positive behaviours in a playful way and in a dynamic interaction between learning, interaction and communication.

Games and Toys are fun both for children and adults and can have an educational value, motivate learners and create additional Rewards and Incentives (T.40). They also have a social component in which individuals interact and learn together in a new context (with teachers, adults or older children guiding learning objectives). The tools should generate enthusiasm and motivation and create interactive engagement with hygiene themes and objects. Learning through play keeps individuals engaged and can help to develop a deep, lasting understanding of the importance of a hygienic lifestyle. There is a wide variety of playful learning materials and guidance on how to conduct hygiene-related games available from different organisations, both as prefabricated kits or using available local materials. Approaches such as CHAST (F.9), Blue Schools (F.8) or 'My School Loo' offer a range of games and materials such as comics, memory and card games or characters for a puppet theatre as well as guidance for facilitators or teachers. Other examples include 'Snakes and Ladders' games with a hygiene focus that can be played with small or large groups or 'E-Gaming' that can reach children remotely. The use of toys (e.g. in 'surprise soaps' with a visible toy embedded in the centre) is another way of harnessing play and curiosity and directly linking it to target behaviours such as handwashing. Games and Toys can and should be combined with other hygiene promotion interventions.

Applicability: Games and Toys are universally applicable in both emergency and longer-term contexts. They predominantly address children of different age groups but can also be played with adults. They are easily combined with existing education or awareness-raising materials and activities (e.g. group handwashing exercises).

😊 Do

- Include children in the development process of Games and Toys (e.g. in the production of the surprise soap)
- Select appropriate games for different age groups
- Consider the involvement of parents in hygiene-related games

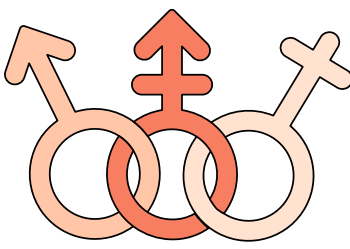
😞 Don't

- Do not rely entirely on Games and Toys to address hygiene issues or change behaviour
- Do not let the game itself displace the goal of learning or be the only incentive to participate
- Do not turn the game into a didactic teaching session

Practical Example: Internally displaced families in Iraq were given a surprise soap to improve handwashing behaviour among children. A pilot study by Save the Children and the London School of Hygiene and Tropical Medicine found that children were four times more likely to wash their hands with soap if it was fun. Children in the camp were involved in choosing the toys that were used. An e-gaming platform called 'Hygienica Castle' was introduced in South Africa to keep schoolchildren learning and practising good handwashing habits during COVID-19. The platform allows children to create their own hygiene superhero avatar and earn points towards fun rewards in exchange for completing a daily tick-list of hygiene habits.

→ References and further reading material for this tool/method can be found on page 296

Gender Analysis

<p>Purpose To understand the different needs, roles, relationships and experiences of girls, women, boys and men for hygiene promotion.</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Gender Analysis looks at the impact of a humanitarian crisis on women, girls, men and boys and enables the WASH response to meet their distinct needs and priorities. It is an integral part of the assessment phase and must be considered throughout the WASH programme cycle.

Gender Analysis looks at the relationships between women, girls, men and boys. It considers their respective roles, access to and control of resources as well as the level of vulnerability and constraints faced by each group (E.3). It analyses who in the population is affected by the crisis, what they need and what they can do for themselves. Sex (and age) disaggregated data are a core component of any Gender Analysis. Data about population demographics is also essential, such as the total number of households affected (disaggregated by sex and age), the number of single female and male-headed families and the number of families headed by children (girls and boys). WASH-related Gender Analysis questions include: what is the extent of WASH knowledge and skills and its relationship to health (women, girls, boys and men). How has the crisis affected them? What are the water uses and responsibilities in different groups e.g. for cooking, sanitation, gardens, livestock? What are the family members' patterns of water allocation (sharing, quantity, quality) and who decides on the allocation? Who is responsible for the maintenance and management of WASH facilities? Are water points, toilets and bathing facilities located and designed to ensure privacy and security, and can different user groups access them safely during the day and night? What are the different needs and preferences for hygiene items? Gender Analysis is conducted through desk reviews, Key Informant Interviews (T.23) and/or Focus Group Discussions (T.14) and supported by gender specialists.

Applicability: Gender Analysis is relevant to all response phases, taking place during the assessment (chapter A), Monitoring (M.2) and Evaluation (M.3) phases and using information collected throughout the hygiene promotion (HP) programme.

☺ Do

- Consider initial Key Informant Interviews (T.23) with some men, women, community leaders, teachers and health workers to understand sensitive gender issues better
- Use Gender Analysis to mainstream gender into HP interventions throughout the response
- Select team members based on their ability to work with girls, women, boys and men and train them to be gender-sensitive
- Consider how individuals experience life differently at different ages and life stages


☹ Don't

- Do not rely solely on secondary data
- Do not only examine women's needs, capacities and coping mechanisms but consider all genders and how they interact

Practical Example: A Gender Analysis done by Oxfam in Nepal aimed to identify the impact of the earthquake on the affected people and understand their needs and coping strategies. Key issues identified included: social taboos and discrimination, power relations, women's participation in planning and decision making, control and access to resources and social subordination and exclusion. Based on the recommendations from the analysis, Oxfam's WASH department explicitly and systematically integrated gender equality considerations into all stages of the project, including in budgetary provision where possible.

→ **References and further reading material for this tool/method can be found on page 296**

Health Surveillance Data

Purpose To use health data on WASH-related disease to inform programme planning 	HP Component <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	Target Group <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities Local Leaders ★★ Society as a Whole
	Response Phase <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	Application Level <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Health Surveillance is the continuous and systematic collection, analysis and interpretation of health data. Local and national morbidity, mortality and other epidemiological data on WASH-related diseases will help to inform and guide water, sanitation and hygiene promotion priorities.

Epidemiological data collection systems are useful for all sectors in all emergencies. Such systems should be initiated if absent, or existing ones supported and continuously improved. Surveillance data acts as an early warning system for disease outbreaks and can indicate if the overall response is having the desired effect. These systems are usually managed and collated by the health service or health sector, but data collected by other sectors (e.g. studies on behaviour or nutritional status) can help to interpret the surveillance data. As with all data, the analysis and interpretation are essential; data must be used with care and disaggregated (by gender and age especially) where possible. WASH-related health data (e.g. the incidence of diarrhoea) cannot be used to measure the causal impact of WASH (as diarrhoea is affected by many factors as well as by WASH) but it should be considered when monitoring, prioritising and adapting WASH interventions. Sources of data include local health clinics and hospitals, national health surveillance systems and sometimes community health workers. Secondary data can also be obtained from previously conducted Demographic Health Surveys and Multiple Indicator Cluster Surveys and these are usually available from UNICEF.

Applicability: Epidemiological data should be sought in all contexts but specific local data may be unavailable if health services are poorly resourced or disrupted. People may be unable to access health services and may not report illness or death – especially if there is a stigma about the disease such as cholera or Ebola. Community health workers often collect basic disease data and this can be useful if no other surveillance system exists. Numbers can be inflated or underestimated if case definitions are unclear and health workers poorly trained.

☺ Do

- Regularly obtain surveillance data on WASH-related disease and death
- Attend inter-sectoral coordination meetings to get an overview and discuss surveillance data
- Involve communities by discussing data with them, carrying out field studies and feeding back information

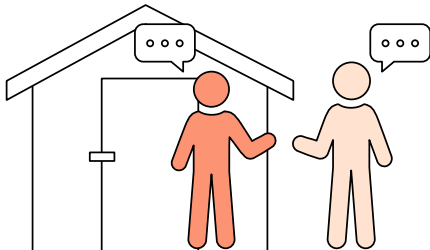
☹ Don't

- Do not use raw data or make assumptions based on limited data without analysis and interpretation
- Do not collect too much data – prioritise requirements early in the response
- Do not use only one data point or source

Practical Example: In Haiti the data on cholera incidence was stratified by department and age, but not by gender. A rapid assessment of mortality from cholera was conducted in Artibonite Department where the largest number of cholera cases was reported. The assessment identified that 67 % of cases were male and 9.2 % were female aged 5–18 years, challenging the assumption that adult women were the most affected. The cholera strategy was then changed to focus more on men.

→ **References and further reading material for this tool/method can be found on page 296**

Household Visit

<p>Purpose To assess the home environment and support and engage with community members in person</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities Local Leaders Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★ Institution ★★ Camp ★★ Rural ★★ Urban

Visiting people in their home environment enables a hygiene promoter to assess the environment and to support community members to adopt good practices specific to their needs.

Household Visits are usually done by community-based hygiene promoters. During the visit, they identify and understand the household's WASH issues and work with the householders to find solutions. Appropriate advice and support are then given based on the needs and context. Such visits enable hygiene promoters to gain a better understanding of hygiene problems. The visit might involve looking at how drinking water is stored and used within the household. It may assess whether there are handwashing stations at key locations. Behaviours such as handwashing can be discussed and demonstrated. Household Visits can also make use of other hygiene promotion methods, such as visual aids or interactive activities. The visits require adequate staff or volunteers and sufficient time. Although Household Visits are time-consuming, they can be effective. Problems and challenges can be discussed, appropriate solutions found, demonstrations carried out in the house and specific hygiene behaviours targeted. Depending on the context, one hygiene promoter can visit between six and ten households per day. The Household Visits team should be well-trained, have good Communication Skills (C.2) and be non-judgmental. They should always start the visit with introductions, explain who they are and ask for permission to visit. Reports on Household Visits should be made so that the information is gathered, documented and used. Monitoring (M.2) of the visits should be routinely carried out, to track whether they are well received and effective.

Applicability: Household Visits are useful in most situations, settings, emergency phases and stages of the programme cycle. Visits are especially helpful to people unable to leave the house (e.g. older people). Sensitive issues such as menstruation are easier to discuss with people from the same household than with a wider group outside. Visits can seem intrusive and people may feel judged; hygiene promoters need to be respectful and sensitive to gain people's trust.

☺ Do

- Visit at a time convenient for the householders, e.g. not during a food distribution
- Vary the discussions and visual aids so that visits are not repetitive and stay interesting,
- Actively listen to and work with people to find solutions

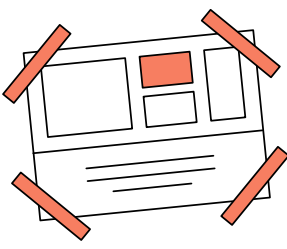
☹ Don't

- Do not lecture, telling people what to do. Observe, listen and discuss: communicate, do not disseminate!
- Do not overwhelm people with too much information on the visit

Practical Example: In 2017 a WASH volunteer system started in a camp in Greece for displaced people from various countries. One of the volunteers' roles was to visit people in their tents. The volunteers worked in male and female teams. During the Household Visits, they observed, listened and advised on topics such as rubbish disposal and handwashing. The team had to be representative of the different nationalities and ethnicities in the camp. They were allocated to different sections of the camp, visiting the homes of people of their nationality/ethnicity, so that they could communicate more effectively.

→ **References and further reading material for this tool/method can be found on page 296**

Information, Education, Communication (IEC)

Purpose To motivate people to take action to prevent WASH-related diseases 	HP Component Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL	Target Group ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	Response Phase ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development	Application Level ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Information, Education and Communication (IEC) interventions refer to the structured development of effective communication materials and methods aimed at motivating people to take action to prevent WASH-related diseases.

IEC materials are used to support the overarching hygiene promotion strategy. They include a range of products such as infographics, flyers, leaflets, brochures, social media posts, television adverts, audio sessions for radio, posters, billboards or murals, as well as communications by hygiene promoters. IEC materials are not powerful enough by themselves to change behaviour. They should be integrated with other activities using various communication channels, including some which allow for dialogue and interaction. To develop IEC materials, a structured approach should be taken. The first step is to understand the situation and then identify risky behaviours, decide what needs to change to have a positive effect on people's health and well-being, select the target audience and identify social and cultural factors that shape beliefs and practices. The second step informs the planning of IEC interventions including the definition of objectives, analysis of community perspectives, selection of IEC methods, materials and channels and the development of an action plan to ensure the production of timely and suitable products. The third step is the implementation phase. This includes working with artists and others to design the IEC materials and pre-testing to ensure materials and messages are understood. Monitoring, evaluation and learning (**chapter M**) examine whether the intervention has been effective and checks if the materials are visible, of interest, acceptable and understood. Interviews (**T.23 or T.27**), spot-check Observations (**T.28**) and Focus Group Discussions (**T.14**) can be used to find out what people understood from the material and whether they are likely to act on the information.

Applicability: IEC materials can be used in any response phase but, to enable their appropriate use in an acute phase, preparation needs to be done in advance. Materials can be useful in all contexts and applied at any scale. IEC materials and methods are part of a communication strategy, often as an element of mass media campaigns (**C.5**) and should therefore follow the same principles. However, IEC can also be used to support Participatory Communication (**C.4**). Working with local professionals will facilitate the process, for example through language use and increasing the acceptability of drawings.

☺ Do

- Use images that are positive and make people feel empowered
- Allow time for pre-testing and use a defined set of questions to obtain good quality feedback
- Ensure that monitoring findings are used to adapt and modify the IEC materials and methods

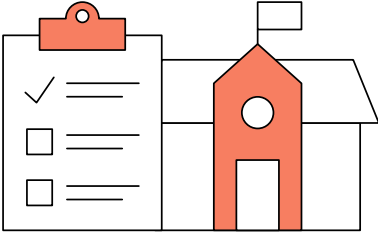
☹ Don't

- Do not use messages that are too general or too complicated
- Do not use negative or judgemental messages

Practical Example: IFRC developed generic IEC materials for health promotion in water, sanitation and hygiene. The resulting series of ten documents support WASH IEC activities. The materials are adapted and used by Red Cross or Red Crescent volunteers in different contexts to raise awareness in the household and community on WASH issues such as diarrhoea prevention, personal hygiene and domestic hygiene.

→ **References and further reading material for this tool/method can be found on page 296**

Institutional Checklist

<p>Purpose To support the identification and organisation of tasks, actions and measures required for an effective and accountable WASH intervention</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Institutional Checklists support stakeholders to plan, divide and monitor tasks and activities. They help to organise schedules and routines to optimise compliance or support self-assessment. The Checklists are typically used in schools, healthcare centres or other institutions.

Institutional Checklists facilitate the identification and implementation of tasks and activities. Where possible, tasks and activities should be jointly agreed upon with the people undertaking them to create a sense of ownership. Categories might include a list of tasks to be undertaken, when and by whom. Ideally, the appropriate category is signed and dated when the task has been completed. Checklists can also be useful for assessment or monitoring activities. If, for example, school latrine cleaning is monitored, Checklists help track when the activity was carried out and by whom. Checklists can assist technical staff or caretakers to carry out regularly recurring operational and maintenance tasks by providing an overview of when, where and how the task should be performed. Checklists can help staff to adhere to specific infrastructural or other standards. They can also enhance accountability by ensuring that everyone knows what to do and whether it has been done.

Applicability: Checklists have a variety of uses and can be employed in most contexts and at all stages in the programme cycle. Institutional Checklists can simplify the fulfilment of responsibilities by providing a visual presentation of the required tasks and measures. They can, at the same time, also create (social) pressure to accomplish them.

😊 Do

- Structure the Checklist so that it is clear and easy to use
- Make Checklists visible to everyone when documenting cleaning schedules or maintenance tasks
- Depending on literacy levels, it may be preferable to use symbols or graphics on the Checklist, rather than text

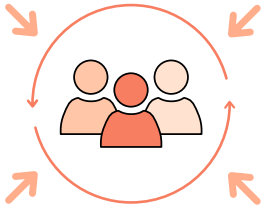
☹ Don't

- Do not overcomplicate a Checklist with long sentences and too many tables to fill in

Practical Example: The WASH in Schools Network provides helpful Checklists for managing COVID-19 in schools, including school entrances, classrooms and toilets. The Checklists are published by GIZ, UNICEF, WaterAid and Save the Children. The Checklists guide educators, practitioners and other school actors on key considerations for when schools reopen, to prevent the spread of COVID-19. The checklists also divide the tasks into weekdays, to be signed and dated by the respective supervisors.

→ **References and further reading material for this tool/method can be found on page 297**

Integrated Behavioural Model (IBM) for WASH

Purpose To provide a conceptual model of the factors influencing WASH to aid programme planning 	HP Component ** Preconditions & Enabling Factors * Community Engagement & Participation ** Assessment, Analysis & Planning * Communication ** Social & Behaviour Change ** MEAL	Target Group Children Adults Older People Persons with Disabilities Local Leaders ** Society as a Whole
	Response Phase * Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development	Application Level ** Individual/Household ** Community/Municipality ** Institution ** Camp ** Rural ** Urban

The Integrated Behavioural Model (IBM) for WASH is a conceptual model and tool to help understand the numerous environmental, psychosocial and technical factors influencing WASH behaviours.

The IBM for WASH brings together several existing behavioural theories and models such as SaniFOAM and FOAM (F.19) and others. It was compiled in 2013 following a systematic review of 15 existing models and frameworks used in the WASH sector. Whilst all the models comprised important determinants of WASH behaviours, no single model addressed all the specific and unique aspects of water, sanitation and hygiene behaviour change, such as reliance on technology, the habitual nature of WASH behaviours and multiple levels of influence. IBM WASH has three dimensions: contextual, psychosocial and technological. It considers the interaction between the different determinants for each dimension at five levels: societal, community, interpersonal, individual and habitual. Successful interventions need to support and maintain behaviour change in all three dimensions and at all five of these levels. Time is needed to assess and understand the different determinants and their appropriateness in each context.

Applicability: It can be applied to all contexts, situations and phases but different determinants may be more or less important in certain situations and contexts. It needs time. It is a useful tool for programme planning, providing an overview of all of the factors that influence WASH and enabling the identification of gaps in knowledge and understanding.

😊 Do

- Use the model to guide programme assessment and implementation and identify gaps in understanding
- Use the model early in programme planning and design
- Consider the habitual nature of WASH behaviours and how they are informed by technology, psychological and social theory and the broader context

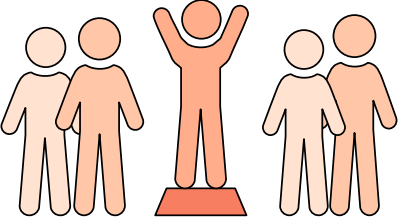
😞 Don't

- Do not address every determinant in the IBM-WASH framework: identify the most important for your population, setting and behaviours
- Do not attempt to measure and quantify every determinant; the framework is largely informed by anthropological approaches and is often better suited for qualitative research than survey methods.

Practical Example: In Bangladesh formative research using the IBM model was used to select the most appropriate trial handwashing stations. Elements of the technology, such as capacity and durability, were critical to acceptability, as were contextual factors such as consistent access to water and the physical location of the technology. Psychosocial factors such as disgust also affected whether a handwashing station facilitated or inhibited handwashing at key times. For example, disgust associated with handwashing stations placed near latrines could prevent handwashing at other times, requiring additional handwashing stations.

→ **References and further reading material for this tool/method can be found on page 297**

Involvement of Local Champions

<p>Purpose To use influential community members and those performing positive behaviours to promote change</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Local Champions can be families, individuals, community or religious leaders who are influential in the community and whose hygiene behaviours can be perceived as positive examples to other community members. Community 'Champions' can help to promote positive behaviours and act as a bridge between service providers and the community.

Few people make decisions or perform actions without considering the opinions and views of those in their social network. Exactly who has the most influence depends on both the individual and the culture of the community. For example, in some societies the mother-in-law is particularly influential; in others, it may be the elders, including uncles. Influential people in a community can become the champions of a specific cause. People's response to issues depends on who they can trust and whose opinions they respect. In the field of hygiene promotion (HP) champions can be people who have improved their sanitation or who regularly practise hygiene measures and are pleased with the results. They are often the best people to explain the benefits to others. Local Champions can help deepen understanding of how people think and what works best for the community.

Applicability: Local Champions can be useful in all response phases and contexts throughout an HP intervention, to explain to the affected community what should or should not be done. They typically have high credibility within the community and can therefore set an example.

😊 Do

- Consider that there might be more than one type of local champion who can help you with the intervention
- Make sure that roles and responsibilities are clear
- Communicate with champions frequently and share programme information as well as obtaining their insights

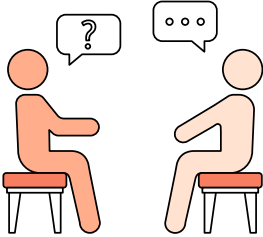
😞 Don't

- Do not exclude people as champions because they have limited literacy or a disability
- Do not manipulate community champions and treat them as if they were programme tools
- Do not forget to continue consultations with other community members and representatives

Practical Example: Pakistan Red Crescent organised pad-making sessions to promote the use of menstrual products and raise awareness of menstrual health. These sessions also provided a valuable opportunity to explore the barriers, enablers, needs and preferences related to menstrual hygiene management (MHM) within the community. During pad-making sessions, the community mobilisation team (which included female and male health workers) identified the most active and skilled participants as MHM champions: key role models and influencers who became enablers for improved menstrual hygiene. The MHM champions trickle down their acquired skills in their communities about how to prepare pads with locally available materials, as well as providing information and referral to health facilities if needed.

→ **References and further reading material for this tool/method can be found on page 297**

Key Informant Interview

<p>Purpose To gather information by interviewing key people in the community</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Interviewing key community members and representatives is a useful method for gathering information on important issues such as WASH norms and practices in a specific context.

Key Informant Interviews can be unstructured (a free-flowing discussion) or semi-structured (using pre-prepared questions). It is useful to interview people with a range of perspectives, expertise, local knowledge and an overview of the context, such as respected leaders, elders, the heads of women's groups, health workers and teachers. Informants are asked to share what they know about the situation, e.g. a health worker can describe morbidity trends in the area, or a women's leader may have information about children's health and hygiene. Responses are cross-checked by conducting several interviews with different informants. The interviewers should have good communication skills (including sensitivity, empathy, listening skills) and be trained to use a question checklist and explore the topic. Interviewers should take notes and may need to work with an interpreter. The Key Informants should be encouraged to talk freely and take the lead in the discussion. As time allows, the range of informants can be increased. Notes of the conversation should be summarised at the end, checking that the participants agree with the key points noted. Although normally carried out face to face, interviews can be done by phone, online or using message apps. Data analysis can help to identify questions and topics for further exploration. The main advantage of Key Informant Interviews is that it is quick, few resources are needed and it is an efficient way of getting local knowledge. A disadvantage is that the interviewee may not represent the whole community.

Applicability: Key Informant Interviews can be used at any time during the response and in most contexts to gather information and feedback. Key Informant Interviews can be done quickly, (a maximum of 90 minutes per interview) and are often used as a rapid assessment tool (chapter A).

😊 Do

- Get a diverse mix of Key Informants
- Be aware that people may tell the interviewer what they think the interviewer wants them to say
- Ask people at the end of the interview if they have any questions to ask

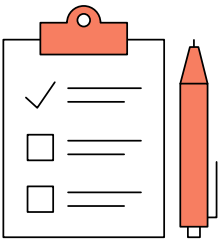
😞 Don't

- Do not use leading questions, e.g. 'when do you wash your hands with soap?'
- Do not raise expectations but be transparent about what is possible
- Do not ask irrelevant questions. Keep to the topic

Practical Example: During a monitoring visit for a flood response operation, the Sri Lanka Red Cross Society (SLRCS) conducted several Key Informant Interviews with those affected, including the head teacher and the men responsible for the operation and cleaning of latrine facilities. The interviews were combined with Observation (T.28) and Focus Group Discussions (T.14), to deepen the understanding of the issues. The team observed piles of garbage in and next to the school premises and discovered that the presence of menstrual waste (used sanitary pads) prevented men from cleaning the venue. Subsequently, the SLRCS implemented a participatory behaviour change approach at the school to solve problems with menstrual waste and promote improved menstrual hygiene management.

→ **References and further reading material for this tool/method can be found on page 297**

Knowledge Attitude and Practice (KAP) Survey

<p>Purpose To support the decision making process to plan, implement and assess hygiene promotion interventions</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

A KAP Survey uses standardised questionnaires to collect and analyse reliable quantitative data to identify the knowledge (K), attitudes (A) and practices (P) of a population on a specific topic to support the planning, design, implementation, monitoring and evaluation of WASH interventions.

A KAP Survey measures what people know (knowledge), how they feel and what they believe (attitudes), and what they do (practices). It is carried out through structured interviews using the same questionnaire for each respondent, generating quantitative results which can be statistically analysed. Questions are intended to identify key knowledge, social skills and know-how commonly shared by a population or target group about particular issues related to hygiene. Data can be collected using printed questionnaires or on tablets with pre-loaded software. The analysed data can help to identify interventions, establish baselines, set priorities and measure change. A KAP survey can measure the extent or coverage of a variable such as latrine use to confirm or disprove a hypothesis. The survey can reveal misconceptions or misunderstandings that may be obstacles to planned activities, or provide a new understanding of an issue. It can help define an intervention strategy in light of the specific local circumstances and cultural factors that influence them. Depending on the scope, context and complexity, a KAP survey can take between several days and several weeks. KAP surveys should not be used as a single method or source of information; they should be complemented by other methods such as Key Informant Interviews (T.23) and Focus Group Discussions (T.14).

Applicability: KAP Surveys are feasible in most contexts and phases. They require a survey team, usually composed of trained interviewers/enumerators and supervisors. It may be necessary to work with other individuals or organisations to determine the sampling plan (the number of people and areas to be interviewed), create or adapt questionnaires, conduct interviews in the local language and enter or analyse data (A.8).

☺ Do

- Ensure a random sampling methodology so that every member of the population has an equal chance of being chosen, to avoid data bias
- Only ask questions required to answer the overall research question(s) or to measure the indicators
- Provide time and resources to ensure training is conducted and translated questionnaires are tested on community members and revisions made before implementation.

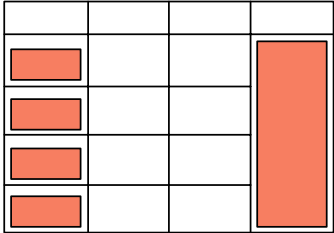
☹ Don't

- Do not over or underestimate the sample size. Be representative whilst interviewing as few households as is possible

Practical Example: REACH conducted a KAP Survey in Za'atari camp, Jordan, to evaluate camp residents' current knowledge, attitudes and practices towards WASH and to assess the changes that had taken place since the last KAP survey. More specifically, it assessed the impact of a new water network on hygiene practices and the camp residents' awareness of the establishment of cluster focal points. It also assessed the camp residents' perceptions of the effectiveness of the WASH-related information and services implemented to strengthen future WASH programming and shift towards greater sustainability.

→ **References and further reading material for this tool/method can be found on page 297**

Logical Framework Analysis and Problem Tree

<p>Purpose To support the analysis, planning, monitoring and evaluation of WASH programmes</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> Children Adults Older People Persons with Disabilities Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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A Logical Framework Analysis (LFA or 'logframe') is a planning process that uses a Problem Tree and Stakeholder Analysis (T.49) and provides an overview of project objectives and indicators and how they will be measured. It illustrates the hierarchy of objectives and how they contribute to programme impact and provides a basis for Monitoring (M.2) and Evaluation (M.3) of activities, outputs and outcomes.

The LFA comprises a set of tools that support planning, monitoring and evaluation. Assessment data (A.4) is analysed with the help of a 'Problem Tree' to identify interventions and actions to address the problems. An overall project goal and the steps necessary to achieve that goal are identified. This hierarchy of objectives (goal, outcomes, outputs, activities) is compiled into a matrix. For each level of the hierarchy, SMART (specific, measurable, achievable, realistic and timebound) indicators are inserted into the matrix, with methods for measuring the indicators called the 'means of verification'. An outline of the risks inherent to the project (i.e. the likelihood of not meeting the objectives) and important assumptions (things that need to be in place to meet the objectives) are also included. The logframe should present a clear and accessible summary of the main objectives, outcomes, indicators and activities. Ideally, the logframe is developed as a team activity and shared with all project stakeholders. The logframe is often a requirement from donors but should be used as a living document to guide the project; it will need adapting as the situation evolves. WASH-related objectives should include indicators of participation and engagement (chapter E), Accountability to Affected Populations (M.4 and F.23), behaviour change and hygiene action (chapter B).

Applicability: The LFA process can be used in all contexts and all projects. It is a requirement for all hygiene promotion and WASH interventions. It takes time, especially in a group, as there will often be debate about each objective and where it sits in the matrix. Training and practice are required and an experienced facilitator is usually needed.

😊 Do

- Use a simple guide to LFA to support the process (see resources)
- Involve key stakeholders in the process wherever possible
- Continue to adjust and update the logframe and use it for monitoring progress

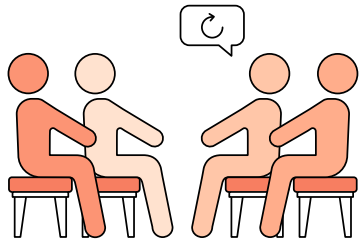
☹ Don't

- Do not compile a logframe and then forget to use and update it
- Do not get bogged down by imperfections in the model but use it as a practical planning framework
- Do not over-complicate the logframe – it should provide a clear overview of the project

Practical Example: A team in Sierra Leone brainstormed the area's WASH problems and underlying factors to develop a logframe; it took two meetings of over three hours each. Some participants were frustrated by the process, feeling that the logframe was too inflexible for a rapidly changing context. Most found it helpful to discuss the issues, agree on the programme objectives and how they would be measured. They also considered what could go wrong and what could be done to mitigate the risks. The affected community was not involved in the development of the logframe, nor was it shared with them.

→ **References and further reading material for this tool/method can be found on page 297**

Most Significant Change (MSC)

<p>Purpose To understand the impact of activities and plan future interventions through participatory monitoring and impact evaluation</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★ Institution ★★ Camp ★★ Rural ★★ Urban

Most Significant Change (MSC) is a method for Participatory Monitoring and Evaluation (M.5) using storytelling. It can be used to understand unpredicted impacts and help plan for future activities.

MSC is a method for qualitative impact Monitoring (M.2), Evaluation (M.3) and Learning (M.6, M.7, M.8). Significant change stories are collected from the target group and other relevant stakeholders. The most important change stories are systematically selected by vetting panels of designated stakeholders through in-depth discussion and analysis about the value of the changes reported in the stories. Changing (hygiene) behaviour is often difficult and the impact of specific project activities is highly dependent on the context. MSC permits a better understanding of which activities are most relevant to affected communities. It also influences future activities to be more context-specific. The MSC focus on listening and taking the opinions of communities seriously often leads to an increased sense of ownership and acceptability of the activities. MSC can also be used to monitor and evaluate bottom-up initiatives that do not have predefined outcomes against which to evaluate. It can give insight into what triggers change in general and, specifically, in relation to hygiene behaviour change. The method is relatively easy to implement across cultures as explanations about indicators are not required; it encourages analysis and data collection because people have to identify why they believe one change is more important than another. MSC can foster a shared vision of the programme between communities, decision-makers and other stakeholders. It provides a rich overview of the changes achieved, including unexpected changes and indirect outcomes which cannot always be captured by indicator-based evaluations.

Applicability: MSC is mainly useful in contexts when it is difficult to predict in detail, or with any certainty, what the outcome of a project or programme will be, where outcomes vary widely across community groups, where there is no agreement between stakeholders about which outcomes are the most important and when interventions intend to be highly participatory and focused on social change. MSC is particularly suitable for large or complex programmes focused on social change, including hygiene promotion programmes.

😊 Do

- Allow a considerable time between implementation and the collection of change stories
- Ensure that participants are representative of the target population and that the process is transparent
- Ensure that stories are verified and triangulated

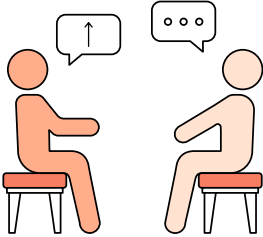
😞 Don't

- Do not forget to define the selection criteria and record why the MSC stories are selected, making sure they are selected through a systematic and transparent process

Practical Example: MSC has been used in 20 districts in Saaahara, Nepal for behaviour change interventions on maternal and child feeding, hygiene and sanitation and agricultural practices. Significant change stories were collected and analysed. One story was told by a woman who had gained knowledge on nutrition and health practices through the programme that she passed on to her daughter-in-law and other mothers. The vetting panel liked that she was a role model encouraging mothers to adopt new behaviours and decided to explore the role of other mothers-in-law in the community to understand if her story was unique.

→ **References and further reading material for this tool/method can be found on page 297**

Motivational Interviewing

<p>Purpose To enhance communication with individuals to support action and change</p> 	<p>HP Component</p> <ul style="list-style-type: none"> Preconditions & Enabling Factors ★★ Community Engagement & Participation Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Motivational Interviewing (MI) is an approach to interpersonal communication between community members and hygiene promoters that identifies people's strengths, aspirations and autonomy in order to motivate them to take action on hygiene. It emphasises listening and asking questions so that people can identify their own solutions for improving hygiene.

The four key principles used for MI are summarised in the acronym RULE: Resisting the urge to tell people what to do; Understanding that the individual must want to change for their own reasons rather than those of the facilitator; Listening and drawing out solutions to the problem rather than presenting ready-made solutions; Empowering the individual to take action if they are able. The role of the facilitator is to affirm and summarise what has been said and enable people to stand back and look at an issue more objectively. MI employs four key techniques: **(1)** Open-ended questions, **(2)** Affirmations, **(3)** Reflective listening and **(4)** Summaries. This approach can be useful for communicating hygiene issues such as handwashing or household water treatment with individuals or groups but can be adapted for any interaction where change is sought. MI tools can help develop interpersonal communication skills. It can also encourage hygiene promoters to be less didactic in their approach. Training and practice are necessary to develop the skills but the main principles and techniques can be learned and practised by all hygiene promoters.

Applicability: This approach to communication can be used in all contexts and phases. The principles can be easily learned. Skills improve through practice and use in real-world situations. It can be scaled up rapidly.

☺ Do

- Listen closely and ask people questions about what prevents or helps them to take action
- Be empathetic and put yourself in the other person's shoes
- Periodically summarise and reflect what has been said and ask if they agree
- Encourage people to define actions they can carry out and agree on what happens next

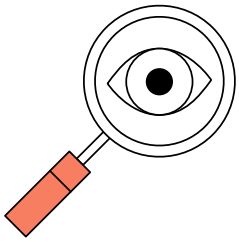
☹ Don't

- Do not tell people what to do, impose your solutions on others or offer un-asked for advice
- Do not argue or be confrontational
- Do not act as if you are an expert

Practical Example: There is limited documented use of MI in the WASH sector although it has been used in several research studies, e.g. in Zambia and elsewhere to promote handwashing. In one of the Zambian studies, health volunteers were trained in MI and made Household Visits (**T.18**) to encourage the use of a household water treatment. Rates of purchase of the promoted disinfectant were much higher in the MI group than in the control group; the rates sustained over the eight months of sales monitoring. In another study, health volunteers visited households every four weeks; evaluation revealed a 16-fold increase in chlorine residuals in the MI group (65%) compared to the group exposed to health education alone (4%).

→ **References and further reading material for this tool/method can be found on page 297**

Observation

<p>Purpose To assess or monitor WASH facilities and hygiene practices</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Observation gathers information about hygiene practices and WASH facilities and is often used in conjunction with other methods such as Transect Walks (T.52), Household Visits (T.18) or surveys (A.8 or T.24). It can be structured using a questionnaire or Checklist (e.g. T.2) or be open and unstructured.

Observations can gather information in public areas or people's homes observing, for example, water collection points, storage of drinking water, communal washing areas, latrines or handwashing areas. It is helpful to agree on the criteria before doing an Observation (e.g. what is 'clean' or 'dirty?') and important to agree on where and who will be observed (e.g. homes with young children < 5 years of age). A structured survey (A.8 or T.24), may require a sampling system to select which homes to visit. Observing during different times of the day will yield different information. For example, early morning is often a good time to observe hygiene practices. Observing a situation can help cross-check and triangulate other information. Nonetheless, it is a snapshot and the context may change rapidly in an emergency. It should be used with other methods such as Key Informant Interviews (T.23). There is the potential for bias as people may change their behaviour if they know they are being observed. Notes should be taken on what was observed and how it was done (e.g. if a checklist was used). The information should be collated and analysed as soon as possible and included in a shared assessment or monitoring report. Observation is a key skill for all hygiene promoters. Training and supervision may be needed to do Observations correctly. Hygiene promoters should be supportive and sensitive to local concerns and customs and be aware that Observation can appear intrusive.

Applicability: Observation is applicable to all response phases and contexts. It is a key method to use in assessments or, if carried out repeatedly, as part of a monitoring system. Observation can also be used to monitor staff performance, their effectiveness and how they are working with the community.

😊 Do

- Be sensitive to the context, ask permission before taking photos
- Be curious; do not only look but listen and smell
- Be aware of bias

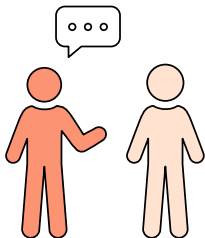
😞 Don't

- Do not have preconceived ideas about what to expect
- Do not observe without recording and using the information
- Do not make people feel uncomfortable or intrude on their privacy

Practical Example: Observation is used as part of the Wash'Em (F.22) Handwashing Demonstration Tool and can illustrate how people interact with e.g. soap and containers when handwashing and what makes the process inconvenient and undesirable in practice. The demonstration is filmed on a mobile phone with the consent of participants and without revealing their identity. The data is analysed using a 'decision making table' to help identify what helps and hinders handwashing.

→ **References and further reading material for this tool/method can be found on page 297**

Peer Education (Child-to-Child)

Purpose To support hygiene and behaviour change interventions for children through peer learning 	HP Component Preconditions & Enabling Factors ** Community Engagement & Participation * Assessment, Analysis & Planning ** Communication ** Social & Behaviour Change * MEAL	Target Group ** Children Adults Older People Persons with Disabilities Local Leaders * Society as a Whole
	Response Phase * Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development	Application Level Individual/Household ** Community/Municipality ** Institution ** Camp ** Rural ** Urban

Peer Education is when children learn hygiene behaviours and practices from each other. The child-to-child concept is that children can gain information and knowledge, pass it on to others and influence other children to make improved decisions regarding hygiene practices.

Peer Education can be an effective tool for children as they tend to engage in group activities during and after school hours. Observing others and being observed during activities such as handwashing or using the toilet creates peer pressure and positively influences hygiene behaviour norms. Peer learning can be gender-specific, especially for female children about menstrual hygiene. Peer learning is a relatively rapid process for children if they are in an environment that is supervised and conducive to learning appropriate hygiene behaviours. Learning happens informally between peer groups or formally where a child is assigned to teach and supervise other children. Behaviours such as handwashing, cleaning and maintenance of WASH facilities and hygiene behaviours during disease outbreaks can all be targeted through peer learning. Champions (T.22) can be identified by schools and communities and assigned to supervise and teach other children. Children are often seen as a homogenous group, but the design of child-to-child programmes must accommodate different age groups and genders. Whilst not strictly 'peer' education, older children can demonstrate by example or teach skills to younger children. Activities may include reading and writing, physical activities, discussions, Games (T.15), Songs (T.47), Role Plays (T.41) and Drama (T.6). It can also be implemented through Mass Media (C.5). Peer learning topics for children should mirror campaigns in the community where specific health risks are high. Peer Education is an element of existing hygiene promotion approaches such as CHAST (F.9), Fit for School (F.10), SLTS (F.2) or School Health Clubs (F.1).

Applicability: Peer Education is applicable in schools and all communities, urban or rural. It can be used in all response phases. However, a structured, sustainable intervention is harder to implement in the acute response phase.

☺ Do

- Build basic competencies of humanitarian staff to work with children and identify child trainers
- Develop and use age-appropriate games and activities for children and use practical activities to reinforce ideas
- Take the opinions and experiences of children seriously

☹ Don't

- Do not mix child peer groups with adults
- Do not compromise child protection and safety for any activity
- Do not limit child-to-child activities to schools

Practical Example: During the Ebola outbreak in Sierra Leone, a radio production team was commissioned to produce the radio series Pikin to Pikin Tok, intended to enhance children's life skills. The series was made up of three different programmes each of which targeted different age ranges. Groups of children were recruited and trained as 'young journalists'. They helped to identify stories, interview key stakeholders and record audio content for the programme, which was then broadcast by the local radio station. Listener groups were set up and supported by trained adult facilitators to engage in discussions about the issues being aired. Children were encouraged to phone in after the radio broadcasts to express their views and opinions.

→ References and further reading material for this tool/method can be found on page 298

Photo Voice and Participatory Video

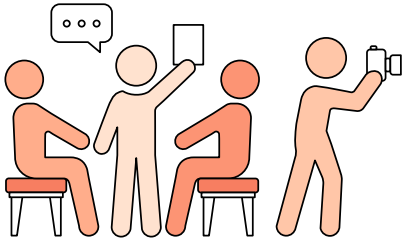
<p>Purpose To enable communities to explore WASH issues through the use of photographs and videos</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Photo Voice is an established method initially developed by health promotion researchers. Participants take photographs and then select some of the images to reflect upon, exploring the reasons, emotions and experiences that have guided their choices. Participatory Video encourages community members to make their own films about hygiene issues in the area and to share and discuss with others.

Both methods involve participants in taking pictures or making films that express their perspectives, views and feelings around a selected topic (e.g. the risk of diseases in an internally displaced camp). Participants then select from the images or films, using them as a stimulus in a group discussion. In Photo Voice, the discussion focuses on why the photographs were chosen, what makes them meaningful and what participants think about each other's pictures. Picture taking can be fun and is accessible to most ages and skill-sets; making short films with mobile cameras has become far easier. These methods have the potential to offer groups, including the most marginalised, the opportunity to communicate their perspective of daily life, capturing their struggles and coping strategies. The methods create a safe environment for critical reflection, engage communities in active listening and dialogue, inspire communities to move towards collective action and help facilitate community change. They can contribute to **(1)** the self-development of participants through fostering recognition of the need for change, **(2)** improved self-awareness of local circumstances and enhanced confidence, **(3)** increased awareness of existing capacities and **(4)** strengthened problem-solving abilities. They can also encourage local, influential stakeholders to listen more attentively to the voice of the community.

Applicability: Photo Voice and Participatory Video can be used in all response phases and for a variety of purposes, including advocacy, research, needs assessment, programme monitoring and evaluation. Participatory video, however, can take longer to implement and may need additional support. There is no blueprint for setting up these activities; they must be customised to the context, thematic area and available resources.

☺ Do

- Take time to select the photographers and video makers based on project purpose
- Organise community meetings to explain the aim and use of the cameras and provide training to participants
- Develop a dissemination strategy that will identify which formats and communication channels to use
- Consider consent and ownership, copyright and use of the pictures

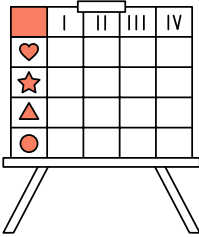
☹ Don't

- Do not tell participants what to film or what pictures to take; allow them to control the process once you have discussed the brief
- Do not accidentally reinforce community power dynamics through the selection of the image-takers

Practical Example: A participant captured an example of water shortage in Freetown, Sierra Leone and explained: 'these people are waiting for water. Some have come 5–6 kilometres. This is where I live. It is a hill. Some come from up, some from down. The time I took this picture is almost evening. Some have been waiting a long time for their turn. The water is coming out slow, it takes time. There is no control. There is not enough supply of water. We are straining.'

→ **References and further reading material for this tool/method can be found on page 298**

Pocket Chart Voting

<p>Purpose To collect and assess sensitive information and stimulate discussion</p> 	<p>HP Component</p> <ul style="list-style-type: none"> Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Pocket Chart Voting is a multipurpose participatory tool that, depending on the purpose, can be used as a complementary assessment or monitoring tool to generate (sensitive) information, recognise patterns, give voice to different members and groups, stimulate discussion, identify differences in experiences and opinions and encourage action on hygiene issues.

Pocket Chart Voting allows participants to anonymously identify and explore sensitive hygiene topics that they may otherwise be too embarrassed to discuss. It is based on a matrix consisting of a horizontal row for the different voting issues and a vertical row often used to represent the focus or target groups. The issues/topics to be voted upon can be presented visually (e.g. pictures, drawings); each one must be explained so that every participant has a full understanding of the issue prior to the voting. The tool is often used to disclose sensitive, taboo or even shameful topics (e.g. defecation practices or menstrual hygiene-related issues); anonymity/privacy must be guaranteed during the voting so that everybody feels comfortable enough to vote honestly. The matrix often consists of open envelopes or pockets for each category in which participants can place their votes. Alternatively, receptacles such as cardboard voting boxes, bowls, or jars can be used. Counters, slips of paper, stones, or seeds are used to cast the votes. The voting usually takes place behind a board or screen so that individual voters cannot be seen while voting. Counting of the votes takes place publicly however and the generated information should be used as a basis for further discussions with the participants. The size of the group should be large enough to ensure the anonymity of the results and small enough that the actual voting process does not become too lengthy.

Applicability: Pocket Chart Voting is easy to use and can be used in all response phases and in many different settings. It can be used during Focus Group Discussions (T.14) or other community meetings. It is important to have a facilitator with previous experience in using the pocket chart. Pocket charts can be made out of locally available material. Prefabricated versions also exist.

😊 Do

- Test the voting exercise first using a very simple question to ensure that all participants have understood the matrix and method
- Use locally-recognisable pictures and graphics so that the participants can relate to them
- Ensure anonymity during the voting process


😞 Don't

- Do not hold multiple voting rounds, otherwise the exercise becomes too lengthy
- Do not forget to share and discuss the results with participants

Practical Example: Pocket Chart Voting was used in Sierra Leone to explore gender roles in relation to sanitation. Voting was first conducted about where men, women, boys and girls preferred to defecate. A discussion followed about how young children often went behind the latrines in the school because they were scared of going inside the dark latrine. Voting also revealed that women often went to the public latrines in pairs for safety and to prevent disturbance, as there were no door locks. Subsequent voting exercises with teenage girls revealed their preferences for different menstrual products and other hygiene items. The agency adapted its intervention to meet the needs more effectively.

→ **References and further reading material for this tool/method can be found on page 298**

Positive Deviancy and Doer/Non-Doer

<p>Purpose To identify community members who practice healthy behaviours in order to influence others who don't</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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The Positive Deviancy and the Doer/Non-Doer tools both aim to identify families or individuals who practise a desired behaviour when many people do not and to find out what motivates them. These motivational factors can then be used to influence others.

Positive Deviancy is based on the observation that, in every community, some individuals or groups seem better at finding solutions to problems, despite having the same lack of resources or facing similar or worse constraints. For example, some people in resource-poor settings avoid malnutrition or choose to build a toilet. The Positive Deviancy approach tries to identify why and how they do this and uses the information to influence others. It involves careful listening and discussion with affected communities to identify solutions to problems using existing resources.

The **Doer/Non-Doer** technique similarly works with the principle that some people (though often a minority) practise a desired behaviour and others do not. Doer/Non-Doer analysis interviews both those who do and those who do not. A questionnaire is often used to identify which motivational factors are the most important for 'doers' compared to 'non-doers'. The percentage difference between them reveals the most likely factors to be successful at influencing the non-doers and which ones should be stressed in communication strategies. Doer/Non-Doer is used in Social Marketing (F.21), FOAM (F.19), RANAS (F.20), Barrier Analysis (T.3) and various other WASH approaches.

The tools should be considered for use in an Assessment (chapter A) but there may not be time for this kind of in-depth formative research in an acute situation. Positive Deviancy is arguably more collaborative and participatory than the Doer/Non-Doer survey and could be considered to be an approach, rather than a tool.

Applicability: Both methods can be used in most settings and response phases but are not often a priority in the initial phase of an emergency. They require time and well-trained facilitators who have some familiarity with the method.

☺ Do

- Involve different community members and work with groups so that they can learn from each other
- Identify both those who practise a behaviour and those who do not through Observation (T.28) and discussion
- Use probing questions and explore in-depth people's practice and motivations using role-play, storytelling and pictures
- Promote positive norms and focus on success through ongoing support and encouragement

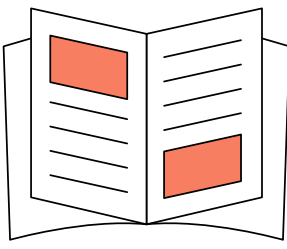
☹ Don't

- Do not tell people what to do or criticise their practices
- Do not use generic messages

Practical Example: Positive Deviancy has been used in various health care settings across the world to help staff identify how to lower infection rates in hospitals. It has also been used in nutrition programmes where it is known as 'The Hearth Approach'. Involving staff in a collaborative process and investigation is more effective than the imposition of solutions. Save The Children used a Doer/Non-Doer survey in a Vanuatu nutrition programme in 2018 and found that non-doers believed that using unclean water to wash their hands would make their baby sick; as a result, they did not practise handwashing (and had trouble remembering the critical times for handwashing). Doers were more likely to feel that their husbands approved of them washing their hands.

→ **References and further reading material for this tool/method can be found on page 298**

Print Media

<p>Purpose To increase awareness, change public opinion and provide information widely and fast</p> 	<p>HP Component</p> <ul style="list-style-type: none"> Preconditions & Enabling Factors ★ Community Engagement & Participation Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Print Media is a cost-effective Mass Communication (C.5) tool to spread information and raise awareness on hygiene-related issues. It can help create demand and influence public opinion and behaviours.

Print Media, such as newspapers, leaflets or brochures, can be used to cover a wide geographical area and spread simple WASH and hygiene-related information to large numbers of people, increasing awareness and interest in improved hygiene. Posters and flyers are more useful for sharing information relevant to a specific community. Print Media usually involves text and, as such, usually reaches only those who can read. However, visualisations and pictures such as comic stories can help make the content more accessible. Print Media is usually a one-way communication method making it more difficult to interact with the target audience or to know whether the information is retained or influencing change. Print Media should be embedded in a wider communication strategy using different channels such as Radio and TV (T.38), Social Media and Text Messaging (T.44), Public Announcements (T.36), Community Drama, Cinema and Puppet Theatre (T.6) or Household Visits (T.18). A good quality Assessment (chapter A) is fundamental to understand what communication channels are generally used by the community and whether Print Media is culturally appropriate and accessible.

Applicability: Print Media can be used in all response phases and in both rural and urban contexts. Newspapers can reach large numbers of people from different segments of the community but can only reach literate people. Flyers and posters can use images to explain and provide information and can be used in a variety of locations; they do rely on physical access for distribution. Print costs can be high.

😊 Do

- Assess priorities and develop the content based on key hygiene behaviours
- Pre-test the messages to make sure they are sufficiently understood
- Try to negotiate for free or reduced-cost media services, explaining that the aim is to benefit the population not for profit


😞 Don't

- Do not use channels that may affect the programme's neutrality and impartiality

Practical Example: To build awareness of Menstrual Hygiene Management (MHM), the Iraqi Red Crescent and the French Red Cross together adapted the MHM educational guide called 'Rosie's World' to the Iraqi context. As well as translating the text into Arabic and ensuring terms and language aligned with the Iraqi context, they also adapted Rosie to look like an Iraqi girl to whom students could easily relate. Printing guides that engaged the local population helped people to better understand MHM issues and support women and girls.

→ **References and further reading material for this tool/method can be found on page 298**

Proportional Piling

Purpose To estimate quantities and proportions and prioritise WASH-related issues, challenges and solutions 	HP Component <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	Target Group <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	Response Phase <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	Application Level <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Proportional Piling is a participatory method that helps to visualise relative proportions. It is useful for working with people who are not used to quantifying data. The method aims to collect information, generate discussion and facilitate consensus and decision making.

Proportional Piling is a simple technique for visualising quantities. It is often used to visually identify the relative shares or importance of different comparable WASH-related issues (e.g. hygiene behaviours, household expenditures, or health problems in the community). It can help to prioritise community challenges and potential solutions. It can be an assessment tool or a decision-making support tool. Proportional Piling is also a valuable facilitation tool as it can quickly generate fruitful discussions about the relative size of the piles and help small groups reach a consensus. The resources needed for a Proportional Piling exercise include a fixed number (usually around 100) of locally available materials such as small stones, dried beans, seeds or pieces of paper or anything of a similar size. Circles or pictures, which represent the topics of concern, can be drawn on the ground or paper. Participants are then asked to divide and pile up the stones or beans according to the proportional importance of the topics under discussion. Each pile is then counted and used for further analysis and discussion. It can be useful to repeat Proportional Piling exercises to compare the issue in the current situation with the pre-crisis situation.

Applicability: Proportional Piling can be used in all response phases, in a variety of contexts and with different target groups. It needs a skilled facilitator and can be done with local materials. Because of the small number of readily-available materials needed, it can be applied easily and quickly. Proportional Piling is not usually a stand-alone tool but is used in conjunction with other participatory assessment tools such as Focus Group Discussions (T.14), Three-Pile-Sorting (T.51) or Pocket Chart Voting (T.31).

☺ Do

- Be transparent about the purpose and aim of the Proportional Piling exercise
- Have a good facilitator to stimulate discussion and obtain accurate information
- Ensure that all people from the interest group are involved and integrated into the piling process

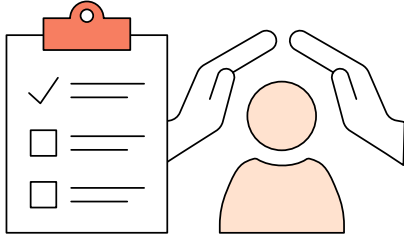
☹ Don't

- Do not use Proportional Piling repeatedly for all the topics in question: it takes time and people may lose interest
- Do not generalise the data and apply it to the wider population by using percentages (A.8)

Practical Example: Proportional Piling was used with nomadic pastoralists in Kenya during interviews with sample households to investigate the relative contribution of the families' various economic activities to the household food supply. The exercise provided indicative values – based on the families' own perceptions – and served as a basis for further discussion. The exercise was carried out twice, for the wet and dry seasons enabling seasonal differences to be assessed and discussed.

→ **References and further reading material for this tool/method can be found on page 298**

Protection Mainstreaming

<p>Purpose To incorporate protection principles and promote meaningful access, safety and dignity in hygiene promotion interventions</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

All hygiene promotion (HP) interventions must proactively include measures to ensure that interventions do not inadvertently cause harm to people or undermine the values, standards and norms that underpin the humanitarian response.

WASH programming that does not address protection mainstreaming can increase vulnerability, exacerbate violence and prevent access to adequate WASH. Working in a team, hygiene promoters must **(1)** prioritise safety and dignity and avoid causing harm as much as possible by preventing and minimising any unintended negative programme effects which may increase people's vulnerability to both physical and psychosocial risks, **(2)** promote meaningful access: access to assistance and services must be in proportion to need and without barriers (e.g. discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing WASH assistance and services, **(3)** be accountable to communities **(M.4)** by establishing appropriate mechanisms **(T.13)** through which affected populations can feedback on the adequacy of interventions and have their concerns and complaints addressed, **(4)** enable participation and empowerment **(chapter E)** by supporting the development of self-protection capacities and assisting people to claim their rights including, but not exclusively, the rights to water, sanitation and health, **(5)** manage risks by Monitoring **(M.2)** potential risks on an ongoing basis and identifying ways to prevent and mitigate them.

Applicability: Mainstreaming protection is mandatory in all HP programmes, throughout the programme cycle and in all response phases and contexts.

☺ Do

- Build the capacity of staff and partners to understand the problem of violence related to WASH and recognise what their responsibilities are
- Make links with protection, gender and gender-based violence specialists to assist in improving programmes and responding to the challenges
- Ensure that WASH facilities are designed, constructed and managed in ways that reduce the users' vulnerability to violence

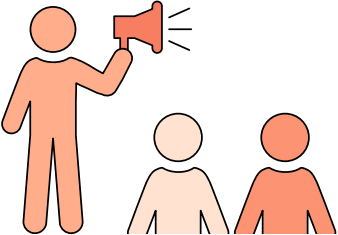
☹ Don't

- Do not consider 'protection' as the sole responsibility of specialists
- Do not be afraid to ask for help and support to fulfil the protection requirements of HP and other WASH staff

Practical Example: In Liberia, examples of violence or vulnerabilities to WASH-related violence were shared during meetings with a range of organisations working in protection, women's empowerment and WASH. For example, in Grand Gedeh, a new borehole was sited next to the town chief's compound at his request. When the NGO returned to monitor, they found that the women would not use the borehole because there were always men sitting outside the chief's house and they were frightened of being harassed. Beating and harassment were common (for women and children) if they stayed away too long from home, including when collecting water. The siting of the borehole should have involved women who were the primary users of the facility.

→ **References and further reading material for this tool/method can be found on page 298**

Public Announcement

<p>Purpose To spread information and key messages to a large number of people quickly</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Public Announcements are a mass communication (C.5) tool to convey important hygiene-related messages quickly. They can reach many people at once and are cost-effective.

Public Announcements aim to spread vital information (e.g. about acute health risks or protective hygiene practices), raise general awareness on an issue and help influence attitudes and behavioural norms (C.9). It is more effective when focused on the most relevant information and conveying a small number of messages at one time. Repeating the message several times is also helpful. Public Announcements need to be made in the local language and adapted to the local context. They are a one-way form of communication with little or no participatory characteristics although they should be based on a community assessment and subsequently Monitored (M.2). Because it is difficult to know whether the information has been clearly understood by the target audience, Public Announcements should be complemented by other tools, methods and messages. The information may also require reinforcement by local health or hygiene promoters using more participatory communication (C.4). Public Announcements are commonly made on Radio or Television (T.38). They can be made using a megaphone or loudspeaker, often in an area where many people gather (e.g. markets); mobile loudspeakers mounted on a vehicle are also used. Public Announcements on radio or television (known as Public Service Announcements) are often free of charge.

Applicability: Public Announcements are particularly useful in the acute response phase when information and messages have to be spread quickly. Because of its simplicity and the limited number of materials required, it can be used in various contexts and address large audiences.

☺ Do

- Ensure that messages are clear and memorable and, if possible, repeated several times
- Use group-relevant and appropriate words and language
- Consider using a slogan or song to make messages more memorable

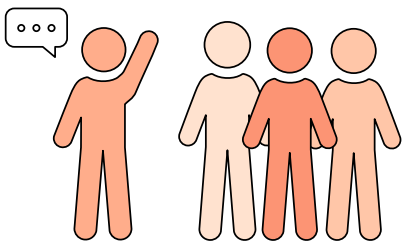
☹ Don't

- Do not spread overly complex messages
- Do not rely on Public Announcements as the only communication tool and consider other more participatory communication methods

Practical Example: During the COVID-19 pandemic, Public Announcements were used frequently by governments around the world to provide information on staying home, social distancing, using facemasks and washing hands. This information was repeated numerous times using different modes of communication, including Radio and TV (T.38) and Social Media (T.44). In the UK the slogan, 'Hands, Face, Space' was used to make this information more memorable. Later Public Announcements focused on the importance of getting immunised and where this could be obtained.

→ **References and further reading material for this tool/method can be found on page 298**

Public Commitment

<p>Purpose To support the creation of social norms that support positive hygiene behaviours</p> 	<p>HP Component</p> <ul style="list-style-type: none"> Preconditions & Enabling Factors ★ Community Engagement & Participation Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

A Public Commitment is the promise to engage in a specific action that a person makes in front of others. There is strong evidence that Public Commitments are effective at changing hygiene behaviours. Public Commitments do not have to be verbal; they can also be made using publicly displayed symbols.

The working principles of a Public Commitment are two-fold. First, a public commitment changes a person's self-perception. After committing to a behaviour (such as handwashing with soap), the person starts to see themselves as, e.g. a 'handwasher'. To be consistent with this self-perception the person performs the behaviour more frequently and, having committed to do so in front of other people, they want to appear consistent. Secondly, witnessing Public Commitments prompts others to act. If a person observes many people publicly committing to a specific behaviour it helps to influence their perception of the Social Norms (B.6) linked to the behaviour; it may prompt the observer to also carry out the behaviour. Public Commitments can be made quickly and for a broad range of behaviours. However, the action has to be feasible (e.g. handwashing facilities must be available and accessible, P.2). Depending on the context, an appropriate communication channel (e.g. village meeting, Household Visit (T.18), Social Media (T.44) or radio show) and commitment ritual (e.g. public verbal pledge, installation of flags or wearing of branded t-shirts) will need to be assessed and agreed upon.

Applicability: Public Commitments are appropriate in most contexts and phases but are unlikely to be a priority in the initial phase of an emergency. The necessary human resources, equipment and time for implementation depend on the selected communication channel and commitment ritual.

😊 Do

- Organise Public Commitment rituals and prompt participants to commit in front of others to make the effect more powerful
- Tailor commitment rituals to the preferences of the target population, context and locally available material and pre-test them with a smaller group
- Anticipate potential problems during verbal commitment rituals, e.g. opinion leaders who might oppose the commitment

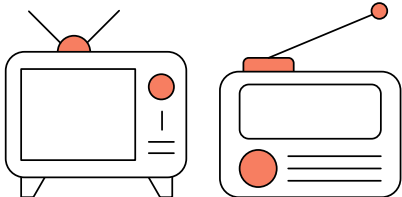
😞 Don't

- Do not sanction or fine individuals who do not adhere to their commitment
- Do not choose commitment rituals that have low public visibility
- Do not choose commitment rituals associated with political parties or sub-groups, as this may limit their reach and create social tensions

Practical Example: As part of a COVID-19 prevention intervention in a refugee camp in Zimbabwe, participants were informed of the benefits of maintaining physical distance and told that leaders approved of this practice. Participants were asked if they would like to commit to this behaviour also. If they made the Public Commitment, they received a branded face mask with a slogan. By wearing the mask, they made their commitment to physical distancing visible to others and they could see who else had made the commitment.

→ **References and further reading material for this tool/method can be found on page 298**

Radio and Television (TV)

<p>Purpose To increase awareness, change public opinion and provide information rapidly to large audiences</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Radio or Television (TV) are cost-effective Mass Communication (C.5) tools that can rapidly spread information and raise awareness on hygiene-related issues, help create demand and influence or change public opinion and behaviours.

Radio and TV can be used to rapidly spread simple WASH and hygiene-related information to large numbers of people, increasing awareness and interest in improved hygiene. They may reach people who are otherwise isolated by geography, conflict, low literacy or poverty. Radios are usually widely available even in countries where TV is uncommon. This makes radio a particularly valuable medium if literacy is low or in communities with a more oral tradition. However, lack of electricity or the need for batteries can be limiting factors. Both Radio and TV are one-way media usually with little or no participatory elements. This makes it difficult to interact with the target audience and to know whether the information is retained or effective in influencing change. However, participatory elements can still be used to engage more actively with the audience. Examples include radio call-ins and encouraging groups to listen or watch together, followed by discussion. The use of Radio and TV should be embedded in a wider communication strategy using different channels, such as the use of Household Visits (T.18) or leaflets (T.19). A detailed Assessment (chapter A) is essential to understand which communication channels are usually used by the community and whether Radio and TV are culturally appropriate and accessible.

Applicability: Radio and TV can be used in all response phases and both rural and urban contexts. They can reach large numbers of people from different segments of the community. People can also be reached remotely (C.8). Radios, in particular, are an inexpensive and popular form of communication. Radio broadcasts are easy to produce though airtime can be expensive.

☺ Do

- Consider using slogans, jingles or Songs (T.47) that are recognisable to the audience
- Always base the selection of communication channels on a prior assessment
- Choose a Radio or TV station that has a wide reach within your target audience, is trusted by the population, broadcasts in the preferred language and does not have strong affiliations to any one group

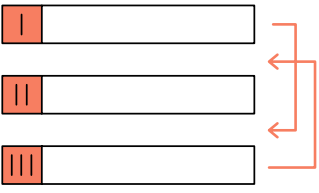
☹ Don't

- Do not use channels that may affect the neutrality and impartiality of the organisation
- Do not underestimate the skills and the time needed to train the team

Practical Example: To build awareness of disaster preparedness among people in Kurigram and Barguna districts, the Bangladesh Red Crescent chose community radio stations as a medium of communication. Their 'Hello Red Crescent: We Listen To You!' has been regularly broadcast. The theme of each radio show is decided through discussion sessions to identify the issues and information that are important to communities. Providing vital information through Radio broadcasts helped people to take action to better protect themselves and their families against disasters.

→ **References and further reading material for this tool/method can be found on page 299**

Ranking

<p>Purpose To identify, discuss and prioritise community health and hygiene issues</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Ranking is a participatory tool used to determine WASH priorities, identify problem areas or assess people's expectations, beliefs, judgements, preferences and opinions. It is most commonly used as a tool for Assessment (chapter A) and, to some extent, as a tool for Monitoring (M.2).

In a Ranking exercise, participants express their views on specific health and hygiene-related issues and prioritise them (usually on a numerical scale such as 1–10). Ranking is a quick way to assess the affected community's hygiene practices, prioritise interventions and get people discussing hygiene issues. It can help identify common practices or perceptions of single hygiene measures. It rapidly highlights key findings while providing the opportunity for deeper analysis. Ranking with a community can strengthen community engagement and acceptance of hygiene measures; it allows many people to participate. Participants consider multiple criteria simultaneously, prompting trade-offs and compromises to reach a decision. The facilitator first defines the scope of the issue in question and determines the Ranking scale or continuum using, for example, a line drawn on the ground or paper. Participants are then encouraged to rank the options along the continuum in an order that reflects their relative importance. The facilitator then encourages further discussion asking if everyone agrees with the positioning and why or why not. In a group, the aim is to keep adjusting the Ranking until a final order is agreed. Simple Ranking assigns a rank to a list of items, e.g. of diseases according to their severity. Pairwise Ranking uses a matrix to compare items, e.g. each disease, in turn with all the others to identify the most important. The results can be different to simple Ranking and prompt more in-depth discussion about why one disease is more important than another.

Applicability: Ranking exercises can be applied in all response phases and in a variety of contexts with different target groups. Ranking is a simple and easy tool that makes use of locally available materials such as stones or twigs. Ranking is a quick method of gathering data and understanding issues from the participant's point of view. It can stimulate discussion, or reach a consensus on people's priorities, or compare the priorities of different user groups with each other.

☺ Do

- Have a good facilitator to stimulate discussion and obtain accurate information
- Ensure that everyone in the interest group is involved and integrated into the Ranking process
- Make sure findings are recorded, shared, discussed and used

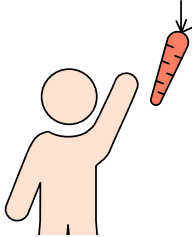
☹ Don't

- Do not generalise the data produced and apply it to a wider population

Practical Example: Ranking exercises were used as part of a gender, gender based violence and inclusion audit in the Rohingya refugee camps in Bangladesh. Participants held up a card representing a specific group (e.g. adolescent boy, male with a disability, woman over 65 years). The group then ranked the difficulty the individuals might face to manage their WASH needs, moving people from their relative position and explaining why they had done so. By the end of the exercise, adolescent girls and boys had been placed at opposite ends of the scale, with girls ranked as having the most difficulty managing their needs. This provoked significant discussion and recommendations on how better to support them.

→ **References and further reading material for this tool/ method can be found on page 299**

Rewards and Incentives

Purpose To motivate a certain choice by increasing its perceived benefits 	HP Component <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change ★ MEAL 	Target Group <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★ Society as a Whole
	Response Phase <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	Application Level <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Rewards and Incentives can be monetary, in-kind or intangible and are given to an audience when they carry out the desired behaviour. They aim to increase the perceived benefits of the desired behaviour or choice and thereby motivate and encourage its practice.

Faced with the choice between several options individuals consciously or unconsciously consider the costs and benefits of the options. For example, to choose handwashing with soap an individual might weigh up the monetary costs of soap and the time required for handwashing with the health benefits, health savings and social appreciation. This trade-off between costs and benefits may not be in favour of particular hygiene behaviours and hence acts as a barrier to it. In such a situation, providing other rewards may create important additional benefits and, as a result, the motivation to practise the behaviour. Rewards can be monetary (e.g. conditional cash-transfer), in-kind (e.g. soap) or less tangible (e.g. appreciation from others or a certificate from a Community Health Club, F.1). Some individuals who have never performed certain hygiene behaviours may have a biased estimate of its costs and benefits through lack of experience. In such cases, Rewards and Incentives can motivate them to adopt the behaviour, discover the true benefits and costs and reevaluate their behaviour. If there are competing undesirable habits, rewards may compensate individuals for the additional cognitive effort required to start the new behaviour and overcome the old habit. Rewards can motivate short-term behaviour change or one-off behaviours (such as constructing infrastructure that would not be economically viable without a reward). Monetary or in-kind rewards may also be useful when engaging community mobilisers by e.g. offering small allowances, food, materials, equipment (such as rain jackets, t-shirts or bicycles) or training certificates.

Applicability: Rewards and Incentives can be implemented in various contexts and response phases but should be used with care. Rewards can be implemented relatively quickly, but they can be costly (depending on the scale), require a systematic process to determine eligibility for rewards and a system to monitor who has received them.

😊 Do

- Critically reflect whether monetary or material rewards are necessary and explore alternative sources of intrinsic motivation
- Ensure that all stakeholders and community members know about the reward system and nobody feels left out
- Carefully design and test the magnitude of the reward – it should be neither too high nor too low

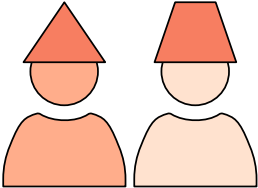
😞 Don't

- Do not use rewards over the long term. Dependency on rewards can become a disincentive and undermine intrinsic motivation
- Rewards should not prompt people to neglect other important activities

Practical Example: A behaviour change campaign to promote Solar Water Disinfection (SODIS) was conducted in Harare, Zimbabwe. To motivate people to use and talk about SODIS every bottle bought in a SODIS bottle centre (created because of a lack of plastic bottle availability) was sold with a voucher with the buyer's name written on it. The buyer was told to give the voucher to someone else who would hand in the voucher at the bottle centre. This entered the buyer in a lottery to win a food hamper. Hence, the more bottles someone bought and the more they talked about SODIS, the higher their chances of winning.

→ **References and further reading material for this tool/method can be found on page 299**

Role Play

<p>Purpose To explore different perspectives and stimulate discussion and learning</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Role Play is the act of temporarily taking on another persona or doing something unfamiliar by putting yourself in someone else's shoes and acting and talking as they might do in a particular situation. A single person or a group can enact a role or situation.

Role Play can be used in a variety of ways and for a variety of purposes. It is typically used as a training exercise, e.g. acting out the role of a hygiene promoter doing a Household Visit (T.18). It can be used to practise communication or other skills in a variety of situations, e.g. carrying out a hygiene promotion activity, sitting on a WASH Committee (T.55), or attending a coordination meeting. It can also be used to problem solve e.g. communicating with a community member who is unwilling to use a latrine or is making a complaint. Participants can be asked to reverse their roles, taking it in turns to see a situation from different perspectives, e.g. male or female. They can enact a good and bad situation, e.g. didactic versus interactive training. Role Play can provoke discussion and unleash creative solutions to problematic issues. A Role Play usually lasts between three and ten minutes – any longer and participants can struggle to find material. Many people feel self-conscious taking on a specific role in front of others or without preparation; they may need time to familiarise themselves with the benefits of the technique. People should not be forced to Role Play if they are very uncomfortable with it. Some may feel more confident in much smaller groups or by simply imagining what might happen in a specific situation and then discussing it with others.

Applicability: Role Play is often used to train WASH personnel but it can be used with community members, during meetings, or to resolve problems in a variety of contexts and response phases. Unlike theatre, it can be used spontaneously without specific tools or equipment as they can be created or visualised if required.

😊 Do

- Clearly explain the process including the benefits e.g. the chance to practise a skill or action in a safe space
- Make space to discuss how participants and observers felt in another role and what can be learned
- Debrief afterwards – make it clear when the activity starts and finishes, especially if discussing difficult situations


😞 Don't

- Do not force people to take on a role if they are not comfortable with the process
- Do not allow the Role Play to go on for too long before discussing the issues

Practical Example: Following an assessment in the Ivory Coast, Oxfam planned various WASH activities, but a community meeting revealed limited support for them. Oxfam decided that subsequent activities would be defined with the community. Leaders, key community stakeholders and Oxfam held a workshop that included a Role Play where Oxfam staff played the community and vice versa. This helped to reveal either other's perspectives and constraints and built trust between the NGO and the community. A more ambitious project was developed as a result and the community contributed additional time and resources, leading to a very successful project.

→ **References and further reading material for this tool/method can be found on page 299**

Routine Planning and Self-Regulation

<p>Purpose To reinforce a positive behaviour and messages by adopting them as structured, routine habits</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities Local Leaders Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Routines help with hygiene behaviour management and reinforce an action to become a habit. The planning of routines can be interactive, initially making Checklists (e.g. T.20) to monitor a repeated hygiene activity (like washing hands) until it becomes a habit.

In emergencies, the habits of households and communities are often disrupted as they find themselves in unfamiliar situations or surroundings. They are confronted with new hygiene challenges such as disease outbreaks and have to adapt to address them. The creation of new, daily hygiene routines such as handwashing, use of toilets and safe handling of food and water can take time. The systematic repetition of hygiene behaviours eventually turns them into a habit as the behaviour becomes automatic and done almost without thinking. The creation of routines can be integrated with peer group activities in institutions like schools (T.50). Routines can be gender-specific e.g. women and teenage girls may have different hygiene routines related to menstruation. Routine Planning should be accompanied by the regular supply of materials such as soap for handwashing (P.6). Including too many messages and tasks in a routine may confuse the target audience and undermine adherence. The ease and effectiveness of the routine is also important for transforming an activity into a habit. If the target audience can see an improvement in their living standards and health, it motivates them to stick to the habit. A hygiene schedule or plan can be provided for children to monitor their progress. Hygiene promoters should build the routine with the target communities using group activities or by providing checklists until the routine becomes a habit. Technology such as smartphones can be used for Routine Planning by setting Cues (T.9) such as regular reminders from message groups.

Applicability: The acute response phase does not provide a favourable environment for Routine Planning and habit formation because of instability and barriers such as lack of access to resources such as soap and hygiene kits (P.6). Routine Planning is more applicable to other phases when there is a more stable environment and time to engage with the community to develop routines through group activities and self-help groups.

😊 Do

- Keep routines simple and easy
- Supervise children's routine by adults initially – both in households and schools
- Use Cues (T.9), e.g. in the form of Print Media (T.33), Checklists (T.20) and IEC Materials (T.19) to encourage routine adherence
- Be sensitive about traditional and religious habits

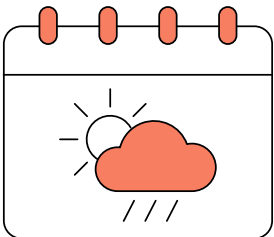
😞 Don't

- Do not provide too much information on a checklist as it can make the routine arduous
- Do not tackle several hygiene habits at the same time

Practical Example: In a Fit for School (F.10) programme in Indonesia, special Routine Planning for Supervised Handwashing in schools (T.50) was introduced to avoid the mixing of different age groups and overcrowding at handwashing stations. The routine is a measure for the safe reopening of schools during the COVID-19 pandemic. Cues and Nudges (T.9) for physical distancing and face masks have also been incorporated in the form of posters to ensure compliance.

→ **References and further reading material for this tool/method can be found on page 299**

Seasonal Calendar

<p>Purpose To learn about cyclical changes and the seasonality of different factors</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★ Institution ★ Camp ★★ Rural ★ Urban
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A Seasonal Calendar is a simple participatory assessment tool to explore and visualise seasonal changes. It provides community-level information about seasonal cause and effect relationships, raises awareness, stimulates discussion and informs planning and decision making.

A Seasonal Calendar is a matrix or table with a linear time scale on one axis (corresponding to the local calendar) and indicators of interest on the other axis. It can be drawn on the ground (e.g. using sticks) or on a big sheet of paper. Depending on the context or type of information needed, potential indicators or questions include: rainfall pattern, prevalence of diseases, changes in livelihood activities, income and expenditure for men and women, availability of money and time, availability of water, or agricultural activities. A facilitated discussion – sometimes in separate Focus Groups (T.14) – can encourage the group to identify the linkages and potential underlying reasons for the differences highlighted. An adapted version of the tool can also be used as a daily activity calendar to, for example, identify what people do in relation to hygiene over the course of a day. A Seasonal Calendar requires a large open space for the target group to convene, a trained facilitator and paper, pens and markers (or sticks if drawn on the ground). It does not require a high level of expertise (or literacy) and is usually done in less than two hours. It can provide baseline information for planning and decision making (chapter A) and, if done repeatedly, it can also be used as a Monitoring (M.2) tool.

Applicability: The Seasonal Calendar is most applicable in the stabilisation and recovery phases but may be useful for an initial market assessment or to better understand changes in the local environment (e.g. times with limited road access) that are likely to affect emergency responses. The tool is more relevant if the participants have lived in the community and are familiar with changes in it over time. It may be useful in identifying times of, e.g. disease prevalence, labour or water shortages and suitable times for WASH infrastructure construction (e.g. after harvest when time is available). It can support community-based climate change adaptation measures.

☺ Do

- Have a local facilitator who speaks the language and relates to the culture and issues discussed
- Consider using symbols or graphics, depending on literacy levels
- Ensure that the matrix is large enough to be easily seen by all

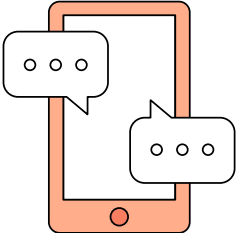
☹ Don't

- Do not collect information without a facilitated discussion afterwards, enabling conclusions to be made jointly
- Do not accept information uncritically; it is based on memory and triangulation may be needed

Practical Example: The IFRC developed and used a Seasonal Calendar for Vector Control (P.5) of the Zika virus to visualise information and analyse how climate change and social and cultural conditions in a specific context were affecting Zika-spreading mosquitoes. It helped communities to track vector risks over time and empowered them to tailor their activities to seasonal risks with, for example, clean-up interventions at times of greatest risk.

→ **References and further reading material for this tool/method can be found on page 299**

Social Media and Text Messaging

<p>Purpose To allow for real-time two-way communication and information-sharing during an emergency</p> 	<p>HP Component</p> <ul style="list-style-type: none"> Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★ Rural ★★ Urban

Social Media and Messaging apps are used as online communication platforms to reinforce hygiene messages and behaviours and provide critical information to the target audience.

The Social Media and Messaging apps that are universally used are Facebook, Twitter, YouTube, Instagram, Tik Tok, WhatsApp, Signal and WeChat. The use of apps differs from country to country and it is important to identify the relevant platforms used in the area. Social media accounts are easy to create. Messages can be shared almost instantly. Messages can also be used as a reminder to encourage habit-formation and can be useful to share messages during Events (T.11) and relevant world days like Global Handwashing Day. Information can be shared in various formats like podcasts, music, videos, animations, simple text and documents. It is important to add a personal or human touch when communicating as this prompts the target audience to perceive it as more trustworthy. Partnering with influencers and local leaders (T.22) to produce content such as photos, videos and podcasts can also help create an instant connection with the audience. Social Media and Messaging apps are less time and resource consuming than other Mass Media (C.5) such as Print Media (T.33) or Radio and TV (T.38). A simple smartphone can deliver messages instantly. A Social Media manager and communications staff may need to be hired depending on the scale of the Social Media outreach to create consistent and reliable content. There are several inexpensive apps available that design and schedule Social Media posts; they could be used instead of hiring additional staff.

Applicability: Social Media and Messaging have proved useful in all phases of emergencies. During an acute response, they disseminate potentially life-saving information quickly (e.g. during disease outbreaks). During recovery, messages can reinforce behaviours and positive habits. Urban contexts often provide more connectivity,

though Social Media platforms are becoming more accessible in rural areas through mobile internet and cell phone networks. Social Media and Messaging are extremely helpful and rapid sources of communication but abusive comments, hate messages, spam and rumour spreading (C.6) are prevalent. Maintenance work is required to constantly respond to negative comments and eliminate spamming.

😊 Do

- Involve the target audience in content creation and use private interaction features like messaging when necessary
- Use appropriate social media metrics to measure progress
- Use verified social media accounts

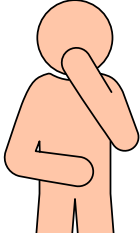
😞 Don't

- Do not use Social Media as a one-way communication channel. Listen and respond to messages and comments
- Do not use jargon and technical terms

Practical Example: Zambian pop star Pompi created a music video with WaterAid on handwashing to curb the spread of COVID-19 in Zambia. The video was shared widely on Social Media channels and WhatsApp in Zambia. In the Syrian city of Aleppo where most of the water supply was broken, secure water points were created and locations shared and constantly updated via phones on Social Media. These posts reached many users who could also get questions answered.

→ **References and further reading material for this tool/method can be found on page 299**

Social Norms and the Use of Shame and Disgust

Purpose To trigger behaviour change by encouraging adherence to social norms and moral behaviour 	HP Component <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change ★ MEAL 	Target Group <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	Response Phase <ul style="list-style-type: none"> ★ Acute Response ★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	Application Level <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★ Institution ★★ Camp ★★ Rural ★ Urban

Social Norms are the informal, mostly unwritten, rules that define acceptable, appropriate and obligatory actions in a given group or society.

Social Norms **(B.6)** can be described as a person's beliefs about what others in their group do (descriptive norms) and what they approve and disapprove of (injunctive norms). Many norms are context specific, differ between groups and change over time but some norms seem to be universal. There are various ways to create 'new' Social Norms, such as identifying hygiene or sanitation Champions **(T.22)**, Exchange Visits **(T.12)**, Public Commitment **(T.37)** or by simply conveying the idea that 'the majority of people are doing this' e.g. handwashing with soap or having their vaccination. Care must be taken not to encourage unwanted Social Norms. For example, media coverage about people not staying at home during COVID-19 lockdowns could inadvertently encourage the same behaviour by others.

Social Norms or their infringement can produce strong emotional responses such as Shame and Disgust; this is widely used in Community-Led Total Sanitation's (CLTS, **F.2**) 'triggering' activities. Shame is an emotion that involves self-reflection and evaluation. Disgust is often described as a cross-cultural human emotion that has evolved as a protective mechanism against contamination and infectious disease. The use of Shame and Disgust (and concurrent positive emotions such as pride, self-respect and dignity) can lead to self-realisation and growth. However, the use of Shame and Disgust during CLTS triggering sessions continues to be debated in the sector. Some see it as unethical as it may degrade and embarrass the community and generate stigma. Others believe that the element of shame is positive and helps to collectively awaken the community to the realities of Open Defecation (OD).

Applicability: Social Norms can be applied in any context or phase of the response. The use of Shame and Disgust in CLTS is most widely used in rural communities and where the majority practise OD. It works best in contexts with sufficient social cohesion and strong local leadership.

☺ Do

- Assess different Social Norms relating to hygiene and consider how they can be used
- Allow people to work things out for themselves when using Shame and Disgust

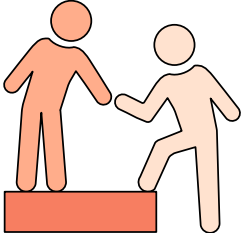
☹ Don't

- Do not tell people what is good and bad
- Do not inadvertently create harmful Social Norms in hygiene communications
- Do not use Shame and Disgust if only a small percentage of a community practises OD

Practical Example: An urban CLTS **(F.2)** intervention conducted by Malteser International in Juba, South Sudan used elements of Shame and Disgust as part of the initial processes of Community Mapping **(T.7)**, Transect Walks **(T.52)** and 'Water and Shit' Demonstrations **(T.10)**. The Transect Walk – also known as a 'Walk of Shame' – was used to visit different OD areas in the community where people were given time to inhale the unpleasant smell and take in the unpleasant sight of large-scale OD while asking questions (e.g. which families use which areas for defecation? Where do women go? What happens during emergency defecation at night?).

→ **References and further reading material for this tool/method can be found on page 299**

Social Support

<p>Purpose To facilitate behaviour change through targeted support</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Adapting to a new behaviour, particularly in an emergency, can be overwhelming. Providing the right form of Social Support from the right person can reduce the feeling that making a change is impossible.

For planning Social Support activities, the 'four Ws' (Who is providing What to Whom and When?) should be considered and carefully answered.

Who: depending on the behaviour, a friend, family member or hygiene promoter might be the best person to provide Social Support.

What: can include **(1)** emotional support offering empathy and providing care, **(2)** instrumental support providing practical, financial or material help, or **(3)** informational support providing advice and guidance.

Whom: for individuals to accept Social Support, important criteria about the supporter should be considered, e.g. gender, age or religion.

When: it is important to consider when the support would be most helpful. It may be after the first information has been received, or later when the person has encountered challenges.

There are various types of Social Support. One-to-one mentoring, where 'the supporter' visits people to perform a certain activity (such as demonstrating how to perform the behaviour **(T.10)** or providing material or emotional support). Another method activates the existing social network of family and friends; family members (e.g. the elder sister or mother) are invited to provide support when needed. Support groups are another option, for people who have tried to perform the new behaviour to share experiences, challenges and solutions. A positive side-effect of encouraging Social Support amongst the target group is that the community's social structure is strengthened.

Applicability: Social Support can be used in all response phases and contexts. Support networks are often initiated by communities themselves.

😊 Do

- Plan carefully and conduct a qualitative assessment (**chapter A**) of the 'four Ws' before the intervention. This also reduces the risk of potentially negative effects should the wrong type of support be provided (e.g. a girl might want emotional support with her menstrual hygiene management but only receives informational support)

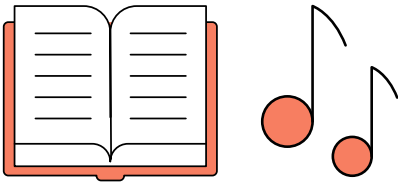
☹ Don't

- Do not only provide Social Support through hygiene promoters but involve existing social networks such as family, friends or neighbours

Practical Example: During India's sanitation campaign, Gram Vikas, a local NGO with a focus on improving the disposal of children's faeces, provided mothers with Social Support. The Support included three activities: **(1)** Household Visits **(T.18)** by promoters to provide informational and emotional support to the mother as she started to practise safe disposal and/or latrine training with her child, **(2)** working with the community's social network to bring other family members into the process (e.g. father and grandmother), encouraging them to provide the mother with a helping hand and **(3)** facilitating regular caregiver support groups where mothers came together to discuss their experience of adopting new practices, sharing the challenges and successes.

→ **References and further reading material for this tool/method can be found on page 299**

Songs and Stories

Purpose To impart knowledge about hygiene habits and to effectively promote behaviour change by using interactive learning and routine 	HP Component Preconditions & Enabling Factors ** Community Engagement & Participation Assessment, Analysis & Planning ** Communication * Social & Behaviour Change MEAL	Target Group ** Children ** Adults ** Older People ** Persons with Disabilities Local Leaders ** Society as a Whole
	Response Phase * Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development	Application Level ** Individual/Household ** Community/Municipality ** Institution ** Camp ** Rural ** Urban

Songs and Stories (e.g. story-telling or comics) are effective, fun methods for both adults and children; they can be used to stimulate discussions and summarise key information making it more memorable. The target groups can be involved in creating, singing, reading and narrating Songs and Stories about hygiene practices.

Songs and Stories are useful methods for increasing knowledge and sharing information, but may not result in immediate behaviour modifications. They can be used to address topics such as handwashing, personal hygiene, or the prevention of diseases and are most effective when people themselves are involved in their creation. Both children and adults usually enjoy Stories but the language should be appropriate for the age group. Rhymes, Songs and repetition can also help to reinforce behaviours. For adults, strong, impactful Stories on disease prevention can support behaviour change. Communities should develop Songs and Stories and can share them with others. Songs and Stories should be appropriate to the religious and cultural context, using the local language and traditional rhythms to make the Songs catchy. The content (the messages, information and key points) are of the utmost importance. Songs cannot change behaviour on their own – children and adults tend to remember the tune but forget the lyrics – so it is useful to use the tool in conjunction with other methods. Real-life scenarios, humour, the use of colour and pictures make Stories entertaining and attractive.

Applicability: Songs and Stories can be useful in all contexts. They can be applied at any scale but are usually more appropriate during the longer-term stabilisation and recovery phases. They might, however, provide solace and entertainment even during the acute response – especially for children. They can also be used as training tools, e.g. for training community mobilisers, or for hygiene promoters to initiate a discussion. The medium of communication may vary depending on the scale. Songs and Stories link well with Events (T.11), such as World Handwashing Day.

☺ Do

- Ensure the key message of the Song or Story is clear and easy to grasp
- Involve the community and creative local partners in their development
- Engage the audience with up-to-date trends, e.g. flash mobs, rap music

☹ Don't

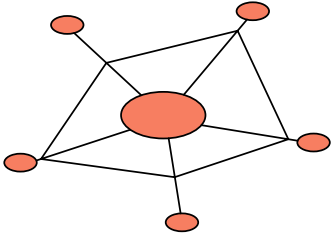
- Do not use Stories and Song that are irrelevant to the context, the situation and the culture
- Do not use inappropriate language that is shaming, humiliating or belittling.

Practical Example: In Guinea-Bissau, UNICEF held a contest for teenagers and aspiring musicians to write and produce Songs about handwashing. The winners were given a chance to release their music on radio spots before Global Handwashing Day. The Songs have since become so popular that they are now played on radio stations across Guinea-Bissau.

In Cox's Bazaar, Rohingya children became hygiene promotion ambassadors during the COVID-19 response by learning through Songs and Stories.

→ **References and further reading material for this tool/method can be found on page 300**

Spidergram

<p>Purpose To facilitate discussions with communities about the participation process and visualise the results</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Spidergrams can be used in a variety of ways and for different purposes. In an emergency WASH programme, they are useful to gather communities' perceptions about their satisfaction with the services provided and their trust in the responding organisations. The Spidergram activity can be repeated to Monitor (M.2) change and discuss progress.

A Spidergram is a visual, participatory tool that can provide a focus for discussions with communities. It can be used with individuals but works better with groups. The objective of the activity is explained to participants and several lines are drawn on the ground or paper radiating from a central point. Each line represents a variable that will be discussed. For example, to investigate community satisfaction the variables could be listening and adapting, inclusion, contextual appropriateness, addressing specific gender-related needs, ownership and information and communication. Each participant is then invited to decide how well the programme is doing on each variable. For example, each participant is given five tokens and can then rank the variable from 1 to 5 along the spider's 'legs' (five is very satisfied with community engagement; 1 is not satisfied at all). The results are discussed and a consensus 'score' is reached. Further discussion can then focus on suggestions for improvement. The end result of the Spidergram is a visual representation of the discussion showing a relative assessment of the level of community engagement for each variable, as well as suggestions for changes to the programme. The main requirements are: flipchart paper, markers, notepad, pens, tokens and a space to sit in a group to draw and discuss. Depending on the size of the group and the context, the process might take one to two hours.

Applicability: The Spidergram can be used in all response phases and in a variety of contexts. It can be used at different stages of the programme cycle. It can be used during the initial planning stage to engage the community or used repeatedly throughout the programme, using the same topics, to monitor changes (e.g. in community perceptions, trust and level of satisfaction). The Spidergram can be replicated in different areas for comparison. If the process of doing the Spidergrams is led by community health volunteers, some training may be needed.

☺ Do

- Start with a discussion so that the community understand the Spidergram purpose and process
- Save the information collected on the Spidergram and use it to influence the programme

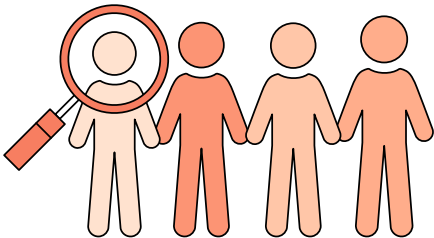
☹ Don't

- Do not rush the process; give people time to discuss
- Do not use written text if participants have high levels of illiteracy. Use pictures to demonstrate discussion points

Practical Example: As part of a process to understand the barriers and enablers in their emergency WASH programmes in Bangladesh and the Democratic Republic of Congo, Oxfam used Spidergrams to measure community participation and satisfaction. They used five indicators: information sharing, involvement in construction, involvement in tap stand design, involvement in site selection and feedback mechanism. The results were used with other information gathered to adjust the programme's focus and make changes based on the community's feedback.

→ **References and further reading material for this tool/method can be found on page 300**

Stakeholder Mapping

<p>Purpose To identify and categorise project stakeholders to guide the engagement and communication strategy and programme planning</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

Stakeholder Mapping is a collaborative process undertaken to determine, analyse and categorise relevant stakeholders according to their level of influence and interest in a particular intervention or project.

Stakeholders are individuals, groups, institutions or organisations that are internal or external to the intervention, have a vested interest in its success and can positively or negatively impact it. Stakeholders should influence the planning, selection of priorities and objectives of interventions to ensure programme relevance and appropriateness. Stakeholder Mapping aims to identify all the potential stakeholders who are affected by the intervention. Actors can be categorised as primary stakeholders (those directly impacted) and secondary stakeholders (those indirectly impacted). It is important to analyse their perspectives and interests, positions for or against an intervention, alliances or conflicts with other stakeholders, their power to affect the intervention or their degree of involvement in the process. Once stakeholders have been identified and analysed, they can be categorised, mapped and prioritised using a matrix to record and compare their level of interest or attitude (opponent, neutral, allies) and level of influence (e.g. what is important to them? What could they contribute to the process? To what degree can they make or break a project? How powerful or influential are they?). It is crucial to actively communicate and engage with different groups throughout the process through formal or informal networking, Key Informant Interviews (T.23) and, later in the process, joint stakeholder meetings. Stakeholder Mapping is often used for Planning (A.9) and as part of the Logical Framework Analysis (T.25) process. It should be a collaborative exercise involving some, or if possible, all relevant stakeholders to increase transparency and foster a mutual understanding and ownership.

Applicability: Stakeholder Mapping can be applied in all response phases and contexts. It provides an essential foundation for the successful planning and implementation of a WASH response. It is a dynamic process and remains important throughout the entire project cycle.

😊 Do

- Engage staff and local actors – local staff are a major source of learning
- Diversify sources of information for identifying and analysing stakeholders
- Revisit the matrix regularly when monitoring the project implementation.

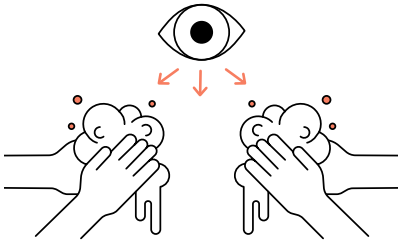
☹ Don't

- Do not rush the activity; get as much information from as many sources as possible
- Do not view the mapping as a one-off exercise and forget to use it or update it during implementation

Practical Example: As part of the Global Disaster Risk Management initiative, Malteser International supported the Government of Myanmar to develop Stakeholder Mapping. The main objective of the study was to analyse the early warning systems of national and international stakeholders in order to identify and address priority gaps. The mapping exercise identified 160 national and international stakeholder organisations and numerous weaknesses in the area of communication. Actions were taken by a variety of stakeholders to strengthen the weaknesses including improving public media messages on forecasts of extreme weather, addressing the digital divide caused by poor internet and telephone connectivity and conducting campaigns among at-risk communities to raise awareness about the types of warning that could be received and the corresponding actions to take.

→ **References and further reading material for this tool/method can be found on page 300**

Supervised Handwashing

<p>Purpose To create a daily routine among children to wash hands in the right way</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Supervised Handwashing is a technique used to instil good handwashing practices among children by teaching them how to wash hands and monitoring their routine in either a household environment or school. Children are taught how to wash their hands correctly and reminded to wash hands during critical times.

Handwashing can be supervised by parents or elders in the household and by teachers in a school environment where group handwashing can be more effective. Handwashing with soap and water as a group activity under supervision draws on the principle of skills-based education. Additionally, it encourages Peer Learning (T.29), may lead to improved Social Norms (B.6) and is a motivating and fun activity for children. Pupils are typically taken through the steps of handwashing to ensure that they are washing their hands effectively. When performed at the same time each day (e.g. before lunch), the activity becomes a routine. Over time, the group activity will contribute towards making handwashing a habit for learners and induce a sense of normalcy. To make Supervised Handwashing a successful activity in schools, hygiene promoters must train teachers, provide necessary group handwashing infrastructure (P.2), ensure soap availability (P.6) and provide pictorial information e.g. by hanging posters close to handwashing stations (T.19). The Beautification (T.4) of handwashing facilities encourages children to adopt group handwashing as a fun activity. Innovative handwashing stations use rainwater collection tanks which allow children to wash hands even if there is no piped water. Investing in adequate infrastructure and the provision of soap and water are the most important requirements for Supervised Handwashing.

Applicability: Supervised Handwashing with children applies in all contexts and stages in the response where low handwashing rates are a problem. During the acute response, simple handwashing structures such as Tippy Taps that can be constructed quickly and provided with

soap may be required. During the stabilisation and recovery phase semi-permanent and permanent handwashing structures can be constructed and training of trainers (such as schoolteachers) carried out before routine Supervised Handwashing is established in schools. It can be scaled up, along with other hygiene habits, at an institutional level using approaches like Fit for School (F.10) and Three-Star Approach (F.11).

😊 Do

- Ensure provision of soap and water (P.2 and P.3) and construct child-friendly handwashing stations
- Consider combining Supervised Handwashing with Songs (T.47)
- Have posters (T.19) and Print Media (T.33) on handwashing near handwashing stations
- Integrate handwashing into school timetables

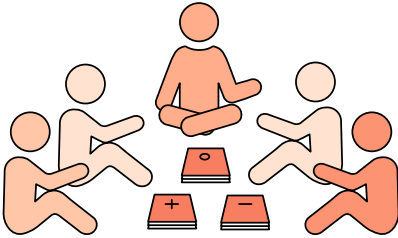
☹ Don't

- Do not shame children in front of peers during handwashing
- Do not provide handwashing infrastructure before training teachers and staff
- Do not place handwashing facilities far away from the classrooms

Practical Example: After cyclone Winston in Fiji, teachers were trained in WASH with the Fijian Teachers Association WASH Unit. The aim was to ensure that children returning to school avoided disease by establishing functional WASH facilities at the worst-affected schools. Teachers were trained to Supervise Handwashing with soap every day and signs were hung up on the steps to the latrines to remind children to wash their hands.

→ **References and further reading material for this tool/method can be found on page 300**

Three-Pile Sorting

<p>Purpose To encourage discussion and learn what different people know, think and do about hygiene</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Three-Pile Sorting is a participatory activity using pictures to stimulate discussion and to explore attitudes, practices and local knowledge concerning hygiene practices.

Three-Pile Sorting is done with small groups of people (6–10), using picture cards related to hygiene practices and relevant to the context (a minimum of 20 is effective). There are generic pictures available but photos or drawings by a local artist can also be used. It needs a trained facilitator. The aim is not to test knowledge but to promote discussion and enable the facilitator to understand the context and how people perceive hygiene practices. The facilitator observes and listens to the discussion as the group goes through the cards, learning about the group's behaviours and beliefs. They can then facilitate a discussion, questioning any misconceptions about hygiene behaviour and motivating people to take action. The activity is explained to the group and they are given a set of cards to assign to a specific pile. The three piles are usually good, bad and in-between but could be sorted into different categories e.g. men, women, children. It is useful to listen to the discussion without intervening but the facilitator should be aware that their presence could inhibit discussion. Once the cards have been sorted, the facilitator leads a discussion, asking why a card has been placed in a particular pile. For example, if the group considers handwashing with soap a good practice, the facilitator can ask if there is anything stopping them from washing their hands or what can be done to encourage that practice. The process helps to establish a dialogue on local knowledge and practices, potential problems and context-specific solutions. The discussion should be documented and notes should be made on key practices, beliefs, issues and solutions.

Applicability: Three-Pile Sorting can be used in all response phases, in a variety of contexts and with different groups of people for an assessment or, used repeatedly, for Monitoring (M.2). It is a useful tool for discussing sensitive topics, such as latrine use, gender issues or vulnerabilities to violence.

😊 Do

- Check that participants understand the pictures by showing them examples
- Ensure that people understand it is not a test of knowledge, but a way of promoting a discussion (there are no right or wrong piles of cards)
- Allow group members to challenge each other and discuss among themselves

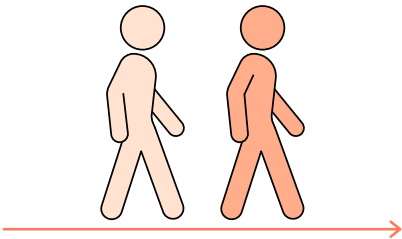
☹ Don't

- Do not interfere with the discussion to direct the sorting of cards or embarrass group members who have different views
- Do not invite an unmanageably large group
- Do not use photographs of the local context that reveal the identity of specific individuals

Practical Example: During the planning of a WASH response in a refugee camp in Uganda, Three-Pile Sorting was done with different groups of people (men, women, adolescents and different ethnic groups). The discussion highlighted points that had not been considered, e.g. women not wanting to use the same latrine as their father-in-law. It also revealed that they knew about the benefits of handwashing, but the water supply was frequently inadequate. In conjunction with other participatory methods, e.g. Focus Group Discussions (T.14), the programme's hygiene behaviour objectives were agreed. The key discussion points were documented for use by new staff.

→ **References and further reading material for this tool/method can be found on page 300**

Transect Walk

<p>Purpose To assess the existing situation by engaging the community in an exploratory walk and discussion</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★ Institution ★★ Camp ★★ Rural ★★ Urban

A Transect Walk is a ‘walking interview’ with community members, following a defined route or path in an intervention area, to observe and learn about existing WASH conditions, practices and challenges.

A Transect Walk is a participatory method conducted with participants selected from the target community to Observe (T.28), better understand hygiene status, practices, problems and challenges linked to WASH and assess opportunities for action and improvement. Points of interest usually include the availability of handwashing facilities and soap, existing water supply and sanitation facilities and personal, domestic and environmental hygiene practices, including waste management. In preparation, key informants are identified who represent all relevant stakeholder groups in the area willing to share their observations. The purpose of the walk, the information to be collected, roles and responsibilities and allocation of tasks among participants need to be discussed and agreed upon with participants. A Checklist (T.2) or question guide derived from the main areas of interest may be helpful. A representative route that covers the full geographical variation of the area should be chosen and, if available, maps or aerial photographs to identify the path. It is important to document the observations and information collected from people. Depending on the context, it may be beneficial to use a camera, voice recorder, existing maps or Global Positioning System devices. It is useful to identify meeting points along the path where everyone stops to record information and discuss any emerging issues. Once the Transect Walk is completed, participants meet to analyse the observations and information.

Applicability: Transect Walks can be used in all response phases and contexts. They are typically applied in rural settings but are increasingly used in urban areas to get a quick overview and establish immediate contact with the community. They are often conducted during the assessment phase (chapter A) but can be used as tools for Participatory Monitoring and Evaluation (M.5) during or at the end of an intervention. They require a skilled facilitator, notebooks and pens and time (usually several hours depending on the size of the area).

😊 Do

- Select a diverse group of participants and/or conduct separate Transect Walks
- Take time to talk with community members during the Walk
- Be flexible and take various opportunities to gather data

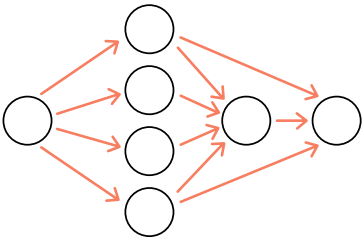
☹ Don't

- Do not try to observe too many factors; keep to the most relevant
- Do not conduct the Walk with too many participants or only with leaders or men.

Practical Example: A Transect Walk was conducted in the rural municipality of San Andres de Tupicocha, Peru to obtain data for a water and sanitation evaluation. Participants were mainly students aged 14–17 years who lived there. They observed, discussed and took notes during the Walk, inspected water tanks and public toilets and explored questions about the sanitary situation in their homes. The information was documented on a map (T.7) and further discussions took place to identify key issues. It was a useful exercise to understand WASH issues in the area.

→ **References and further reading material for this tool/method can be found on page 300**

Transmission Routes and Barriers (F-Diagram)

<p>Purpose To support the understanding of how diarrhoea and other diseases spread and how it can be prevented</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★ MEAL <p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole <p>Application Level</p> <ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban
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Pathogens found in excreta (e.g. bacteria, viruses, worms and protozoa) can spread diarrhoea and many other diseases. The F-Diagram (A.2) is a tool that illustrates the main transmission routes and the potential barriers to prevent faecal-oral transmission.

Understanding the routes through which an individual can become infected helps to target interventions to reduce the spread of disease. The F-Diagram is one of the many tools in the Participatory Hygiene and Sanitation Transformation (F.6) approach; it has been used in multiple contexts and with other programme approaches to explain disease transmission. The F-Diagram provides a visual explanation and illustrates the main transmission routes of pathogens from the faeces of one infected person to another. Transmission can occur via Fluids (e.g. contaminated water), people's Fingers, Flies, via Fields where open defecation is prevalent and via Food that is unwashed, uncooked, inadequately cooked or uncovered. Since all these paths start with the letter F they are easily memorised. Additional pathways include 'floods' where contaminated water can easily spread pathogens and 'fomites' that carry a disease (e.g. household surfaces, materials and objects). It can be useful to consider animal as well as human faeces. The diagram illustrates possible barriers and interventions that can impede transmission. Barriers such as improved sanitation (where faeces are safely contained), handwashing with soap, food hygiene, water treatment and protection of the water source can prevent an initial contact with faeces (primary barrier) or help to prevent faeces being ingested by another person (secondary barrier). Participants are often provided with individual pictures and asked to construct the diagram and transmission routes for themselves. As with most interactive activities, facilitators need to enable the participants to discuss freely whilst being knowledgeable and confident about the transmission routes.

Applicability: The F-Diagram can be used in various ways for training and problem-solving with community members, WASH personnel and other humanitarian actors. It is appropriate in a variety of contexts and can be used with different age groups, including children, in all phases of the response and stages of the project cycle.

😊 Do

- Use the tool interactively to enable a variety of stakeholders to understand Transmission Routes
- Use picture cards or posters (T.19) or make use of locally available materials to visualise transmission routes
- Apply the transmission routes to the specific context and encourage participants to engage in problem solving

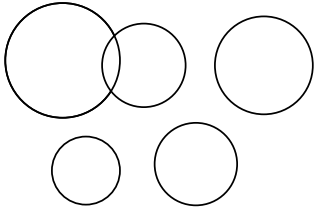
😞 Don't

- Do not rush the activity as it can take time for people to digest and learn the transmission routes
- Do not use the whole diagram with groups that are unfamiliar with visual images – break it down into sections

Practical Example: In a WASH programme in Ghana, the F-Diagram was particularly useful coupled with Community Mapping (T.7) as it enabled the community members, including children, to understand how their food and water sources became contaminated and to discuss the health and cost implications. This helped to create demand for safe drinking water and household and institutional latrine facilities in all the surrounding villages.

→ **References and further reading material for this tool/method can be found on page 300**

Venn Diagram

<p>Purpose To explore different perceptions of relationships</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> ★★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban

A Venn Diagram is a participatory tool used to explore how different stakeholders perceive the relationships between different factors.

Venn Diagrams can demonstrate people's different perceptions of the context, including the power dynamics and the needs of key stakeholders within the community. The group draws circles of different sizes to represent different structures, organisations or variables in their context. The circles are drawn so that they overlap, depending on the degree of contact that the structures have with each other. The size of the circle represents the importance people attribute to the different variables. The distance between the circles also reflects the relationships between the variables. The exercise is not a test; there are no right or wrong answers. One purpose of the activity can be to explore how the community works – who makes the decisions and how organisations or different groups of people relate to one another. Community perceptions may differ from the perceptions of the WASH team. Key groups to be considered (depending on the context) could include local or international organisations, government, community leaders, elders, youth leaders, religious leaders, health staff, community mobilisers and hygiene promoters, engineers, teachers, refugees/displaced/host populations. The findings are recorded, shared, discussed and used for programme planning and monitoring. The main resource needed is a good facilitator. The Venn Diagrams can be drawn using a stick on the ground or paper (flipcharts), scissors, marker pens and pencils. The participants need to gather in a suitable location. Depending on the context and the objective, the activity can take about an hour, including discussion time.

Applicability: Venn Diagrams can be used in a variety of settings and contexts. They are a useful tool as part of an Assessment (**chapter A**) and can be used in conjunction with other tools (e.g. Stakeholder Analysis, **T.49**) and planning for a WASH programme (**A.9**).

😊 Do

- Ensure the facilitator can explain the process to the participants and lead a discussion without interfering
- Make the participants feel comfortable so they can talk freely
- Compare different Venn Diagrams; discuss similarities and differences

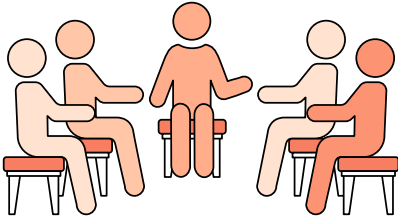
☹ Don't

- Do not invite an unmanageably large group of people
- Do not jump straight into the activity; give the participants time to understand, discuss, practice, experiment
- Do not use Venn Diagrams on their own; they should be used with other tools such as Community Mapping (**T.7**)

Practical Example: As part of a review of a WASH programme in Southern Africa, the WASH team was divided into two groups: engineers and hygiene promoters. They were asked to draw Venn Diagrams which included as variables the people they were working with, different sectors of the community, other organisations and key stakeholders. A comparison of the Venn Diagrams from the two groups revealed that the engineers did not overlap their work with the hygiene promoters, demonstrating that the two teams were working with little collaboration and coordination (**P.9**).

→ **References and further reading material for this tool/method can be found on page 300**

WASH Committee

<p>Purpose To enhance active community involvement and ownership for water and sanitation services</p> 	<p>HP Component</p> <ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	<p>Target Group</p> <ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole
	<p>Response Phase</p> <ul style="list-style-type: none"> Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<p>Application Level</p> <ul style="list-style-type: none"> Individual/Household ★★ Community/Municipality ★ Institution ★★ Camp ★★ Rural ★★ Urban

A WASH Committee consists of members elected by the community who are responsible for keeping the water supply, sanitation and hygiene facilities and services operational. It comprises women and men representing different ages and groups e.g. people with disabilities and vulnerable groups who use or depend on specific WASH facilities.

A WASH Committee aims to enhance community involvement in WASH projects and enable a sense of ownership so that facilities and services are maintained and last as long as possible (E.7). It supports the capacity of a community to actively engage in planning, implementing and monitoring their water supply and sanitation facilities (P.3 and P.4). The decision to set up a WASH Committee and the Terms of Reference (ToR) is the responsibility of the community; the role of the hygiene promoter is to facilitate this process. WASH Committees usually include a chairperson, secretary and treasurer. In addition, they may include hygiene facilitators and caretakers and other important stakeholders. WASH Committees meet at regular intervals according to an agreed agenda to discuss or update the WASH situation in the community. Ideally, they should meet with community members (depending on the needs of the specific context) to discuss problems and update them on WASH activities and plans.

Applicability: Setting up WASH Committees can be time-consuming and many potential committee members will be busy with additional responsibilities early in an emergency. As a result, it is more applicable to the later stages of the response (e.g. recovery phase and prolonged camp settings) or in development contexts. It needs experienced community mobilisers or hygiene promoters to motivate, provide guidance and strengthen community capacity.

😊 Do

- Use existing community structures to set up a WASH Committee rather than creating new ones
- Ensure a diverse and representative group of committee members
- Jointly develop and agree on clear ToRs according to the needs

😞 Don't

- Do not allow local politics or powerful groups to interfere with the effective running of the committee
- Do not withdraw support until the WASH Committee members have adequate capacity to manage the WASH services independently

Practical Example: In Thailand, Malteser International set up WASH Committees in the refugee camps and surrounding host communities. An important aim was to discuss WASH-related issues to avoid conflict between the displaced and host communities over the sharing of water sources. The WASH Committees of the displaced and host communities were each responsible for implementing small-scale projects that they had identified. The projects aimed to improve WASH in their respective communities with each other's support. Coordination meetings were conducted with the representatives of the WASH Committee to discuss WASH-related issues and the sharing of water sources.

→ **References and further reading material for this tool/method can be found on page 301**



PART 3:
Hygiene Promotion
Frameworks and Approaches

This section is a comprehensive compilation of the most commonly used hygiene promotion (HP) frameworks and approaches. It includes widely used participatory approaches focused on improving sanitation and hygiene conditions such as Community-Led Total Sanitation (CLTS, F.2), Participatory Hygiene and Sanitation Transformation (F.6) or Community Health Clubs (F.1 and F.3), a variety of approaches targeting children or the immediate school environment such as CHAST (F.9), Fit for School (F.10), Three Star Approach (F.11) or Toilets Making the Grade (F.12) and approaches targeting women and girls such as WASH Social Architecture (F.15). The section also includes approaches based on behavioural science such as Wash'Em (F.22), RANAS (F.20) or FOAM and SaniFOAM (F.19) and more specific approaches targeting accountability such as Accountability to the Affected Population (AAP, F.23) and participation such as Community Perception Tracking (F.24). There is often a degree of overlap between the categories.

Each framework or approach is summarised in two pages and includes a short description, tools and methods used as part of the approach, additional in-depth information regarding its applicability, the main requirements and investments needed, evidence of effectiveness, some practical 'Do and Don't' priority actions and an example case study. Some key decision criteria are summarised in the top table of each framework or approach and provide easy-to-grasp general guidance about the response phase, application level, target group, the HP components it is related to and its main purpose.

The matrix on the following page provides an overview of key decision criteria to support the context-specific selection of appropriate frameworks and approaches; it can give a first indication of which framework and approach may be suitable in a particular context. The matrix is subdivided into five categories: Hygiene Promotion Component, Response Phase, Target Group, Application Level and Target Behaviour.

The Hygiene Promotion Component category of the matrix refers to the six key HP components described in the first section of this Compendium. The category indicates whether each framework and approach is commonly used in relation to the components in the six chapters of Preconditions and Enabling Factors (chapter P), Community Engagement and Participation (chapter E), Assessment, Analysis and Planning (chapter A), Communication (chapter C), Social and Behaviour Change (chapter B) and Monitoring, Evaluation, Accountability and Learning (MEAL, chapter M). The suitability of a framework or approach in relation to any of the HP components is indicated by asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

All the frameworks incorporate some form of community engagement and communication and aim to influence and change behaviour. The asterisks have been assigned according to their relative appropriateness.

The Response Phase indicates for which phase of the response a specific framework or approach is appropriate and suitable. It is subdivided into the phases of acute response, stabilisation, recovery, protracted crisis scenarios and development. An indication of whether a framework or approach is suitable for a specific response phase is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable). The level of appropriateness is decided through a comparison between the different frameworks and approaches, mainly based on applicability and the speed of implementation.

The Target Group refers to segments of a population who could better participate when using a specific framework or approach. It is subdivided into children, adults, elders, people with disabilities, local leaders and society as a whole. An indication of whether a framework or approach is suitable for targeting a specific population segment is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

The Application Level refers to the spatial context and scale for which the frameworks or approaches are most appropriate. It is subdivided into the following levels: individual/household, community/municipality, institution, camp, rural and urban contexts. An indication of whether a framework or approach is suitable at a specific spatial level is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

The Target Behaviour refers to the most important hygiene behaviours typically addressed as part of HP interventions. An indication of whether a framework or approach is suitable at targeting a specific hygiene behaviour is given using asterisks (two asterisks: suitable, one asterisk: less suitable, no asterisk: rarely suitable or unsuitable).

Frameworks and Approaches Matrix

- ** Two asterisks: suitable**
*** One asterisk: less suitable**
No asterisk: rarely suitable or unsuitable

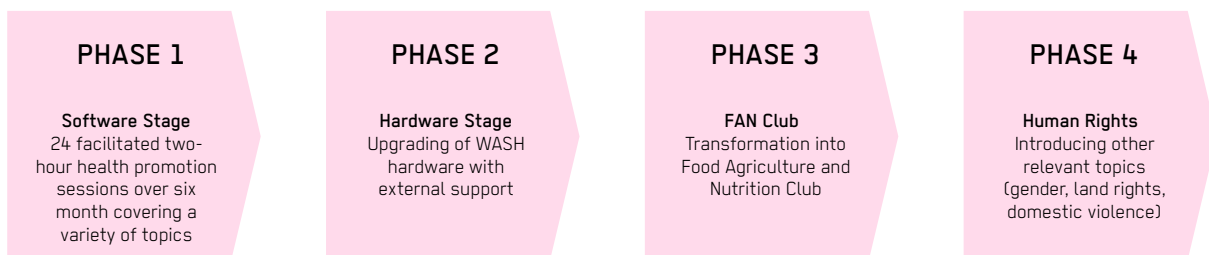
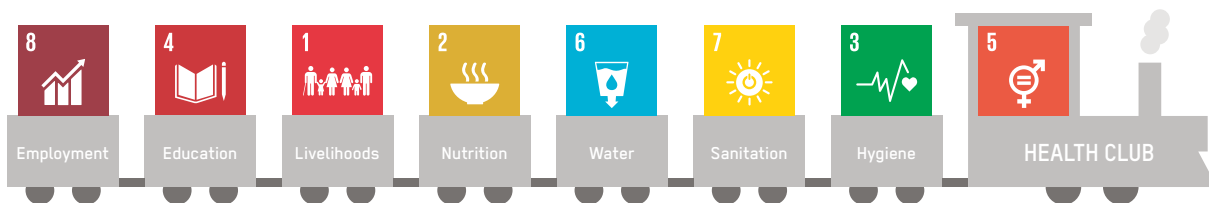
		HP COMPONENT						RESPONSE PHASE				
		Preconditions and Enabling Factors	Community Engagement and Participation	Assessment, Analysis and Planning	Communication	Social and Behaviour Change	Monitoring, Evaluation, Accountability and Learning	Acute Response	Stabilisation	Recovery	Protracted Crisis	Development
Approaches with Focus on Participatory Sanitation and/or Hygiene												
F.1	Community Health Club (CHC)	*	**	**	**	**	**			*	**	**
F.2	Community- Led Total Sanitation (CLTS)	*	**	*	**	**	*		*	**	**	**
F.3	Emergency Community Health Club (eCHC)	*	**	**	**	**	*	*	**	**	**	*
F.4	IFRC's 8 Steps for Hygiene Promotion in Emergencies	**	**	**	**	**	**	**	**	**	**	**
F.5	Mum's Magic Hands (MMH)	**	*	**	**	**	**	**	**	**	**	**
F.6	Participatory Hygiene and Sanitation Transformation (PHAST)	*	**	**	**	**	**	*	**	**	**	**
F.7	Sani Tweaks	*	**	**	**	*	*	**	**	**	**	**
Approaches Mainly Targeting Children and Schools												
F.8	Blue Schools	**	*	**	**	*	*		*	*	*	**
F.9	Children's Hygiene and Sanitation Training (CHAST)	*	**	**	**	**	**		*	**	**	**
F.10	Fit for School (FIT)	**	*	**	**	**	**					**
F.11	Three Star Approach (TSA)	**	*	**	*	*	**					**
F.12	Toilets Making the Grade (TMG)	**	**	**	**	*	**			*	*	**
Approaches Mainly Targeting Women and Girls												
F.13	Baby WASH	**	**	**	**	**	**	*	**	**	**	**
F.14	IFRC's 8 Steps for Menstrual Hygiene Management (MHM) Action	**	**	**	**	**	**	**	**	**	**	**
F.15	WASH Social Architecture	**	**	*	**		*	*	**	**	**	**
Approaches Based on Behavioural Science												
F.16	Approach Focused on Behavioural Determinants (ABCD)	*	*	**	**	**	*	*	*	**	**	**
F.17	Behaviour Centred Design (BCD)	**	*	**	**	**	**	*	**	**	**	**
F.18	Communication for Behavioural Impact (COMBI)	*	*	**	**	**	**	*	**	**	**	**
F.19	FOAM and SaniFOAM	**	*	**	*	**	**	*	*	**	**	**
F.20	Risks, Attitudes, Norms, Ability and Self- Regulation (RANAS)	*	*	**	*	**	**	*	*	**	**	**
F.21	Sanitation and Social Marketing	**	*	**	**	**	*		*	**	**	**
F.22	Wash'Em	*	*	**	*	**	*	**	**	**	**	*
Approaches Targeting Participation and Accountability												
F.23	Accountability to Affected Population (AAP)	*	**	**	**	*	**	**	**	**	**	**
F.24	Community Perception Tracking (CPT)		**	**	**	*	**	**	**	**	**	**

[illegible]

Community Health Club (CHC)

Purpose To improve health, hygiene and living conditions by empowering people to help themselves using a club structure

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<ul style="list-style-type: none"> Acute Response Stabilisation ★ Recovery ★★ Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole 	<ul style="list-style-type: none"> ★ Individual/Household ★★ Community/Municipality ★ Institution ★ Camp ★★ Rural ★ Urban



Adapted from Africa AHEAD

Community Health Clubs (CHC) are groups of 30–100 voluntary members who improve local WASH practices through shared knowledge and understanding, resulting in positive hygiene behaviour change and social capital. In weekly health sessions, for at least six months, the group makes informed decisions and, together, improve their standards of hygiene and living conditions.

The CHC approach was developed by Africa AHEAD based on the assumption that all people, even those with few resources, can help themselves to prevent disease through improvements in hygiene. Health promotion is an entry point to longer-term development. CHC members are empowered to do as much as they can for themselves, minimising dependency on donor handouts, through a four-phase process known as AHEAD (Applied Health Education, Agriculture and Development). The first phase is the ‘software stage’ of health promotion, holding 24 two-hour weekly participatory sessions for six months covering common preventable diseases, with recommended practices for homework that can easily be done each

week with few resources and no external material inputs. It is completed when as many members as possible graduate with a certificate of full attendance and compliance with recommended practices. The second phase is the ‘hardware stage’ when water and sanitation facilities are upgraded, supported by inputs and technical support from donors, NGOs or local governments. In the third phase, the CHC evolves into a FAN club (Food, Agriculture and Nutrition) and members share a communal nutrition garden enabling a balanced diet and healthy nutrition for all. The fourth phase includes a human rights component covering more complex functional issues such as gender equity, land rights, social inclusion, illiteracy, support of the vulnerable, domestic violence, substance abuse and teenage pregnancy.

School Health Clubs (SHC) adapt the CHC approach to target children at school. They are extracurricular clubs initiated by school teachers who are trained in the content. The syllabus is similar to the CHC’s so that children share their parents’ knowledge and understanding. In weekly sessions, school children learn how to improve hygiene

and living conditions at home, leading to hygiene behaviour change at school and at home for all generations. Schools are often the most effective means of networking with all families in an area as most households have school-going children. Parent-teacher committees can provide a springboard into the community.

Tools and Methods used

Participatory activities to stimulate dialogue and problem identification:

- WASH Committees (T.55)
- Transect Walks (T.52)
- Community Mapping (T.7)
- School field projects doing spot Observation (T.28) in the community
- Ranking (T.39)

Identifying appropriate local solutions:

- Transmission Routes and Barriers (T.53)
- Three-Pile Sorting (T.51)
- Songs and Stories (T.47)
- Community Drama and (Puppet) Theatre (T.6)
- Role Play (T.41)
- Demonstration and Show and Tell (T.10)
- Peer Education (T.29)
- Competitions (T.8)
- Clarifying school responsibilities using Institutional Checklists (T.20)

Community self-monitoring:

- Observation (T.28) in a household inventory with Household Visits (T.18)

Applicability: The standard CHC approach is highly adaptable but generally more suited to the stabilisation and recovery phase or as a development intervention. CHCs (and SHCs) are used in rural and urban communities and can be used in camps in post-conflict and emergency situations (eCHC, F.3) for local clean up and to support WASH projects.

Main Requirements/Investments Needed: CHCs are often used in small NGO projects, though the model is most cost-effective when taken to scale using Ministry of Health structures (as evidenced in Rwanda's national programme of 14,000 CHCs). The main inputs required are for the development and printing of toolkits (approximately 24 illustrated card sets) for the participatory training of CHC members, as well as some support for village-based CHC facilitators. Historically, few organisations have the time or expertise to develop a tool kit specifically for their project (unless, like Rwanda and Zimbabwe, a national tool kit is already available). To address this constraint, Africa AHEAD now offers organisations online training for CHC facilitators with materials that can be adapted to a

local context. There is also an online CHC register to enable Monitoring (M.2) of hygiene behaviour change using a ready-made Smartphone survey for Data Collection and Analysis (A.4).

Evidence of Effectiveness: A recent review of the literature examined the evidence from WASH-focused CHC interventions in low and middle-income countries. It found that the most consistent evidence was linked to WASH behaviours and knowledge, with significant effects on defecation practices, handwashing behaviours and WASH knowledge. It also found evidence of impact on social capital and collective action and concluded that 'the model's holistic focus and emphasis on individual and collective change offer promising potential to address multiple health and development determinants'.

😊 Do

- Aim to include over 80 % of the targeted community in large CHCs (up to 100 members)
- Ensure CHC facilitators are drawn from the local community for longer-term sustainability
- Ensure CHC facilitators are well trained and have a tool kit of visual aids

☹ Don't

- Do not omit the use of the membership card and certificate as it is essential for community mobilisation
- Do not reduce the number of training sessions (24), time for each session (2 hours), appropriate spacing of training sessions (weekly) and duration of the training (6 months)
- Do not initially provide material inputs as it causes division between people

Practical Example: Within 12 months of establishing 37 CHCs in the rural areas of Chipinge District, Zimbabwe there was over 80 % adherence to zero open defecation or hygienic latrines, functional handwashing facilities and soap, refuse pits, pot racks, safe water source, drinking water and bath shelters for 2,388 CHC members. Similarly, during one of the worst cholera epidemics seen in Africa (2008) with 89,000 cases and 4,000 deaths nationally, 36 CHCs halted the spread of cholera in Sakubva, a high-density urban suburb of Mutare, when 4,500 CHC members undertook a massive clean-up of solid waste and supported the widespread adoption of handwashing with soap and other hygienic behaviour leading to zero cholera deaths.

→ **References and further reading material for this framework/approach can be found on page 301**

Community-Led Total Sanitation (CLTS)

Purpose To mobilise, trigger and empower communities to take action to become open defecation free

HP Component	Response Phase	Target Group	Application Level
★ Preconditions & Enabling Factors	★ Acute Response	★★ Children	★ Individual/Household
★★ Community Engagement & Participation	★ Stabilisation	★★ Adults	★★ Community/Municipality
★ Assessment, Analysis & Planning	★★ Recovery	★★ Older People	★ Institution
★★ Communication	★★ Protracted Crisis	★★ Persons with Disabilities	★ Camp
★★ Social & Behaviour Change	★★ Development	★★ Local Leaders	★★ Rural
★ MEAL		★★ Society as a Whole	★ Urban



The Community-Led Total Sanitation (CLTS) approach facilitates communities to conduct their own appraisal and analysis of open defecation, mobilising people to identify and find solutions to their sanitation and hygiene needs. CLTS encourages people to improve their situation by utilising local knowledge, technology and innovation.

CLTS's focus is on behaviour change and collective community action. The process uses participatory methodologies and activities, such as Community Mapping (T.7) and Transect Walks (T.52), to facilitate communities to analyse their sanitation practices and faecal-oral pathways. CLTS involves a series of steps from pre-triggering to triggering, post-triggering, follow-up, open defecation free (ODF) verification and monitoring. During 'triggering', communities come to realise that they are eating each other's shit, motivating them to become ODF. The word shit is deliberately used to create an emotional response to generate community action. Triggering often takes between three and five hours and is supported by a team of facilitators. Although triggering is central to the

approach, CLTS also requires substantial 'pre-triggering' (e.g. meeting with local leaders and gathering information) and follow-up activities. Post-triggering and post-ODF activities include technical support, follow-up visits, verification and certification of ODF status, celebrations and ongoing Monitoring (M.2), Evaluation (M.3) and Learning (M.6, M.7, M.8). Although focused initially on open defecation, CLTS has since been integrated with complementary approaches such as market-based programming (P.8), financing and other approaches in this Compendium, including handwashing and Menstrual Health and Hygiene (P.7) programmes. For example, triggering tools adapted for handwashing with soap are often included as criteria in ODF certification.

School-Led Total Sanitation (SLTS) is a CLTS adaptation to improve sanitation and hygiene in the school environment and the school's catchment communities. The approach uses schools, as respected institutions in the community, as entry points. School communities are triggered, including learners, teachers, parents, school management committees, school administration staff and

village heads. The process, approach and resources are similar to CLTS. Children may play an active role as agents of change throughout the process, but pre-triggering analysis should carefully assess when and how to involve them, adhering to the 'do no harm' principle.

Tools and Methods used

Pre-triggering:

- Observation (T.28)
- KAP Survey (T.24)
- Involvement of Local Champions (T.22)

Community Assessment and Triggering:

- Transect Walks (T.52)
- Community Mapping (T.7)
- Transmission Routes and Barriers (T.53)
- Social Norms and Shame and Disgust (T.45)
- Involvement of Local Champions (T.22)
- Public Commitment (T.37)

Post-Triggering:

- Social Support (T.46)
- Rewards and Incentives (T.40) through ODF certification process
- Participatory Monitoring (M.5)
- Accessibility and Safety Audit (T.1)
- Exchange Visits (T.12)

Post-ODF:

- Participatory Monitoring (M.5)
- Involvement of Local Champions (T.22)

Applicability: CLTS initially emerged and is most widely used in rural communities. Although examples are relatively few, CLTS has been adapted to post-emergency and fragile contexts and urban environments and refugee settlements (e.g. in Bidibidi, Uganda and Cox's Bazar, Bangladesh). It is more often recommended for the recovery phase when community needs are less acute. Due to the collective nature of the approach, CLTS is not recommended for communities with underlying conflict and low social cohesion. Triggering disgust can also lead to feelings of shame that, if unaddressed, may lead to stigma and bullying of vulnerable individuals and groups (T.45). It has been adapted for fragile areas, especially those with limited access, by using a decentralised approach where local leaders and community health workers facilitate the process with remote support and (or) follow up by phone.

Main Requirements/Investments Needed: Time should be taken to understand the social context and physical environment before implementation, especially in post-emergency and fragile contexts. As no subsidies are offered, CLTS is often seen as very cost-effective. However, it is heavy on human resources and requires frequent visits to the community at each step. Facilitators for these community-level activities require training and ongoing

support. Resources are also needed for monitoring, ODF verification and certification.

Evidence of Effectiveness: There are a limited number of research studies on CLTS and their findings are mixed, often because the interventions and their contexts are different. Questions also remain about the sustainability of outcomes. Findings suggest CLTS is most effective in villages that are small, remote, cohesive and have strong local leadership, high levels of open defecation and social cohesion and – rare in prolonged crises – no prior history of subsidies. In post-emergency situations and fragile contexts, its effectiveness is increased when it is part of an integrated health services approach.

😊 Do

- Ensure that the necessary pre-triggering, post-triggering and post-ODF follow-up is done
- Ensure facilitators have the required skills, attitudes and behaviour and follow 'do no harm' principles to avoid victimisation and stigma
- Encourage people to undertake tasks themselves and support each other to empower and build self-confidence

☹ Don't

- Do not rely solely on triggering (triggering alone is unlikely to produce sustainable outcomes)
- Do not disrespect communities, be rude or tell people what to do
- Do not assume all communities are the same: tailor the response to the local context and needs of different groups

Practical Example: In Afghanistan, Tearfund implemented CLTS in returnee villages, focusing its efforts on facilitation, promotion, marketing and training of WASH Committees (T.55) and leaving the construction, production and distribution of latrines to the local community, households and tradespeople. Follow-up was conducted through Radio (T.38) and community-level promotion. Hygiene practices were further embedded through working closely with mullahs (T.22) who incorporated hygiene messages into community teachings.

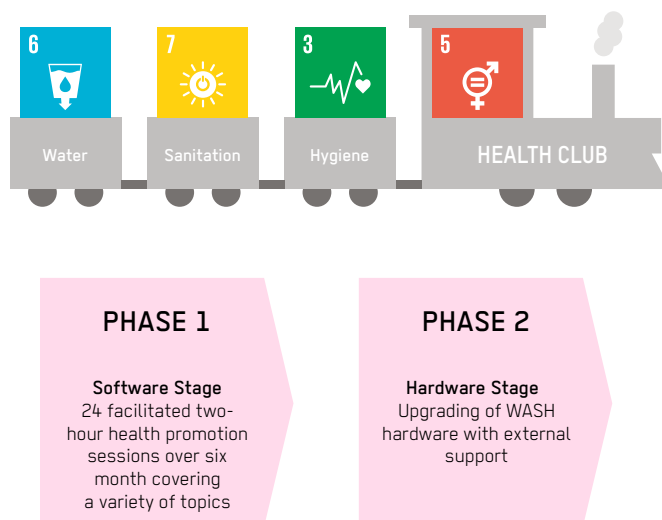
In the Philippines, UNICEF introduced a Phased Approach to Total Sanitation following the Haiyan Typhoon. CLTS, Sanitation Marketing (F.21) and Mass Communication (C.5) were used to create demand with Zero Open Defecation (ZOD) declared once all households in a community used a hygienic toilet with soap and water nearby. Some implementers provided poor and vulnerable households with in-kind subsidies and vouchers to assist latrine construction. Once ZOD was achieved, communities were provided with financial rewards to further develop facilities.

→ **References and further reading material for this framework/approach can be found on page 301**

Emergency Community Health Club (eCHC)

Purpose To establish community support structures to improve WASH practices in emergencies

HP Component	Response Phase	Target Group	Application Level
★ Preconditions & Enabling Factors	★ Acute Response	★ Children	★ Individual/Household
★★ Community Engagement & Participation	★★ Stabilisation	★★ Adults	★★ Community/Municipality
★★ Assessment, Analysis & Planning	★★ Recovery	★★ Older People	★★ Institution
★★ Communication	★★ Protracted Crisis	★★ Persons with Disabilities	★★ Camp
★★ Social & Behaviour Change	★ Development	★★ Local Leaders	★★ Rural
★ MEAL		★★ Society as a Whole	★★ Urban



Adapted from Africa AHEAD

After an emergency, traumatised individuals can benefit greatly by supporting each other in a group, becoming community volunteers in Emergency Community Health Clubs (eCHC) and coordinating their efforts to improve WASH practices in the area. The result can be positive hygiene behaviour change, building-back infrastructure and increasing social capital through shared understanding and increased trust.

In a crisis, emergency-affected people themselves can prevent the outbreak of epidemics such as cholera through good hygiene and sanitation. Even those with limited resources can dig a hole before defecating and cover their faeces, wash their hands thoroughly with soap and keep themselves and their children clean. After such trauma, people can best support each other by working together in an organised group. By becoming a member of an eCHC, individuals are strengthened by helping each other to adhere to basic standards of personal hygiene. Through practical action, they can start recreating the community with the support of (new) neighbours

and friends. Although external humanitarian interventions may be required if infrastructure has been destroyed, wherever possible the affected population should be involved in making the decisions and supported to maintain their dignity. The eCHC is a shorter version of the standard 24-session training in Community Health Clubs (CHC, F.1) and consists of only eight WASH topics that address the immediate issues of water and sanitation-related diseases such as cholera, typhoid, or dysentery. The speed of implementation is dictated by the circumstances, but the training normally takes two months, with all members meeting once a week for a two-hour session. However, the training can also be condensed into a fast-track daily training or a one-day workshop, depending on the context, or extended to include other infectious diseases – especially if there is a need for regular handwashing with soap, safe water and sanitation. As with the standard CHCs, the ideal is to register members and issue membership cards (though lack of time may prevent this).

Tools and Methods used

Participatory activities to stimulate dialogue and problem identification:

- Transect Walks (T.52)
- Community Mapping (T.7)
- Ranking (T.39)

Community organisation and identification of local solutions:

- Story with a Gap
- Transmission Routes and Barriers (T.53)
- Demonstrations and Show and Tell (T.10)
- Three-Pile Sorting (T.51)
- Songs and Stories (T.47)
- Community Drama and (Puppet) Theatre (T.6)
- Role Play (T.41)
- Peer Education (T.29)
- Radio (T.38) incl. jingles, slogans and call-in programmes
- Social Media and Text Messaging (T.44)

Applicability: The eCHC is ideal for the stabilisation and recovery phase in post conflict or disaster situations, to ease individual trauma through collective problem-solving. Once the acute crisis has passed and the stabilisation phase begins, the eCHC can be used (and potentially extended to become a standard CHC (F.1) by registering members and enabling the full training to be completed with certification). This qualification can provide the affected population with a sense of achievement in a time of unprecedented difficulty and they may retain the knowledge and non-risk hygiene behaviour once the situation normalises or they are resettled.

As a response to COVID-19 eCHCs have had to adapt when large groups cannot gather safely. In these situations, the eCHC should be divided into smaller digital clusters of ten households each. Each cluster elects a head who leads the sessions following instructions from a local radio broadcast. Alternatively, cluster heads can be sent pictures through a messaging app such as WhatsApp. This adaptation in a time of COVID-19 still needs to be further piloted and researched.

Main Requirements/Investments Needed: The main costs are for the tool kit, training of trainers, transport and fuel to ensure adequate access to the community. The training can be face-to-face or via radio or virtual meeting platforms (e.g. Zoom, WhatsApp). A corresponding toolkit and online training of facilitators is available from Africa AHEAD. The toolkit, however, may not always fit the local context; generic toolkits may have to be used and adapted. A programme coordinator is needed and a project officer should be based in every camp and run at least five CHCs each.

Evidence of Effectiveness: Emergency CHCs have been used in Internally Displaced People's (IDP) camps in Northern Uganda between 2003 and 2006. The CHC model was also adapted to meet the post emergency situation in Haiti after the earthquake where cholera was running out of control. Both programmes elicited a strong, positive community response. However, there is little documented evidence for eCHCs and more research is needed.

😊 Do

- Aim to include over 80 % of the IDPs in an eCHC so that unity is built up in the camp
- Use project officers in an emergency context to mobilise and train IDPs/refugees
- Use radio programmes (T.38) and messaging/WhatsApp groups (T.44) to reinforce on-the-ground training in a remote response
- Aim to convert eCHCs into standard CHCs for longer-term sustainability of good hygiene practice

😞 Don't

- Do not reduce the duration of the training unless doing so is unavoidable
- Do not exclude anyone from joining; it does not matter how big the CHC becomes. CHCs can be split if they reach more than 100 members
- Do not meet in a large eCHC group during COVID-19 outbreaks

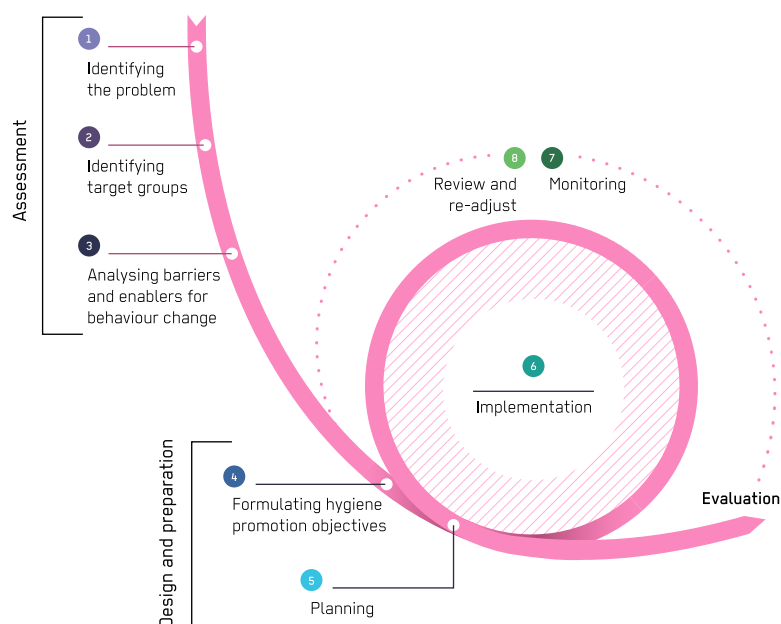
Practical Example: In Northern Uganda (2002) 89% of the population had fled from their villages to live in 33 IDP camps in Gulu District. 25 clinicians from a local NGO were trained as CHC facilitators and sent to 15 IDP camps. They started 116 CHCs and mobilised a total of 15,522 regular members (42% of all households) who met weekly for 25 hygiene sessions over six months. Before the intervention, latrine coverage was 5% with widespread open defecation. After only 4 months, CHC members had constructed 8,504 latrines, as well as 6,020 bath shelters, 3,372 drying racks and 1,552 handwashing facilities, with an estimated 100,000 direct beneficiaries at less than five USD per person. The CHC model was successfully replicated in Pader District.

→ **References and further reading material for this framework/approach can be found on page 301**

IFRC's 8 Steps for Hygiene Promotion in Emergencies

Purpose To ensure all emergency WASH programmes include effective hygiene promotion

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ** Preconditions & Enabling Factors ** Community Engagement & Participation ** Assessment, Analysis & Planning ** Communication ** Social & Behaviour Change ** MEAL 	<ul style="list-style-type: none"> ** Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development 	<ul style="list-style-type: none"> ** Children ** Adults ** Older People ** Persons with Disabilities ** Local Leaders ** Society as a Whole 	<ul style="list-style-type: none"> ** Individual/Household ** Community/Municipality ** Institution ** Camp ** Rural ** Urban



Source: IFRC 2018

The 8 Steps for Hygiene Promotion in Emergencies guideline is an eight step systematic, structured approach to ensure that hygiene promotion (HP) is effective, relevant to the context and is accountable to communities. There is an e-learning module to train staff and volunteers.

During an emergency response HP has often focused on 'disseminating messages' rather than meaningful engagement with the community. The eight step approach highlights the need for Community Engagement (**chapter E**) at all stages of the programme, listening and working with the affected community, ensuring the response is effective and appropriate to the needs. It is important to work systematically through the key steps, rather than initiate HP activities that may not be appropriate for the context, e.g. overlooking the most vulnerable groups or potential Barriers and Motivators (**T.3**) for behaviour change. The eight steps and key content are:

Step 1: Identifying the problem: understanding the causes and consequences, needs and capacities of the community

Step 2: Identifying target groups: understanding who should be prioritised and their communication needs and preferences

Step 3: Analysing Barriers and Motivators (**T.3**) for behaviour change: understanding people's behaviour, their influences, values, beliefs and social pressures

Step 4: Formulating HP objectives: setting objectives that enable people to take action

Step 5: Planning: developing an HP plan, designing HP methods, tools and materials

Step 6: Implementing: training and supervising volunteers, linking with 'hardware' and relief distributions

Step 7: Monitoring (M.2) and Evaluation (M.3): selecting monitoring methods, indicators and the evaluation focus

Step 8: Reviewing and re-adjusting: emphasising an iterative process, programme documentation and hand-over

The focus is on HP for a variety of public health risks related to safe disposal of excreta, effective handwashing and reducing the contamination of household drinking water. Although every situation is different, this systematic approach assists with quality assurance, links to agreed standards, supports effective implementation and uses monitoring and feedback to guide programme revisions.

Tools and Methods used

The guide includes a wide variety of tools and methods, depending on the community and emergency context.

It particularly emphasises participatory methods such as:

- Focus Group Discussions (T.14)
- Pocket-Chart Voting (T.31)
- Three-Pile Sorting (T.51)
- Community Drama, Cinema and Puppet Theatre (T.6)
- Songs and Stories (T.47)
- Games and Toys (T.15)
- Household Visit (T.18)
- Barrier and Motivator Analysis (T.3)

Applicability: The main focus is on emergencies and humanitarian contexts, although it is useful in all contexts including rural, urban or camp situations and longer-term responses. The main advantage of the eight step approach is to encourage the WASH team to think logically through the process of an HP response, rather than starting with a message-based response. The guide is easily adapted and replicable in all situations. It is available in different languages (e.g. English, French, Spanish and Arabic). A corresponding free e-learning course is available in English, French, Spanish and Russian.

Main Requirements/Investments Needed: An HP team is needed to implement the key HP actions throughout the project cycle using community-based volunteers. The team should be appropriately trained (depending on the needs) with a focus on Community Engagement (chapter E), participatory approaches and Accountability (M.4) along with hygiene and health. Supervision and monitoring of community-based volunteers need to be planned and budgeted for. Resources such as office equipment, stationery supplies and IEC (T.19) materials that can be used for various activities are also needed. IFRC's HP Box includes a selection of items that are useful for hygiene promoters to rapidly start activities immediately after a disaster. It includes example picture cards for four different regions (Africa, Asia, Middle East and North Africa and the Americas), materials to make puppets, loud-speakers, materials to make a banner, example posters and basic office stationery.

Evidence of Effectiveness: An increasing number of National Societies' staff and volunteers have completed the online e-learning module or have been trained using the eight steps outlined in the guide. The IFRC has noted improvements in the quality and depth of HP plans and activities through the use of the systematic step-by-step approach.

😊 Do

- Engage with all sectors of the community and at all stages of the programme; listen and discuss to understand the problem, the context and the needs
- Focus on participatory methods and communication channels that are trusted and appropriate
- Consider the barriers and motivators to behaviour change: reduce the barriers and build on the motivators!

☹ Don't

- Do not only rely on campaigns with one-way messaging but also think about two-way communication through trusted channels
- Do not just rely on increasing knowledge, as knowledge may not lead to action
- Do not make assumptions: talk with people and observe

Practical Example: In 2020 the Hellenic Red Cross, with IFRC and partners, used the approach to implement HP in Moria camp, Lesbos, Greece. Several rapid assessments were done using local volunteers from the five main ethnic groups (or nationalities) present in the camp. The assessments investigated socio-cultural aspects, communication preferences and ways to increase trust. Based on this information and in dialogue with the community, decisions were made on the feasible siting of WASH facilities. Hygiene promotion activities included the use of puppets, murals and other engaging activities for children. Feedback was actively collected and used to revise and improve the facilities and activities. For example, men requested baby showering facilities (as they were also responsible for caring for children). Tables with small basins to bathe infants were then added to the male facilities. Single women in some areas of the camp reported feeling afraid to use the toilets or showers at night. In response, the WASH team collaborated with the government to move those women to shelters right next to the shower blocks, so they did not have to walk through the camp at night to reach the facilities.

→ **References and further reading material for this framework/approach can be found on page 301**

Mum's Magic Hands (MMH)

Purpose To use emotional motivators to promote handwashing with soap among caregivers

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ** Preconditions & Enabling Factors * Community Engagement & Participation ** Assessment, Analysis & Planning ** Communication ** Social & Behaviour Change ** MEAL 	<ul style="list-style-type: none"> ** Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development 	<ul style="list-style-type: none"> ** Children ** Adults ** Older People ** Persons with Disabilities ** Local Leaders ** Society as a Whole 	<ul style="list-style-type: none"> ** Individual/Household ** Community/Municipality ** Institution ** Camp ** Rural ** Urban



Example MMH Materials, Source: Oxfam 2018

The development of Mum's Magic Hands (MMH) was based on research indicating that emotional motivators like nurture and affiliation can motivate mothers to wash hands with soap. The MMH programme consists of different interactive, creative tools using both emotional and health motivators to increase handwashing practice.

In 2014 Oxfam, in partnership with Lifebuoy and Unilever, examined the challenges to achieving effective handwashing with soap at key times. Research was conducted in three countries to better understand the Motivators and Barriers (T.3) to handwashing with soap. Nurture (caring for and bringing up children) was found to be one of the most powerful motivators driving handwashing with soap among mothers. Even during a crisis, mothers continue to nurture their children to ensure they develop and succeed in their lives. Handwashing fits into this narrative of 'nurture' leading to 'success' – not as a tool for good health, but rather as part of a broader set of values or good manners such as cutting nails, brushing and combing hair, honesty or hard work that are part of 'living a good life'. Affiliation (or be-

longing to a group) was also seen as a driver in emergency contexts. Mothers tend to unite together in emergencies, supporting each other and sharing resources. The findings were used to design an interactive Behaviour Change (chapter B) programme called Mum's Magic Hands with a set of promotional activities, tools and a training programme for hygiene promoters and handwashing Champions (T.22); with the aim of encouraging handwashing with soap to prevent diseases like diarrhoea. An engaging story forms the core narrative of the programme, with Games (T.15) and interactive activities, Rewards (T.40) such as scratch cards and certificates and several 'Nudges' (T.9) including stickers and visual reminders. Participants are engaged through consultations and dialogue using the tools, which leads to actions by the target groups to ensure handwashing with soap. It is not a standalone programme but should be integrated into the WASH response. Adaptations were made recently to include COVID-19 prevention, linked to handwashing. Changes have also been made to include men and children and to focus on their role in handwashing behaviour promotion.

Tools and Methods used

Assessment:

- Focus Group Discussion (T.14)
- Observation (T.28)
- Key Informant Interview (T.23)
- Barrier and Motivator Analysis (T.3)

Promotion:

- Demonstration (T.10)
- Household Visit (T.18)
- IEC Material (T.19)
- Cues and Nudges (T.9)
- Public Commitment (T.37)
- Rewards and Incentives (T.40)
- Songs and Stories (T.47)
- Games and Toys (T.15)

Monitoring and evaluation:

- Feedback Mechanism (T.13)
- Key Informant Interview (T.23)
- Observation (T.28)

Applicability: The MMH approach has been tested in different phases including stable, fragile and less fragile contexts and has proved relevant to each phase in promoting handwashing behaviour. Experience has shown that the MMH approach in emergencies is effective for targeting mothers and other caregivers. The approach has been researched and the findings illustrate that caregivers continue to play a significant role in the wellbeing of the children, even in unpredictable contexts. MMH materials and tools can be made even more interactive when pre-tested and adapted to the relevant contexts. This can include translating the storyboard into local languages, or changing the pictures, to make it more acceptable and improve comprehension. Men and other groups have also been included as caregivers, helping to extend inclusion in the wider population group, increasing the target and reach for behaviour change in handwashing. In 2020, the tools were also tested in response to the COVID-19 pandemic.

Main Requirements/Investments Needed: A set of MMH resources is available including a storyboard, scripts visuals, stickers, training materials and a field guide for both emergency contexts and longer-term situations. In addition, MMH needs hygiene promoters trained to understand the approach and a budget for translation, printing and for training hygiene promoters and community champions. A sample programme implementation plan with a suggested timeline is available including suggestions for Monitoring (M.2) using both quantitative methods such as structured Observations (T.28) and qualitative methods such as Focus Group Discussions (T.14). It is important to ensure that the necessary WASH facilities are also provided (P.2, P.3, P.4, P.5, P.6).

Evidence of Effectiveness: The MMH approach has been widely used across the humanitarian sector in different contexts. Partners in the Hygiene and Behaviour Change Coalition implemented MMH in South Sudan and Northern Syria. The approach was effective in both contexts.

😊 Do

- Pre-test the materials and tools
- Contextualise tools and resources for ease of acceptance
- Provide training for hygiene promoters

😞 Don't

- Do not override community views and feedback from the pre-testing exercise
- Do not implement MMH in the absence of hardware facilities (handwashing facilities)
- Do not feel like you need to run the activities sequentially or in a fixed period of time; the approach is designed to be flexible to allow WASH actors to dip in and out of these as the context allows

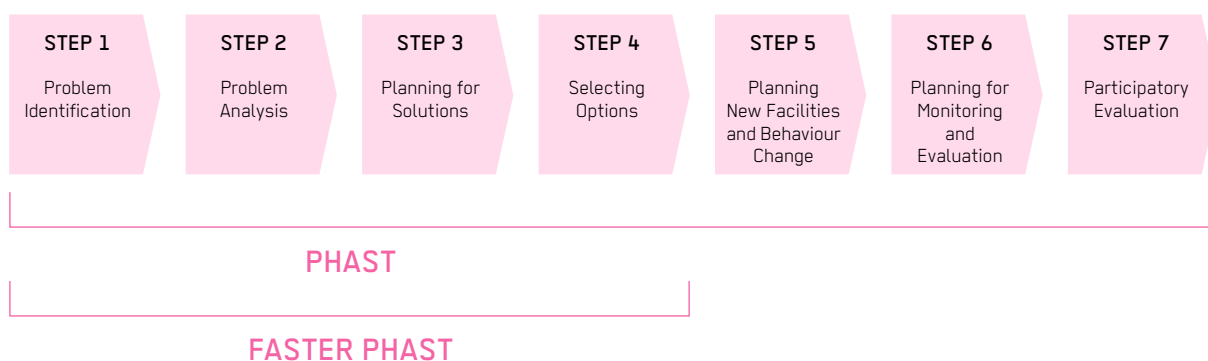
Practical Example: In Nepal and the Philippines Oxfam works with local implementing partners and local government. MMH has been a strong pillar of the programme and is potentially being incorporated into the partners' local capacity, continuing beyond the project lifespan. Materials and tools have also been adapted and shared for preventing COVID-19 transmission through the promotion of effective handwashing.

→ **References and further reading material for this framework/approach can be found on page 302**

Participatory Hygiene and Sanitation Transformation (PHAST)

Purpose To empower communities to improve sanitation and hygiene behaviours and encourage community-management of WASH facilities

HP Component	Response Phase	Target Group	Application Level
★ Preconditions & Enabling Factors	★ Acute Response	★★ Children	★ Individual/Household
★★ Community Engagement & Participation	★★ Stabilisation	★★ Adults	★★ Community/Municipality
★★ Assessment, Analysis & Planning	★★ Recovery	★★ Older People	★ Institution
★★ Communication	★★ Protracted Crisis	★★ Persons with Disabilities	★★ Camp
★★ Social & Behaviour Change	★★ Development	★★ Local Leaders	★★ Rural
★★ MEAL		★★ Society as a Whole	★ Urban



Adapted from WHO 1998

Participatory Hygiene and Sanitation for Transformation (PHAST) is a participatory learning and planning methodology using a step-by-step approach designed for extension workers to promote hygiene and sanitation behaviour change, particularly in rural communities.

The PHAST process involves seven steps that broadly correspond to the programme cycle: problem identification, problem analysis, planning for solutions, selecting options, planning for new facilities and behaviour change, planning for monitoring and evaluation and participatory evaluation. Each step has accompanying tools (e.g. picture sets) or interactive exercises that encourage people to conceptualise and think through hygiene problems and how they can address them. The steps should be followed in order as each step supports participants to move to the next step, enabling people to overcome the previous step's constraints to change. The participatory approach aims to build people's self-esteem and confidence to work together to make changes. The concept of empowerment of communities is central to the approach. Regular

contact between the extension worker/hygiene promoter and each community is envisaged for at least six months. Through discussion and debate, a community-defined response to the problems is encouraged. The methods used are similar to many Participatory Learning and Action methods but the process is less open-ended and guides people towards solving sanitation and hygiene issues. The process requires trained facilitators and, whilst the tools and exercises can be learned quite quickly, skill and an attitude of respect for community capacity and knowledge.

'Faster PHAST' applies the principles of PHAST to the pressures and time constraints of the emergency context, shortening the process to three or four steps and encouraging more frequent contact with communities to achieve faster change. The preparation of the toolkit and training of facilitators can take some time and it may be difficult to introduce PHAST in an acute emergency context. However, the individual tools provide useful ways to get groups talking and thinking about what they can do together to address sanitation and hygiene problems.

Tools and Methods used

- Unserialised Posters (T.19)
- Community Mapping (T.7)
- Three Pile Sorting (T.51)
- Pocket Chart Voting (T.31)
- Transmission Routes and Barriers (T.53)
- Gender Analysis (T.16)
- Sanitation options
- Question box
- Participatory planning
- Participatory Monitoring (M.5)

Applicability: PHAST is more suitable for longer-term development interventions but can be adapted for use in emergencies by reducing the number of steps (Faster PHAST='PHASter') or for use with children by using more child-focused activities. It is usually inappropriate for the acute phase of a response as significant time for preparation and training is required (unless PHAST has previously been used). Many of the tools can be used on their own for assessment or to stimulate discussion with a community or group. The tools can also be adapted and used for other purposes such as Gender Analysis (T.16) and Menstrual Health and Hygiene (MHH, P.7) issues.

Main Requirements/Investments Needed: PHAST is time and resource-intensive as each facilitator is required to provide ongoing support to each community, visiting at least weekly or more depending on the urgency of the situation. The facilitators also require training and ongoing support. Context-specific materials need to be developed. The process can yield results in a few weeks but can take up to six months depending on the readiness and capacity of specific groups to take action.

Evidence of Effectiveness: A recent review of the available evidence indicated that social mobilisation and community participation methods including Community-Led Total Sanitation (CLTS, F.2) and PHAST are effective methods in promoting community hygiene and sanitation.

😊 Do

- Develop and test context-specific materials for the activities before you start
- Encourage participants to consider and analyse their situation and enable the group to identify problems and solutions for themselves
- Encourage participants to identify concrete actions and develop a plan; collaborate with them to Monitor (M.2) and Evaluate (M.3)
- Ask participants to evaluate your role in the process and how you can improve your facilitation skills

☹ Don't

- Do not teach, direct or suggest to the group what you think they should do (unless they specifically ask)
- Do not work with too big a group – break large groups into smaller groups where the community is large
- Do not make assumptions about the right response to an activity
- Do not use the activities in a mechanistic way – do not use exactly the same approach for each group

Practical Example: PHAST was used by IFRC during a cholera outbreak in Western Uganda in 2006 along with door-to-door sensitisation. Existing volunteers, who had previously been trained in the use of PHAST, employed four of the seven activities – Three-Pile Sorting (T.51), Pocket Chart (T.31), Transmission Routes and Barriers (T.53) – and reduced the number of steps to three. Sanitation coverage increased by 12 % despite challenging soils and in one district the local authority instituted bylaws to improve household sanitation. The outbreak was contained as a result of increased awareness of safe hygiene practices.

→ **References and further reading material for this framework/approach can be found on page 302**

Sani Tweaks

Purpose To promote best sanitation practices through improved consultation and listening to sanitation users

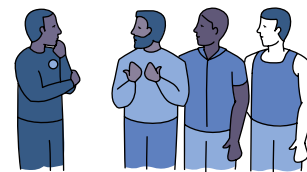
HP Component	Response Phase	Target Group	Application Level
* Preconditions & Enabling Factors	** Acute Response	** Children	** Individual/Household
** Community Engagement & Participation	** Stabilisation	** Adults	** Community/Municipality
** Assessment, Analysis & Planning	** Recovery	** Older People	** Institution
** Communication	** Protracted Crisis	** Persons with Disabilities	** Camp
* Social & Behaviour Change	** Development	** Local Leaders	** Rural
* MEAL		** Society as a Whole	** Urban



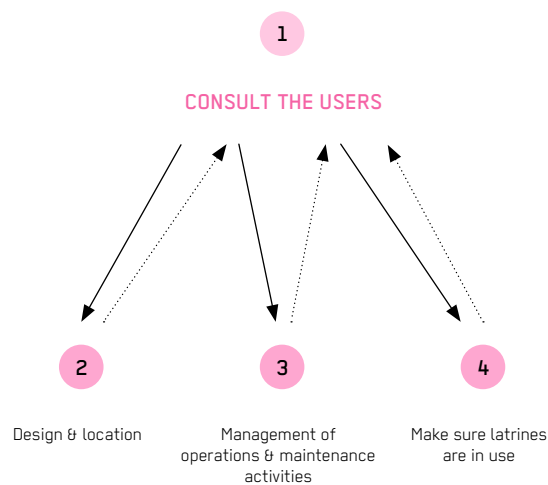
Listen to children



Listen to women and adolescent girls



Listen to men



Source: Oxfam 2018

Sani Tweaks is a series of communication tools and interactive online and face-to-face sessions intended to inform technical field staff, encourage them to consult and listen to sanitation users and inspire them to make continuous improvements to their designs. It is these small ‘tweaks’ that ultimately make the difference between whether someone uses a latrine or not.

Studies have shown that agencies often fail to adequately consult or collect and act on feedback from the users of the latrines they build. This leads many people – especially women and girls – to stop using the latrines as they find them inaccessible, unsuitable and unsafe. To address this, Oxfam developed Sani Tweaks, a series of communications tools and training sessions that promote best practices in sanitation through a continuous process of ‘consult, modify, consult’. The foundation of the Sani Tweaks approach is a checklist (T.2). It outlines the key questions and considerations for WASH practitioners, in consultation with the users, for the construction of emergency Sanitation Facilities (P.4). Importantly,

Sani Tweaks also promotes best practices by targeting Behaviour Change (chapter B) in WASH practitioners so that sanitation programmes are based on and responsive to the needs of users. The resources have been designed using a range of adult learning methods and communication styles to engage as wide a group of WASH practitioners as possible.

Tools and Methods used

Tools for consulting the user:

- Assessment Checklist (T.2)
- Focus Group Discussion (T.14)
- Observation (T.28)
- Key Informant Interview (T.23)
- Transect Walk (T.52)
- Community Mapping (T.7)
- Participatory Monitoring (M.5)

Tools to roll out Sani Tweaks:

- Sani Tweaks website, checklist, booklet, videos and training programme

Applicability: The Sani Tweaks approach applies to all contexts. It is particularly relevant for emergency WASH responses where sanitation facilities are often constructed quickly with minimal consultation with users. The Sani Tweaks checklist supports WASH actors in the first phase of emergency responses. It serves as an aide-memoire for the main elements of sanitation provision and the key questions to ask users to support the provision of facilities and services (P.4) that best meet their needs and protection concerns.

The Sani Tweaks tools have the advantage of being applicable to multiple contexts and at different stages of a humanitarian response. Furthermore, the tools can be used to continuously strengthen the capacity of teams throughout a response, using different checklists, videos and booklets at different points. The tools reinforce the importance of consultation with users and allow WASH practitioners to put themselves in the shoes of the communities they serve.

Main Requirements/Investments Needed: The Sani Tweaks communication tools and approach do not require additional or specialist human resources; they are accessible to all existing WASH practitioners. Sani Tweaks does require a willingness to listen and learn from sanitation users and for WASH practitioners to apply the ‘consult, modify, consult’ approach in their work. The principles in Sani Tweaks should be incorporated into regular programme activities, not implemented as stand-alone projects. The Sani Tweaks tools have been purposefully developed to be easily adapted to a range of circumstances and training needs. For those unable to attend a Sani Tweaks workshop, the open-access tools are on Oxfam’s website in several languages. The Sani Tweaks learning platform (under development) will allow a self-paced exploration of best sanitation practices. The Sani Tweaks materials are available to all WASH practitioners and agencies are actively encouraged to adapt the tools according to their needs, for example changing colours, logos and wording to facilitate context-specific use.

Evidence of Effectiveness: Sani Tweaks workshops have been held in many countries with a high level of satisfaction. Feedback on the communication tools and resources to date has been overwhelmingly positive and has prompted the ongoing development of additional tools to meet the learning needs of WASH practitioners. Initial evaluations show that participation in Sani Tweaks workshops and the use of Sani Tweaks tools prompts practitioners to change their approach, consulting more regularly with users and ‘tweaking’ sanitation facilities to improve their privacy, comfort and safety.

😊 Do

- Consult with users, modify designs, make changes to sanitation facilities and consult again
- Put yourself in the shoes of the user – would you feel comfortable using the latrines that you have built?

☹ Don’t

- Do not consult without making a change; responding to users’ feedback to improve sanitation facilities is vital to address concerns, build trust and increase the use of the facilities
- Do not view consultation and sanitation provision as a one-off action – excreta disposal and the improvement of conditions for users is a continuous process

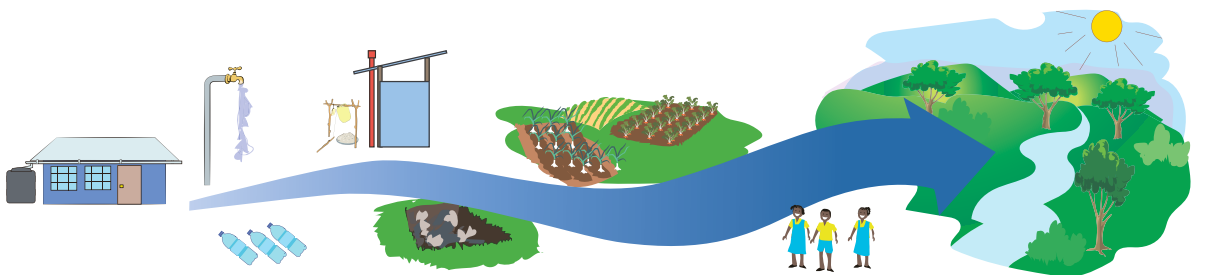
Practical Example: The ‘Ask Andy’ videos on the Oxfam Sani Tweaks webpage highlight two practical examples of making sanitation facilities safer and more private. The videos show simple tweaks that can be made to latrine designs. The tweaks address common issues often encountered in the construction of emergency sanitation facilities that lead to a decrease in use, by women and girls in particular. These practical examples apply to different organisations, countries and contexts for emergency response.

→ **References and further reading material for this framework/approach can be found on page 302**

Blue Schools

Purpose To engage children in hands-on learning about hygiene measures and environmental conservation themes

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> * Preconditions & Enabling Factors ** Community Engagement & Participation ** Assessment, Analysis & Planning ** Communication * Social & Behaviour Change * MEAL 	<ul style="list-style-type: none"> Acute Response * Stabilisation * Recovery * Protracted Crisis ** Development 	<ul style="list-style-type: none"> ** Children * Adults * Older People * Persons with Disabilities * Local Leaders * Society as a Whole 	<ul style="list-style-type: none"> Individual/Household * Community/Municipality ** Institution * Camp ** Rural ** Urban



My Drinking Water



Sanitation and Hygiene



Growth and Change
(Gender and MHH)



From Soil to Food



From Waste to Resources



Environment

Source: Swiss Water and Sanitation Consortium

A Blue School offers a healthy learning environment and exposes students to environmentally-friendly technologies and practices that can be replicated in their communities. Becoming a Blue School is a step-by-step process. The starting point is to ensure that children have access to safe water (P.3), use well-maintained latrines (P.4) and maintain good hygiene practices. Once this is achieved, Blue Schools goes beyond WASH and focuses on Menstrual Health and Hygiene (P.7), gardening activities, safe management of Solid Waste (P.6) and environmentally-friendly practices.

The Blue Schools kit was developed by members of the Swiss Water and Sanitation Consortium (SWSC) and Eawag in 2018. It provides a set of guidance documents and reference materials to implement the approach. In a Blue School, children's learning and practice is central. The aim is that children (1) drink safe water and understand the importance of it, (2) use well-maintained latrines and maintain good hygiene practices including menstrual health and hygiene, (3) practise and replicate safe solid

waste management (SWM) and (4) experience sustainable agricultural techniques as well as good land and water management practices. It starts by addressing WASH needs and practices. Once they are improved, the activities that follow will depend on the specific needs and priorities of each school. The Blue Schools kit is available in different languages and includes (1) a concept note introducing the basics of the approach and providing a road map with recommendations on how to engage government and school stakeholders and ensure sustainability, (2) a catalogue of low-cost technologies to implement at school level or in the surrounding community and a catalogue of practical exercises for teachers to complement the lessons from the national curriculum and (3) a complementary facilitator's guide providing a template for visual support to initiate discussions with children on each Blue Schools component and a summary of practical exercises selected by the school stakeholders.

Tools and Methods used

The Blue Schools approach does not impose any tools or curriculum. The kit is a compilation of different tools to be selected by school stakeholders and include among others:

- Assessment Checklist (T.2)
- Beautification (T.4)
- Drama and Puppet Theatre (T.6)
- Competition (T.8)
- Cues and Nudges (T.9)
- Demonstration, Show and Tell (T.10)
- Events (T.11)
- Games and Toys (T.15)
- Gender Analysis (T.16)
- IEC Materials (T.19)
- Observation (T.28)
- Peer Education (T.29)
- Pocket Chart Voting (T.31)
- Public Commitment (T.37)
- Rewards and Incentives (T.40)
- Role Play (T.41)
- Songs and Stories (T.47)
- Transect Walks (T.52)

Applicability: The Blue Schools kit has been designed for students in upper primary school or secondary school, but the concept can be implemented with any age group. The approach works best in development, rather than emergency, contexts as it is a longer-term process requiring commitment from school stakeholders, parents and government counterparts. However, the materials from the kit can be adapted to any context; some could also be used with adults.

Main Requirements/Investments Needed: The technologies and practical exercises displayed in the Blue Schools catalogues include guidance on the materials required and cost considerations.

Evidence of Effectiveness: The SWSC is implementing the Blue Schools approach in Benin, Burkina Faso, Cambodia, Ethiopia, Madagascar, Nepal, Niger, Sudan and Uganda and is currently building the evidence for the approach which will be documented on the SWSC website.

☺ Do

- Assess the national school curriculum to identify topics where Blue Schools activities could enhance classroom learning and extra-curricular activities
- Identify official student clubs and associations through which Blue Schools activities could be implemented
- Ensure that school stakeholders are driving the process, for example by identifying the technologies and practical exercises best suited to the local ecological zone and socio-cultural norms

- Ensure team members have the required skills, attitudes and behaviour to facilitate the process. They must be conscious of, and advocate for, environmental conservation to inspire the youth they serve

☹ Don't

- Do not impose pre-defined solutions on school stakeholders
- Do not assume all schools are the same! Each school will select different technologies and practical exercises depending on their needs, ecological zones, priorities and interests
- Do not design large gardening projects at schools where students are expected to work. The kit describes small-scale garden designs for demonstrating water conservation and sustainable low external input agricultural techniques

Practical Example: The SWSC is currently implementing Blue Schools in ten countries in over 175 schools. It uses a monitoring framework based on the Joint Monitoring Programme service ladder approach for WASH with additional Blue Schools topics of Menstrual Health and Hygiene (P.7), Solid Waste Management (P.5), school gardening and environmental activities. Several organisations are now using the Blue Schools kit and implementing Blue Schools programmes. There is no single way to implement Blue Schools: school stakeholders select the activities that are most relevant and interesting and decide on the order of activities and how to implement them. Project teams facilitate the decision making process without imposing preconceived solutions.

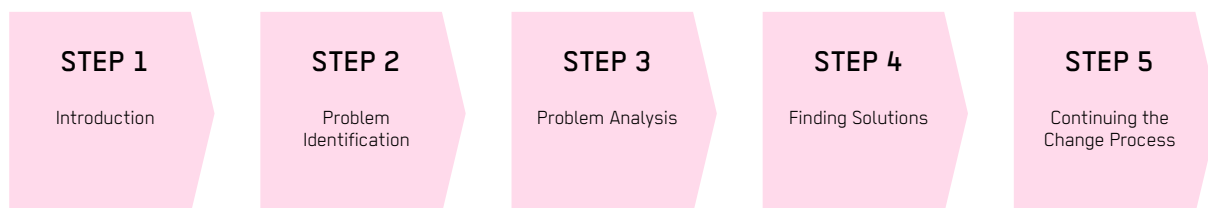
In Banteay Meanchey province, Cambodia, SWSC member Caritas Switzerland piloted Blue Schools in eight schools from 2018–2020. Working with local partner organisations and in close collaboration with the provincial government, the project improved drinking water and sanitation services, including a wastewater treatment system and facilities for menstrual hygiene. Children participated in SWM activities, environmental activities such as tree and flower planting and in the upkeep of the WASH facilities. They learned about the link between good hygiene and health and improved their hygiene practices. Prior to the pilot, teachers co-designed activities through workshops on the components using the Blue Schools Kit, selecting low-cost technologies and practical learning exercises for their students. The teachers are now inspiring other teachers from surrounding schools and parents to replicate good practices. Blue Schools has been aligned with the Three Star Approach (F.11) and is currently being scaled-up in partnership with the Cambodian government, private and civil society partners.

→ **References and further reading material for this framework/approach can be found on page 302**

Children's Hygiene and Sanitation Training (CHAST)

Purpose To promote good hygiene and sanitation practices in schools and at home

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> * Preconditions & Enabling Factors ** Community Engagement & Participation ** Assessment, Analysis & Planning ** Communication ** Social & Behaviour Change ** MEAL 	<ul style="list-style-type: none"> * Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development 	<ul style="list-style-type: none"> ** Children * Adults * Older People * Persons with Disabilities * Local Leaders * Society as a Whole 	<ul style="list-style-type: none"> Individual/Household * Community/Municipality ** Institution * Camp ** Rural ** Urban



Adapted from Caritas Switzerland

Children's Hygiene and Sanitation Training (CHAST) is an approach that targets primary school children. Through its step-by-step and participative process, it promotes good hygiene and sanitation practices in schools and at home by raising children's awareness on transmission routes of waterborne and hygiene-related diseases as well as how to block them.

CHAST was first developed by Caritas Switzerland in Somaliland in 2002 and is inspired by the Participatory Hygiene and Sanitation Transformation (PHAST, **F.6**) approach. It is based on the premise that hygiene practices are largely acquired during childhood and it is therefore much easier to change children's habits than those of adults. The latest edition of the Caritas CHAST kit contains a methodology outline explaining the basis of CHAST, a facilitator's guide with step-by-step guidance and a CHAST flipchart with visualisation materials. CHAST drawings and materials have been adapted to different country contexts by Caritas Switzerland (Kenya, Somaliland, South Sudan and Ethiopia) and other organisations, including

the Red Cross Red Crescent (Iraq, Solomon Islands, Rwanda, Pakistan, Vietnam). There is also an adaptation specific to trachoma reduction.

CHAST offers a variety of educational games and practical exercises to ensure that each child can learn based on its preferred learning style and age. The materials to facilitate the activities and topics include puppets (**T.6**), memory card games (**T.15**) and posters (**T.19**) among others. Hygiene topics covered include safe drinking water, use of well-maintained latrines, personal hygiene (including handwashing, face washing, tooth brushing and keeping clothes clean, covering food and washing utensils), environmental hygiene and Menstrual Health and Hygiene (**P.7**).

CHAST encourages 'learning by doing' and peer learning. It prompts the children to discuss among themselves, practise and learn from each other, thereby promoting the approach of Peer Education (Child-to-Child, **T.29**). It is intended to be participative and fun. CHAST also encourages the establishment of children's clubs (often called School Health Clubs, **F.1**). A WASH in Schools (WinS)

roadmap is also available, which provides the framework for project teams to implement CHAST, ensuring the engagement of all key stakeholders, buy-in from school actors and a Monitoring (M.2) framework.

Tools and Methods used

For lower primary school children:

- Puppet Theatre (T.6)
- Pocket Chart Voting (T.31)
- Activities such as colouring
- Visual IEC (T.19)
- Three Pile Sorting (T.51)
- Role Play (T.41)
- Card Games (T.15)
- Songs and Stories (T.47)
- Discussions (T.14)
- Transmission Routes and Barriers (T.53)
- Demonstration (T.10)
- Group Handwashing (T.50)
- Cues and Nudges (T.9)

Additional tools for older children:

- Transect Walks (T.52)
- Competition (T.8)
- Community Events (T.11)
- Exchange Visits (T.12)

Applicability: CHAST targets students in primary schools, but it can also be implemented in the community for children that do not attend school. It is a longer-term process that requires commitment from school stakeholders, parents and government counterparts. As a result, it is not usually applicable in the early stages of the response and is more suited to longer-term and development contexts. For children to put the learning into practice, the school must have access to a reliable water source (P.3), functioning sanitation (P.4) and handwashing facilities (P.2). CHAST provides detailed step-by-step guidance and a kit of materials; it can therefore be used in contexts where the teachers have limited understanding of hygiene practices and limited access to teaching materials.

Main Requirements/Investments Needed: To carry out CHAST at least one CHAST kit per school is required (value between 150–200 USD) and trained project teams able to train teachers. It also needs the buy-in from head teachers and teachers before CHAST is rolled out in their class. Rolling it out will depend on each school and context, but can take up to three months per class.

Evidence of Effectiveness: An impact assessment, jointly conducted by the Swiss Tropical and Public Health Institute and Caritas Switzerland on a larger CHAST programme in Ethiopia, found that the overall frequency of open defecation at school decreased from around 60 % at baseline to less than 30 % at the endpoint. Significantly more children used soap to wash their hands at the endpoint (90.4 %) than at baseline (72.4 %). A project evaluation in Ethiopia further found that CHAST (including a trachoma-specific training section) was able to decrease ocular discharge, nasal discharge and flies on the faces by 25 %, 30 % and 20 % respectively among children aged 1–9 years.

😊 Do

- Ensure buy-in from the local government, school stakeholders and parents
- Ensure training are as participative and practical as possible
- Engage all teachers from one school in CHAST, so that they all roll it out to their classes at the same time
- Promote exchange between schools, events with parents so that good practices can be transferred to communities

☹ Don't

- Do not expect awareness-raising alone to lead to sustainable behaviour change! Approaches such as CHAST must be complemented by other activities that create an enabling environment and institutionalise good practices
- Do not rush: if you have limited time, choose a different method
- Do not overwhelm teachers – they have enough to do. Help them to find the best way to embed CHAST in the school programme

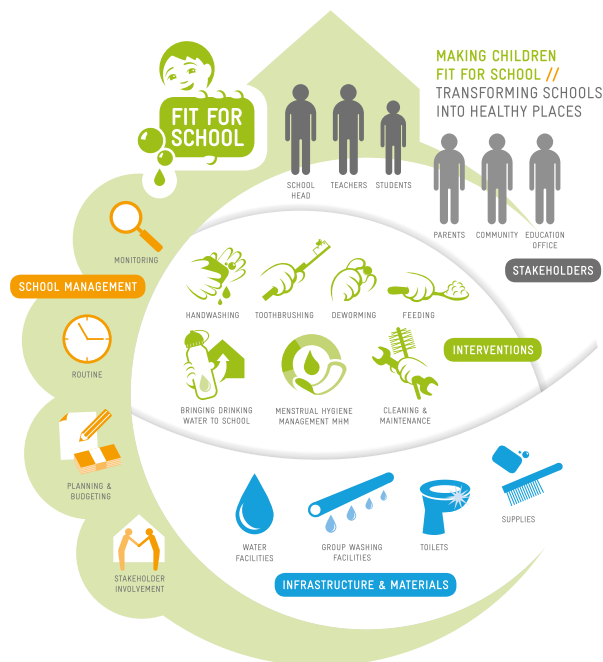
Practical Example: In Ethiopia, CHAST is one of the recommended approaches in the national WASH in Schools guidelines and has been rolled out in different regions in over 170 schools, with 700 teachers trained. CHAST is implemented as part of an integrated WinS project, with special attention paid to engaging government and school stakeholders during the design phase. Teachers play a central role in institutionalising good hygiene and sanitation practices; it is essential to train all the teachers from one school so that they can all train their class and reach all children. CHAST should come alongside WASH infrastructure improvements initiatives (if required) and other initiatives and nudges to ensure that the learning can be put into practice.

→ **References and further reading material for this framework/approach can be found on page 302**

Fit for School (FIT)

Purpose To support Ministries of Education in WASH in Schools programme implementation

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors * Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<ul style="list-style-type: none"> Acute Response Stabilisation Recovery Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> ★★ Children * Adults Older People * Persons with Disabilities * Local Leaders Society as a Whole 	<ul style="list-style-type: none"> Individual/Household Community/Municipality ★★ Institution Camp ★★ Rural ★★ Urban



Source: Fit for School

The Fit for School (FIT) approach recognises WASH as an integral factor in creating conducive learning environments. It therefore supports Ministries of Education (MoE) to apply school-based management to implement national WASH in Schools (WinS) programmes. Improving access to WASH addresses key determinants of health and well-being.

The FIT approach is based on four core principles: simplicity, sustainability, scalability and systems thinking. An effective WinS programme must be based on the best possible evidence, be cost-effective and simple to implement in all schools. The approach aims to ensure sustainability, clarification of roles and responsibilities, allocation of financial resources as well as functional Monitoring (M.2) systems that inform different levels of programme management.

Leveraging existing systems and resources are essential elements of the FIT's scalability. The approach works through the education sector, especially on a sub-national level, to establish sustainable programme

management and implementation within local structures. By introducing performance transparency and Accountability (M.4) measures, organisational behaviour is guided to prioritise WASH. The speed of implementation may be slow at the onset, but its systemic focus ensures change in the longer-term and at scale.

Aligned with these principles, a package of low-cost WinS interventions is developed, based on the country context, with a particular focus on the development of low-cost handwashing facilities, daily group hygiene activities, bi-annual deworming and the creation of cleaning and maintenance routines for WASH infrastructure. Institutionalising these interventions addresses some of the most prevalent diseases among school children. Basic and functional WASH infrastructure is a prerequisite for positive hygiene behaviour. To provide a healthy environment, schools need access to drinking water (P.3), usable and gender-segregated toilets (P.4) and handwashing facilities with water and soap (P.2).

Tools and Methods used

- School-Based Management (SBM) builds on the capacity of school heads to manage their schools (including financial management) and engage with the wider school community. Members of the community can contribute in various ways to improve the WASH conditions in the school based in their community; this could include the construction of Handwashing Facilities (P.2), participation in Monitoring (M.5) or cleaning, repair and maintenance. Even schools with limited resources can start the journey to improve WASH conditions and routines one step at a time
- Monitoring (M.2) and Accountability (M.4) systems measure step-wise improvements that are made transparent through digital dashboards. Practical action is guided by the use of Checklists (T.2) while translating performance into recognisable metrics
- The use of enabling measures such as policy support, stakeholder alignment, integration into planning and resource allocation and large-scale capacity strengthening through the MoE

Applicability: The FIT approach is mainly used in development contexts using the school setting to support the institutionalisation of health-promoting behaviour in children. It can be used in conjunction with the Three Star Approach (F.11). Recognising the value of SBM, FIT strengthens the capacity of the education sector to implement and monitor WinS and open the doors of schools to strong partnerships with parents and the school community. As resources are limited, the support and efforts of community members, local governments and NGOs are needed to address the gaps so that national WinS standards can be reached. The involvement of the school community guarantees that solutions are pragmatic, affordable and relevant to the local context. The FIT approach was developed in the Philippines in close collaboration with the MoE and adapted for three other countries (Cambodia, Lao PDR and Indonesia) through the development of replicable implementation models and guidelines. As the models have been integrated into WinS programmes, government-led scale-up in the respective partner countries is ongoing.

Main Requirements/Investments Needed: At the core of the FIT approach is support to schools wherever they are in their WinS journey. Capitalising on existing systems and resources is an essential strategy for scalability and sustainability. The involvement of all levels of the education system in partnership with the school community is imperative to maximise ownership, transparency and accountability. By assigning practical actions to responsible actors,

the success of the programme is mostly driven by the collaborative effort of the relevant stakeholders to reach a certain, clearly designed WASH status (see also Three Star Approach, F.11).

Evidence of Effectiveness: The FIT approach has shown great promise in contributing to the scale-up of WinS programmes. For example, the Laotian Ministry of Education and Sports has expanded the approach from 22 model schools to over 1,100 schools in five years. The positive effects of the interventions aimed at changing everyday routines have been demonstrated in all countries. For example, a long-term study in the Philippines shows improved children's health and less absenteeism in participating schools.

😊 Do

- Focus on activities that can be easily implemented without the need for major investment and that lie within the skills and mandates of the government workforce
- Use locally available resources to make procurement and logistics easier and to simulate the real situation in the long-term
- Only promote interventions which the government could and would fund independently

☹ Don't

- Do not introduce interventions that require external support to maintain

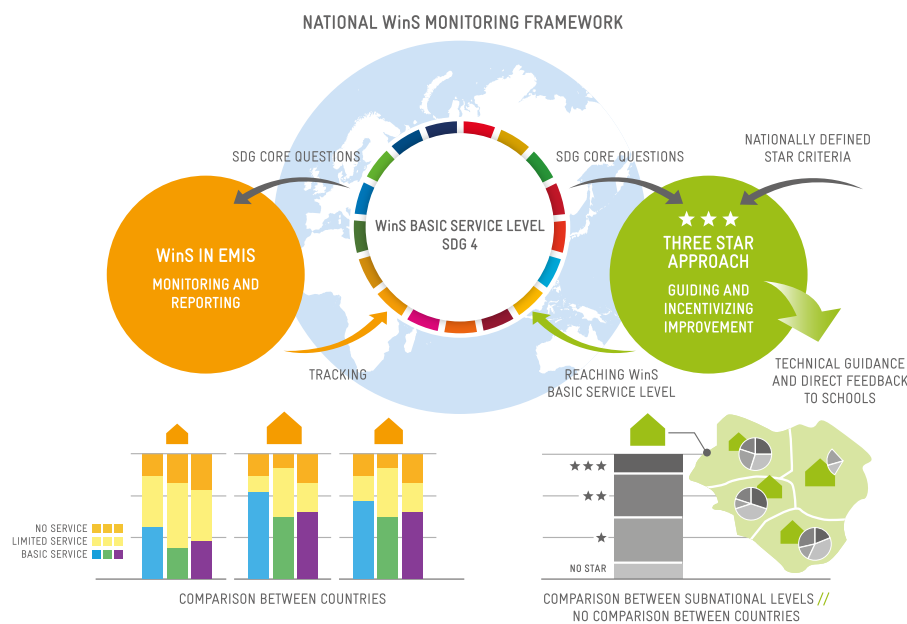
Practical Example: A longitudinal health outcome study measured the impact of FIT interventions in partner countries, specifically in Cambodia, Indonesia and Lao PDR. Over the initial two-year implementation period from 2012 to 2014, it was revealed that FIT contributed to better access to WASH facilities and improved practice of handwashing with soap at critical times. Furthermore, the programme strengthened the implementation of existing national deworming programmes. Daily tooth-brushing practices led to between 17% and 37% less tooth decay among students in implementing schools. The interventions showed additional positive health effects in weight increase and a reduction of absenteeism. In the WinS programme in the Philippines public schools recorded impressive improvements in their compliance with WASH indicators. The number of schools meeting the indicators and reaching national standards has tripled from 9% when the WinS programme started to 26.5% of the nearly 40,000 participating schools.

→ **References and further reading material for this framework/approach can be found on page 302**

Three Star Approach (TSA)

Purpose To provide a clear pathway for schools to meet national WASH standards by defining benchmarks and providing incentives and recognition to reach them

HP Component	Response Phase	Target Group	Application Level
** Preconditions & Enabling Factors * Community Engagement & Participation ** Assessment, Analysis & Planning * Communication * Social & Behaviour Change ** MEAL	Acute Response Stabilisation Recovery Protracted Crisis ** Development	** Children * Adults Older People * Persons with Disabilities * Local Leaders Society as a Whole	Individual/Household Community/Municipality ** Institution Camp ** Rural ** Urban



Source: Three Star Approach

The Three Star Approach (TSA) for WASH in Schools (WinS) is a benchmarking system designed at a Ministry of Education (MoE) national level to categorise schools according to their WinS status. These benchmarks are defined by the Sustainable Development Goals (SDG) basic service level and national priorities to guide schools towards reaching national WASH in Schools standards.

The Three Star Approach was jointly developed in 2013 by GIZ and UNICEF. The approach is based on the SDGs for WinS. It is an accreditation system that defines benchmarks for specific WASH standards and allocates a corresponding star rating. The TSA outlines the pathway for schools to gradually improve and reach the national standard. A corresponding Monitoring (M.2) system measures the WinS status of each school, usually on an annual basis, and tracks progress over time. The TSA is intended to support countries in the management of WinS at a national, sub-national and school level by providing a clear direction on priorities for the different star levels and by setting incentives to reach them and acknowledge per-

formance. The TSA uses the Joint Monitoring Programme indicators to reach the SDG targets (access to drinking water, access to gender-segregated improved toilets and access to handwashing stations with water and soap) as well as nationally defined targets and standards. While the respective SDG targets and indicators are globally defined and reported, the TSA is a system for the MoE to manage its WinS programme, provide technical guidance at a sub-national and school level and monitor progress. Some MoE have invested in the development of additional guidance and interactive tools for use by teachers, as part of the TSA.

Tools and Methods used

- WinS policy and implementing guidelines
- WinS assessment tool
- Operation and maintenance costing app
- Orientation videos for the use of monitoring and evaluation
- Massive Open Online Course

Applicability: The TSA is applicable as a MoE management support tool for all countries as part of longer-term development interventions. It can be used in conjunction with the Fit for School (F.10) approach or any other approaches targeting schools. It provides a model that countries can use for national benchmarking depending on national conditions. It can be used by all schools within a country using a self-assessment form and results can be uploaded onto an electronic monitoring system. Dashboards to visualise the results at a national, provincial or city level can be produced, showing the percentage of schools reaching a certain star level or other specific indicators. If no national monitoring system is in place, categories for stars can be defined and schools can rate themselves by using the assessment form. This will help schools realise their own status, assess the achievements and gaps and use the results to plan for improvement of WinS conditions. The plan can then support the mobilisation of funds to reach the next star level and, ultimately, the national standard.

Main Requirements/Investments Needed: The development of a country-specific TSA with a definition of categories and respective indicators and a monitoring system is a rigorous process. It is done at a national level within MoE, usually supported by the WinS technical working group which includes the organisations actively supporting the WinS programme within a country. The TSA development process facilitates an alignment of strategies of all relevant development partners with the direction set by the national level of the MoE. As good models already exist, exchange platforms between countries can be established to support learning from each other and shorten the time and resources required.

Evidence of Effectiveness: The TSA approach is currently used in a variety of countries where significant improvements in WinS have been achieved.

In the Philippines, the MoE's national monitoring system has been in place for four years and has shown an impressive improvement. The system is now being used by 92 % of all elementary and high schools in the country. During the first round of national monitoring, only 9 % of schools reached star level but the 2021 data shows 26 % of schools reaching star level.

Likewise, the Cambodian MoE uses the TSA to manage the WinS programme. The monitoring results show that the number of schools that do not reach a star level has declined by nearly 5 % per year. In 2018/19 almost one in three schools did not reach a star level; this was already reduced to only one in five by 2020/21. Progress is further shown by the fact that the percentage of schools with one star also went down, whereas the percentage of schools with two or three stars almost doubled in the same period.

😊 Do

- Define the national standard based on the SDG basic service standard and national priorities
- Define star categories using simple and measurable indicators. Simplicity is essential
- Develop a national monitoring system for WinS using a self-assessment of schools
- Ensure transparency and accountability of results and triangulate with different school stakeholders (e.g. parent-teacher associations and the community)

☹ Don't

- Do not use a complex matrix of indicators
- Do not use complex validation processes as this will limit scalability and increase costs
- Do not compare TSA results between different countries: each country develops its own benchmarks

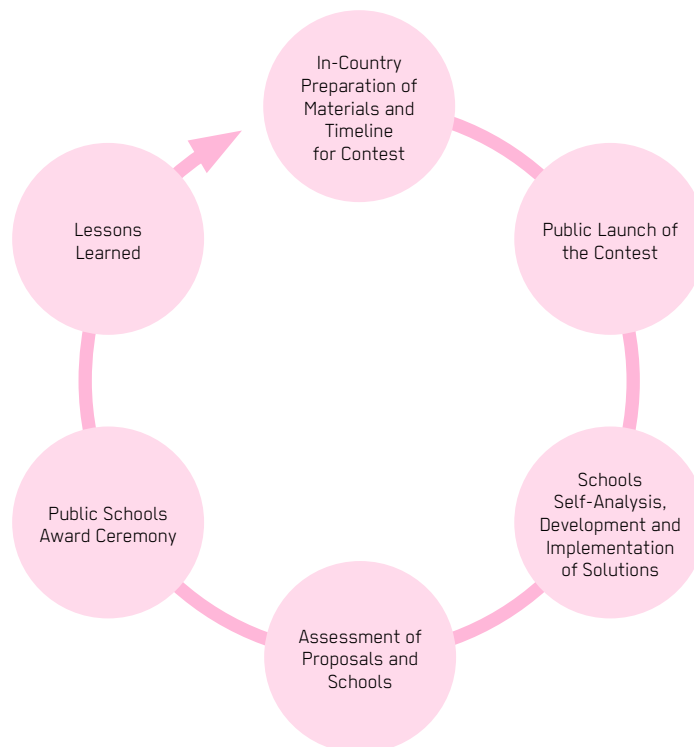
Practical Example: One example of at-scale implementation of TSA is by the Philippines Department of Education. In the most recent 2019/20 TSA monitoring cycle, the number of non-participating schools had been reduced by half from the 2017/18 baseline. The proportion of schools that started the process but dropped out also reduced significantly. Over the years the percentage of schools achieving any star levels has improved significantly. The proportion of one-star schools has almost doubled since 2017/18. There is a fourfold increase in two-star schools between baseline and the latest round of WinS monitoring. Finally, the number of schools reaching the national WinS standards (three-star level) has increased drastically from a baseline of only 41 schools to nearly a thousand in 2019/20.

→ References and further reading material for this framework/approach can be found on page 302

Toilets Making the Grade (TMG)

Purpose To trigger and enable schools to improve their own individual school sanitation and hygiene situation

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★ Social & Behaviour Change ★★ MEAL 	<ul style="list-style-type: none"> Acute Response Stabilisation ★ Recovery ★ Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> ★★ Children ★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole 	<ul style="list-style-type: none"> Individual/Household ★ Community/Municipality ★★ Institution ★ Camp ★★ Rural ★★ Urban



Source: GTD

Toilets Making the Grade (TMG) is a school competition framework aiming at activating schools to improve their own sanitation and hygiene situation with minimal external input. It triggers teamwork between management, administration, parents, pupils and maintenance staff using a 'tool kit' (inspirational package) that allows them to analyse the situation and develop and implement improvements using their own means. It provides potential for media advocacy and political ownership.

TMG mainly works at three levels **(1)** direct school sanitation and hygiene improvements, **(2)** capacity strengthening at a local government level and **(3)** national advocacy for WASH in Schools (WinS). TMG provides a methodology to foster teamwork within the schools bringing together a diverse group of school stakeholders with different perspectives on challenges and solutions regarding sanitation and hygiene. Many of the solutions target the operation and maintenance of school WASH facilities, such as blocked toilet pipes or the provision of soap, but can also be adapted to facilitate COVID-19 safer schools. Equipped

with an inspirational package of self-analysis tools, the school teams develop a common understanding of sanitation and hygiene-related challenges and their root causes. The understanding is developed between learners, school management, maintainers and other peers at school and possibly even the surrounding community. Based on the root causes the teams then develop simple and cost-effective solutions which schools are able to implement with their own means. These solutions can be as simple as cutting soap into smaller pieces to avoid soap stealing, asking children to show that they have remembered to bring toilet paper from home during morning assembly or establishing a kiosk selling snacks to pay for the operation and maintenance of WASH facilities. Schools are incentivised by recognition and prizes **(T.40)**. All schools that participate benefit from the process and those with the best ideas and solutions can win additional prizes. Sponsors should be secured early in the process to ensure locally attractive prizes. Ideally, the competition takes place through the government, achieving a new perspective of school WASH through the preparation

and judging process. The recognition through local or national authorities (or local artists or celebrities) in the final award ceremonies has proven to be very effective as an incentive to participate and for national advocacy for school WASH.

Tools and Methods used

- Competition (T.8)
- Rewards and Incentives (T.40)
- Events (T.11)
- Print Media (T.33)
- Radio and TV (T.38)
- Social Media (T.44)

Specific inspirational TMG tools for self-analysis and identification of solutions:

- Four-Senses-Inspection
- Every-vote-counts
- Root Causes
- Contest submission form that helps to structure results

Applicability: TMG is a cost-effective and scalable approach that can be adapted to different contexts. It can be used in both rural and urban areas, tailored to a specific target area or school type or used nationally for all schools. The criteria used to compare schools can be locally adapted. The approach is more suitable for stable environments and is mainly used in development contexts. It may also be applicable in protracted or fragile contexts with less government involvement; the tool kit and materials can be adapted for use in any context. It can also be used to complement existing WinS initiatives such as Fit for School (F.10). A global TMG web portal is available to ease implementation, making the approach easier to upscale.

Main Requirements/Investments Needed: To set up and organise a TMG contest at least one person with communication and organisational skills is needed to bring together all relevant stakeholders. Generic materials and templates are available but have to be adjusted and designed to the specific context; they may need translating. The planning process can take several months, particularly if implemented at scale and through the government. The actual implementation can be done in one term or over one school year. Ideally, the competition includes a large-scale launch and an awards ceremony with high-level representation and good media coverage; it should be attractive to both learners and adults. Enough time should be scheduled for the school assessment and awards ceremony.

Evidence of Effectiveness: TMG was developed to empower schools with the tools to improve sanitation and hygiene themselves. The lessons learned from its implementation in Uganda since 2019 show that the engaged schools were able to create collective responsibility as a school team with different perspectives, as well as plan, budget and implement WinS solutions on their own. At the institutional level, the awareness of WinS increased, knowledge and experience were exchanged and different local government departments improved their school inspections.

😊 Do

- Provide enough time for planning, preparation, design and translation
- Make sure that all stakeholders are involved from the beginning and that they fully understand the contest's approach
- Identify prizes that truly trigger participation (e.g. responsibly using sponsors or celebrities)
- Ensure the collaboration of different local government departments to assess and judge contest entries

😞 Don't

- Do not put the focus on the performances (e.g. poems or dance) instead of the sanitation and hygiene self-analysis and the development of specific ideas and solutions.

Practical Example: The TMG school competition has so far been implemented at various scales and with different partners in Germany, Uganda and Pakistan. It was modified for COVID-19 safer schools in Jordan. In 2017/2018 TMG was implemented in Kampala, Uganda with all 79 public schools participating and, as a result, amplifying a collective sense of responsibility. GT0 supplied the contest methodology and adapted it to the local context in collaboration with GIZ and local partners. In close collaboration with the School Management Committees and the Kampala Capital City Authority, the contest yielded routine, school-driven WASH budgeting and planning to implement the identified WASH-related solutions and interventions.

→ **References and further reading material for this framework/approach can be found on page 303**

Baby WASH

Purpose To improve child health outcomes by creating an enabling environment and facilitating the adoption of optimal care practices during pregnancy, child birth and infancy

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★ Persons with Disabilities ★ Local Leaders ★ Society as a Whole 	<ul style="list-style-type: none"> ★★ Individual/Household ★ Community/Municipality Institution ★★ Camp ★★ Rural ★★ Urban

THE 2-2-3 BABY WASH PRIORITIES

PREGNANCY	LABOR, DELIVERY, POSTNATAL	NEWBORN, INFANCY AND EARLY CHILDHOOD
Household	Facility	Household and Community
<ol style="list-style-type: none"> 1. Prepare household for a WASH safe birth 2. Prepare household for a clean environment 	<ol style="list-style-type: none"> 1. Facilitate a WASH safe birth 2. Facilitate hygienic postnatal care 	<ol style="list-style-type: none"> 1. Protect household by assuring a clean environment 2. Protect community by ensuring a clean environment 3. Protect by promoting breast feeding and increasing nutrient intake

Adapted from World Vision 2017

Baby WASH is a comprehensive approach that creates an enabling environment for improved household hygiene behaviours. It facilitates the adoption of optimal care practices during pregnancy, childbirth and infancy with the aim of improving child health outcomes in the first years of life.

Faecal ingestion and prolonged exposure to faecal microorganisms due to poor water and sanitation conditions at the household level have a significant impact on malnutrition and stunting in children under two years of age. This is primarily because babies spend time crawling and putting things in their mouths, increasing their risk of exposure to pathogens. The Baby WASH approach aims to prevent stunting through a reduction of environmental enteric dysfunction (EED) and other WASH-related diseases. Because infants under two years of age spend most of their time at home with their mothers or caregivers, the focus is on households. In addition, the approach aims to promote maternal health and avoid infections following childbirth by ensuring access to water and sanitation

(P.3 and P.4) in health facilities, delivery rooms and postpartum rooms including bathing shelters. For women who do not remain in the health facility, postpartum hygiene can be supported with hygiene promotion and hygiene kits to use at home. To prevent infants from ingesting contaminants several actions are required: regular handwashing, exclusive breastfeeding, correct disposal of infant faeces, effective water storage, reduction of open defecation in the community and clean play spaces and toys. The burden of household chores, childcare and water collection often falls to women and girls. It is important to integrate gender sensitivity (E.3) into interventions to ensure that this burden is not increased and that gender-transformative approaches can be harnessed to e.g. create a more equitable distribution of childcare and domestic responsibilities and to allow for mothers' greater involvement in decision making.

Tools and Methods used

This is not an exhaustive list as the Baby WASH approach should be adapted to the context. Overall, any activity that can be applied at a household level is relevant for Baby WASH.

- Gender Analysis **(T.16)**
- Care Groups **(T.5)**
- Demonstration, Show and Tell **(T.10)**
- Exchange Visit **(T.12)**
- Institutional Checklist (e.g. in postnatal wards) **(T.20)**
- Stakeholder Mapping **(T.49)**
- Three-Pile Sorting **(T.51)**
- IEC Materials **(T.19)**

Applicability: The Baby WASH approach is more relevant if it is endorsed and integrated into the national health programmes (particularly Maternal, Newborn and Child Health programmes and policies) as it ensures a coherent approach from pregnancy onwards. However, a focus on children under two years old and their particular needs can be integrated into any hygiene promotion programme from the acute to the development phase.

Main Requirements/Investments Needed: Working with pregnant women and new parents requires specific skills and should be considered when recruiting team members. It may require the production, improvement or adaptation of existing guidelines, training materials and manuals as well as the capacity strengthening of key stakeholders. Financial support and resources for Baby WASH may need mobilising via different sectors such as education, health, nutrition and WASH.

Evidence of Effectiveness: Evidence is available from various contexts. Some studies show that children who live in 'cleaner' (e.g. more sanitary and hygienic) households have reduced parasitic infections, less severe EED and greater linear growth. Limited research suggests that the correct disposal of faeces (both human and animal) in the immediate household environment can reduce diarrhoeal disease in children by more than 30 %.

😊 Do

- Conduct a Stakeholder Mapping **(T.49)** across all sectors to ensure that Baby WASH activities work with existing initiatives **(P.9)** and maximise efficiencies
- Coordinate at minimum with the health and nutrition sectors **(P.9)**: Baby WASH is an integrated approach, not a stand-alone intervention

☹ Don't

- Do not focus exclusively on women but include other caregivers such as young girls and older people
- Do not forget the fathers in the design of the approach

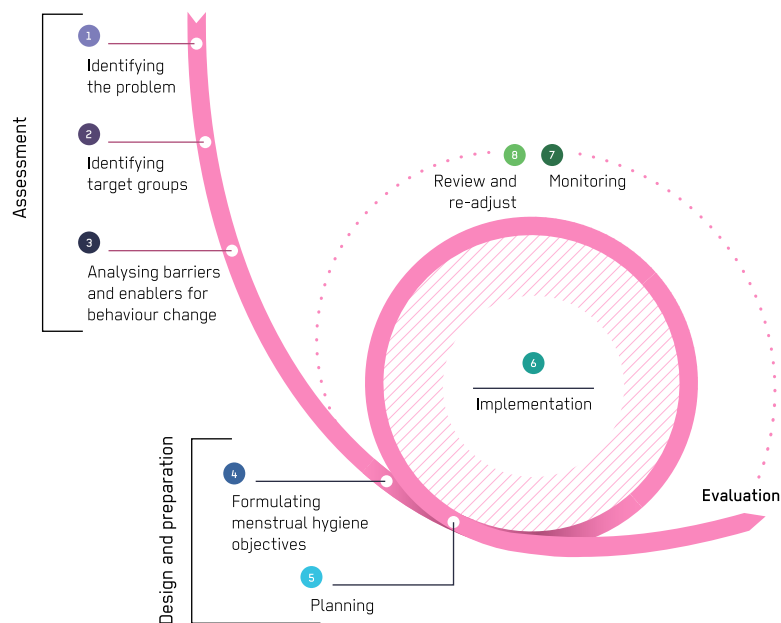
Practical Example: In 2017, Ethiopia's Ministry of Health developed national Baby WASH guidelines, supported by UNICEF. The guidelines detail how Ethiopia's National Programme provides a platform for mainstreaming Baby WASH through the country's WASH structure. It brings together four ministries – Education, Finance, Health and Water Resources – and, in some regions, Agriculture and Rural Development and Women, Children and Youth Affairs. Baby WASH sits at the intersection of critical interventions for childhood health; the guidelines illustrate simple entry points and possible approaches to programming in Eastern and Southern Africa.

→ **References and further reading material for this framework/approach can be found on page 303**

IFRC's 8 Steps for Menstrual Hygiene Management (MHM) Action

Purpose To ensure comprehensive and effective menstrual hygiene management actions

HP Component	Response Phase	Target Group	Application Level
** Preconditions & Enabling Factors	** Acute Response	** Children	** Individual/Household
** Community Engagement & Participation	** Stabilisation	** Adults	** Community/Municipality
** Assessment, Analysis & Planning	** Recovery	** Older People	** Institution
** Communication	** Protracted Crisis	** Persons with Disabilities	** Camp
** Social & Behaviour Change	** Development	** Local Leaders	** Rural
** MEAL		** Society as a Whole	** Urban



Source: IFRC

IFRC's 8 Steps for Menstrual Hygiene Management (MHM) action is a step-by-step iterative process for assessing, planning, monitoring, reviewing and re-adjusting and evaluating menstrual hygiene action. It provides guidance and practical tools for designing and implementing appropriate, comprehensive and effective MHM action (P.7) in humanitarian contexts for the Red Cross Red Crescent and can be adapted for use by other organisations and for different contexts.

The guide follows an eight step systematic approach coherent with the programme cycle and aligned with IFRC's 8 Steps for Hygiene Promotion in Emergencies (F.4) for easy integration and consistency:

- Step 1:** Identifying the problem
- Step 2:** Identifying target groups
- Step 3:** Analysing barriers and motivators for behaviour change
- Step 4:** Formulating hygiene behaviour objectives
- Step 5:** Planning and design

Step 6: Implementation

Step 7: Monitoring and evaluation

Step 8: Review, re-adjust

The three essential components for an effective MHM response are **(1)** access to menstrual products and supportive items, **(2)** private, safe and appropriate WASH facilities and **(3)** information. The components are all influenced by individual preferences and socio-cultural factors including taboos, restrictions and physical barriers. Continuous engagement and consultation with women, girls, men and boys is critical, to ensure that MHM actions are responsive, address needs and challenges and are socially and culturally appropriate. It is important to identify women and girls who may be marginalised or need additional support, such as those with physical disabilities, learning difficulties, transgender people or unaccompanied girls.

Tools and Methods used

The 8 Steps for MHM action include a number of practical tools that are available for download from IFRC's WASH webpage in different formats and languages. They include amongst others:

- Checklists (T.2)
- Focus Group Discussion (T.14) guides for assessment and post-distribution monitoring
- Minimum items to be included in dignity or MHM kits
- Pocket Chart Voting (T.31)
- Observation (T.28)
- Example IEC material (T.19)
- Example outputs and indicators (T.25) for the emergency plan of action
- Guidance on cash and voucher assistance for MHM (P.8)
- Three-Pile Sorting (T.51)

Applicability: The guide and tools are designed for preparing and responding to menstrual hygiene needs in humanitarian situations. They can also be used for longer-term programming, to train staff and volunteers, assess menstrual hygiene practices, preferences, socio-cultural attitudes, taboos and restrictions and trusted sources of information. The main advantage of the 8 Steps is to encourage a systematic, comprehensive approach to MHM which addresses the three essential components of MHM, rather than only focusing on the distribution of MHM items. The guide and tools are easily adapted for different situations and languages and are available in English, French, Spanish and Arabic. Some tools are available in Portuguese, Swahili, Kirundi and Bislama.

Main Requirements/Investments Needed: Comprehensive MHM action requires an investment in both 'hardware' (e.g. retrofitting or constructing latrines (P.4), solid waste facilities (P.5), distribution of MHM items (P.6), or access to water (P.3)) as well as 'software' (e.g. engagement with women and girls to understand their needs and preferences, information sessions and social and behaviour change communication to break down cultural restrictions or taboos). The hygiene promotion (HP) team is critical to the implementation of MHM actions throughout the project cycle, often through community-based volunteers. The selection of volunteers should be based on an understanding of the local socio-cultural context and what is appropriate for the specific community. The training and capacity strengthening of male and female volunteers (and staff) for MHM are important. Resources (human, financial) and time must be allocated (as part of preparedness, in an emergency or through longer-term development programming). The supervision and monitoring of community-based volunteers must also be planned and budgeted. Additional resources for HP materials such as IEC (T.19) materials, or Pocket Chart Voting (T.31), may be needed.

Evidence of Effectiveness: Several Red Cross Red Crescent National Societies have successfully adapted and used the approach in preparedness activities, acute humanitarian responses and recovery programming. This is evidenced by the growing number of country-specific MHM kits which have been developed and distributed, the development of standard operating procedures for hygiene and MHM kits and adapted versions of KAP Surveys (T.24), Checklists (T.2) and IEC (T.19) materials in different languages.

😊 Do

- Keep users at the centre and focus on participatory Engagement (chapter E) and Assessment (chapter A) of MHM practices, needs, preferences and socio-cultural context
- Think about the 'life cycle' of all MHM items distributed – using pads/cloth is only the first step. Washing, drying and disposal of menstrual waste are important and must be considered
- Involve men and boys in MHM programming

☹ Don't

- Do not only focus on distributing MHM items. WASH facilities (P.2, P.3, P.4, P.5, P.6), information and social-cultural aspects are just as important
- Do not address MHM in a silo. MHM is a cross-sectoral issue and coordination with sexual and reproductive health, protection, shelter and relief is critical (P.9)
- Do not rely only on quantitative data and Observations (T.28). Use participatory methods to stimulate discussion

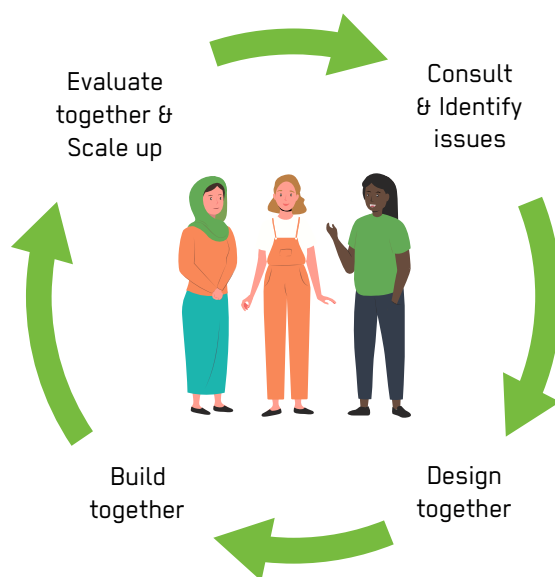
Practical Example: The Iraqi Red Crescent Society (IRCS) took a user-centred approach to adapt MHM kits and education materials based on the 8 steps and made use of several of the IFRC's tools. An assessment to understand the socio-cultural aspects of MHM in Iraq and to adapt the WASH infrastructure was done. Based on the participatory consultation and user feedback, IRCS developed MHM kits at a national level and then further localised the MHM kits in Sinjar province, as part of an early recovery programme. Post-distribution monitoring resulted in a number of changes and improvements to the distribution process, MHM kits and overall MHM programming.

→ **References and further reading material for this framework/approach can be found on page 303**

WASH Social Architecture

Purpose To engage women and girls in generating appropriate, gendered WASH facilities

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★★ Community Engagement & Participation ★ Assessment, Analysis & Planning ★★ Communication Social & Behaviour Change ★ MEAL 	<ul style="list-style-type: none"> ★ Acute Response ★★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> Children ★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★★ Society as a Whole 	<ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★★ Institution ★★ Camp ★★ Rural ★★ Urban



Adapted from Oxfam

The WASH Social Architecture approach identifies community-based solutions using design perspectives from women and girls, guided by feminist architects and exposes the diversity of females' experiences on the gendered use of WASH facilities.

People receiving aid should be involved in the decision making process. User or human-centred design is a creative problem-solving approach, putting the needs and experiences of the intended end-users at the centre of the design process. The focus is on the users' needs, experiences and lives; continuously involving people through an iterative process, designing, building and re-building as needed. The WASH Social Architecture approach uses the user-centred design approach and works with different female population groups (women and adolescent girls) to understand their preferences, capacities and motivations to participate in the construction and management of the WASH facilities. Detailed designs for WASH facilities, such as laundry and drying spaces for Menstrual Health and Hygiene (P.7), or materials for menstrual hygiene

management (P.6), bathing spaces and women's gathering places are made with the women and adolescent girls. Each of the designs considers socio-cultural norms, privacy, safety and dignity aspects as well as the location's topography. The approach needs coordination between the WASH, shelter, gender and protection sectors (P.9). Strategic advocacy by WASH agencies across all sectors is required, hence the approach must involve people who can influence standards (e.g. the Government), pressure organisations to align with minimum standards, upgrade existing facilities and enforce consultation as an integral part of all levels of implementation. The approach can take time to implement but results in WASH facilities that are acceptable and appropriate, rather than wasting time creating facilities that are not used and have to be replaced. The Sani Tweaks (F.7) model of 'consult, modify, consult' drew on the findings of the Social Architecture approach and presents a versatile, simplified and easily adopted means of ensuring users are consulted and engaged in facility design.

Tools and Methods used

- Focus Group Discussions (T.14)
- Observation (T.28)
- Community Mapping (T.7)
- Key Informant Interviews (T.23)

Applicability: The WASH Social Architecture approach is commonly used in urban contexts but is increasingly used in rural and humanitarian contexts. Its success in the Rohingya camps in Cox's Bazar, Bangladesh, demonstrates that the approach can be used in a range of contexts although extensive consultations might not be possible in an acute emergency. The approach can take time and care should be taken if it is used as a small pilot project within a wider area; the result could lead to unrest if there are different facilities for different groups. The key advantage is the engagement with the community in the planning and construction process, revealing their perspectives and leading to the construction and management of WASH facilities that are more appropriate to their context and needs.

Main Requirements/Investments Needed: It is helpful to have female architects to facilitate the process, working alongside the WASH engineers and hygiene promoters (with translators if needed). Time is needed to hold at least three Focus Group Discussions (FGD, T.14) with each group (adult women, adolescent girls, older women) for an initial brainstorming of the needs, design and final review of the models based on the designs. It also requires training for the team on the process, good listening skills and the effective facilitation of FGDs with women of different age groups. Teams also need materials such as paper and pencils, cardboard to make models, flip charts and marker pens to document key discussion points.

Evidence of Effectiveness: Recent research on strategies for providing menstruation-supportive WASH facilities in refugee camps in Cox's Bazar, Bangladesh, showed that innovative participatory methodologies and design approaches – such as the WASH Social Architecture approach – showed promising results, but their longer-term viability is dependent on the continuing engagement of woman and girls and the availability of resources. An evaluation of the Oxfam WASH Social Architecture programme in Bangladesh showed that, although the scale

of intervention was small, the women appreciated that the programme had addressed their safety and privacy, that enabling women to design their latrines and wash areas to suit their needs had worked and there was some evidence of empowerment among the women.

😊 Do

- Consult the community in age and sex-disaggregated groups to facilitate openness in giving feedback
- Consult both male and female groups even if facilities will only be used by females, to support social cohesion
- Consult continuously from the design stage, onto the construction and usage stage of the WASH facilities

😞 Don't

- Do not impose 'expert ideas', but facilitate conversations with women and girls to develop their own solutions
- Do not aim for fancy designs, but use the consultation process to amplify the voice of women and girls and translate their views into functional WASH facilities and spaces they prefer

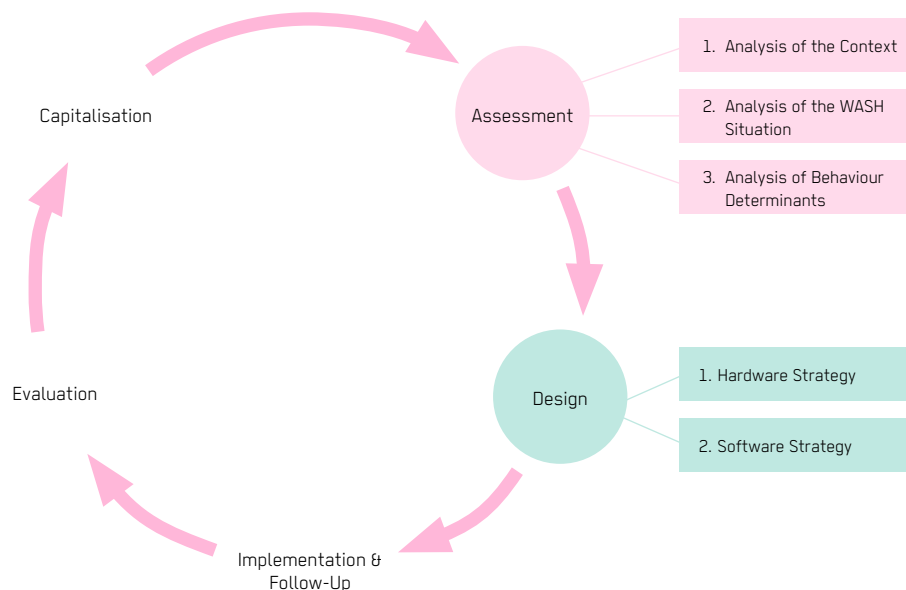
Practical Example: The WASH Social Architecture approach was used by Oxfam to help design and implement menstruation-supportive WASH facilities in the Rohingya refugee camps in Cox's Bazar, Bangladesh, including building more female-friendly toilets. The project had three phases: data collection, construction and scaling up. Architects were involved in the design phase. They worked with small groups of women, encouraged different thinking, looked at the space and what could be done with it and considered the social and environmental aspects rather than using a standard design and basic engineering approach. This resulted in the creation of spaces for menstruating girls and women to change, dispose of, wash and dry menstrual materials, all of which are integral components for MHH (P.7). The WASH facilities also had useful adaptations, such as hand rails/poles, water supply and more privacy.

→ **References and further reading material for this framework/approach can be found on page 303**

Approach Focused on Behaviour Change Determinants (ABCD)

Purpose To identify critical behaviours and their determinants to serve as a basis for designing relevant WASH interventions

HP Component	Response Phase	Target Group	Application Level
★ Preconditions & Enabling Factors	★ Acute Response	★★ Children	★ Individual/Household
★ Community Engagement & Participation	★ Stabilisation	★★ Adults	★★ Community/Municipality
★★ Assessment, Analysis & Planning	★★ Recovery	★★ Older People	★ Institution
★★ Communication	★★ Protracted Crisis	★★ Persons with Disabilities	★★ Camp
★★ Social & Behaviour Change	★★ Development	★ Local Leaders	★★ Rural
★ MEAL		★★ Society as a Whole	★★ Urban



Adapted from Solidarités International

The Approach focused on Behaviour Change Determinants (ABCD) is a socio-anthropological approach based on the study of behaviours and their determinants to help humanitarian and development actors design relevant and sustainable WASH interventions. It targets the most problematic practices in a community by using the most effective determinants to generate a positive change in the community's behaviour.

ABCD should be integrated into the assessment (**chapter A**) and design stages of the project cycle. The assessment phase, in particular, is supported by the use of qualitative and quantitative data and participatory tools enabling the triangulation of information and engagement of the target communities to develop an appropriate operational strategy. During the assessment, the first objective is to identify, quantify and prioritise the WASH behaviours that pose a risk to the community's health. Secondly, the psychological, socio-cultural and environmental determinants that favour or prohibit target WASH practices must be identified and ranked and the most effective

determinants selected to change those practices. Although the methodological framework of the ABCD approach has been formalised, it remains flexible and can be adapted to various intervention contexts. It targets five key hygiene-related behaviours that have the most impact on diarrhoeal diseases **(1)** washing hands with soap, **(2)** adopting appropriate defecation practices, **(3)** keeping the latrines and dwelling areas free from excreta, **(4)** providing clean drinking water and **(5)** safely collecting, transporting and storing drinking water. However, other behaviours can be integrated into the approach if there is solid evidence to show they also have a significant impact on diarrhoeal risks.

Tools and Methods used

Tools for identification of behaviours and their determinants:

- Literature review
- Immersion and Observation (**T.28**)
- Focus Group Discussion (**T.14**)
- Community Mapping (**T.7**)

- Transect Walk (T.52)
- Historical calendar and Seasonal Calendar (T.43)
- Classification of well-being (to identify social dynamics)
- Gender Analysis (T.16)

Tools linked to health determinants (fear of disease, perceived health etc.):

- Ranking (T.39)
- Disease perception matrix
- The game of risk

Tools linked to economic determinants:

- Expenditure priority tools

Tools that enable exploration of behaviours and practices (including levers and obstacles):

- Water source perception matrix
- Pocket Chart Voting (T.31)
- Behaviour/practice matrix
- Household Visit (T.18) including individual interview guide

Determinant comparison tools:

- Doer/Non-Doer Analysis (T.32)
- Classification cards

Others:

- ABCD staff training curriculum

Applicability: The considerable amount of time required to implement ABCD makes it unsuited to an acute response phase. The approach is better suited to recovery and development interventions and can be used in rural, peri-urban and camp contexts. The approach requires prior training. It is helpful to use ABCD from the start of a project to maximise its potential. The approach covers a significant proportion of hygiene-related issues. This can be a strength but is also a weakness, as the issues need to be studied simultaneously and can lead to the need for multiple interventions at one time.

Main Requirements/Investments Needed: An ABCD team usually includes one project manager, one activities manager and several interviewers or awareness-raisers. The ABCD approach takes between 30 to 100 days and consists of one day for team training, four to six weeks for data collection, two to four weeks for data analysis and designing of the operational strategy, half to one day for team training on each implementation activity and at least one week for piloting. Staff must also be trained to implement the ABCD.

Evidence of Effectiveness: The behaviour change principles of ABCD have a solid scientific foundation and draw on health and social psychology research. It is also aligned with RANAS (F.20) and Evo-Eco models of behaviour change (see references). Although no large-scale evaluation has been conducted to measure its effectiveness, short-term Monitoring (M.2) and Evaluation (M.3) activities in the Central African Republic and the Democratic Republic of Congo showed a positive impact on hygiene behaviours.

😊 Do

- Use the ABCD approach from the beginning of (and throughout) a WASH project
- Make sure all staff have understood the approach and its principles
- Identify communication channels or points of interaction with the community to complement the ABCD approach

😞 Don't

- Do not skip any phases in the approach to save time as it may result in poor context analysis
- Do not ignore the importance of WASH infrastructure to enable change in conjunction with other determinants

Practical Example: ABCD was implemented in 2014 in a peri-urban neighbourhood of Kinshasa and three neighbourhoods in the Bas-Congo region in the Democratic Republic of Congo. The key behaviours targeted by the approach were 'keeping the latrines free from excreta' and specific behaviours for children under-five. The key determinants of practices were knowledge (about the contamination of waterborne diseases), prestige (of having a clean latrine), disgust (of excreta and dirty water), maternal love (prioritising the health of the child), fear (of waterborne diseases), habit (of collecting dirty water and washing hands in a communal basin), access (to a source of drinking water and a handwashing facility) and economics (cost of illness versus the cost of soap). Three strategies for three neighbourhood profiles were designed. The approach targeted mothers and fathers of children under five (fathers were often involved in latrine maintenance). The selected communication channels were Household Visits (T.18), posters (T.19), video projections (T.6), Radio (T.38) and local leaders (T.22).

→ **References and further reading material for this framework/approach can be found on page 303**

Behaviour Centred Design (BCD)

Purpose To achieve behaviour change through creating surprise, disrupting the environment and prompting re-evaluation

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ** Preconditions & Enabling Factors * Community Engagement & Participation ** Assessment, Analysis & Planning ** Communication ** Social & Behaviour Change ** MEAL 	<ul style="list-style-type: none"> * Acute Response ** Stabilisation ** Recovery ** Protracted Crisis ** Development 	<ul style="list-style-type: none"> ** Children ** Adults ** Older People ** Persons with Disabilities ** Local Leaders ** Society as a Whole 	<ul style="list-style-type: none"> ** Individual/Household ** Community/Municipality ** Institution ** Camp ** Rural ** Urban



Adapted from Aunger and Curtis 2016

The Behaviour Centred Design (BCD) approach is a five-step process for designing behaviour change interventions: (1) Assess, (2) Build, (3) Create, (4) Deliver and (5) Evaluate. BCD interventions aim to achieve behaviour change by creating surprise, prompting a re-evaluation of the behaviour and disrupting the environment in which the behaviour is practised.

BCD interventions use three working principles. First, an intervention has to gain the participants' attention. To achieve this, the intervention should be perceptible and surprising. Second, an intervention has to prompt participants to perceive the target behaviour as the best possible option. To achieve this, participants are prompted to re-evaluate the behaviour. Third, the intervention should disrupt the environment in which the behaviours are practised, for example by modifying the physical environment, setting reminders or making the environment more enabling of the new behaviour.

To design interventions that follow these principles, BCD has developed a five-step process. In the **Assess** step,

programme designers review and compile the existing evidence about the practices and determinants of the behaviours of interest, define the target behaviour to be changed and hypothesise a potential theory of change for the intervention. In the **Build** step, formative research is conducted to better understand the practices and determinants of the target behaviour, develop a robust theory of change and a creative brief that forms the basis of the **Create** step. In this step, a creative team develops concepts for the intervention which are further developed in an iterative process of feedback from programme designers. Once the intervention concept is agreed upon, intervention materials are developed in an iterative process of design, feedback and pre-testing. In the subsequent **Delivery** step, interventions are implemented and monitored. The final **Evaluation** step considers both the outcomes (behaviour change) and the process of change (the psychological, social and physical change mechanisms of the campaign). The BCD approach has been used for several hygiene and nutrition behaviours but could also be used for other public health programming, product design and more.

Tools and Methods used

The BCD research tools and methods place a particular emphasis on non-cognitive approaches rather than talk-based methods. For data collection, BCD therefore recommends tools such as videoing (T.30), Observation (T.28), and photographs and interventions such as Cues and Nudges (T.9). The following tools of this Compendium could be used for the BCD approach:

Build step:

- Observation (T.28)
- Stakeholder Mapping (T.49)
- Pocket Chart Voting (T.31)
- Photo Voice and Participatory Video (T.30)
- Games and Toys (T.15)

Delivery step:

- Community Stories (T.47)
- Games and Toys (T.15)
- Beautification (T.4)
- Songs and Stories (T.47)
- Community Drama and (Puppet) Theatre (T.6)
- Cues and Nudges (T.9)
- Public Commitment (T.37)

Evaluation step:

- Observation (T.28)
- Focus Group Discussion (T.14)
- Other tools from the Assessment and MEAL sections (chapter A and chapter M).

Applicability: The BCD approach can be used in a wide range of contexts because the formative research carried out during the Assess and Build steps tailor the intervention to the context and target audience. The BCD working principles are drawn from behavioural science and its overall procedure has been corroborated through various evaluation studies. BCD is useful in gaining new insights and developing innovative ideas for addressing persistent challenges in hygiene; it can also be used for product design. A further strength is its iterative sequences between formative research, design and testing. However, the full approach requires close collaboration between several teams – the programme designers, field researchers, creative designers and members of the target audience. It requires considerable human resources and intensive field work. It takes time. BCD is therefore less suitable for acute emergency response and resource-limited settings.

Main Requirements/Investments Needed: Each step of the BCD approach is best implemented by a specialised individual or team (librarians, qualitative researchers, creative designers, monitoring and evaluation specialists). BCD provides a framework for collaboration

between these disciplines; that requires training for each of the team members. Steps A to B can be implemented within a few weeks. Implementing the other phases largely depends on the resources available and the campaign design.

Evidence of Effectiveness: The effectiveness of BCD to design behaviour change campaigns in the development context has been corroborated for various target behaviours and contexts, such as handwashing with soap (HWWS) in India, various hygiene behaviours in Zambia, food hygiene in Nepal and breastfeeding in Indonesia. The SuperAmma campaign in India, for example, achieved 19% HWWS (as compared to 4% in the non-intervention control) six weeks after the intervention and 37% HWWS (as compared to 6% in the control) six months after the intervention. After one year, handwashing rates were still at 29%.

😊 Do

- Collaborate with creative professionals and rely on their expertise for the design step
- Test campaign ideas early and frequently. This indicates what might or might not work early in the process

☹ Don't

- Do not skip any of the five steps. Each step is required and adds important information to the design process
- Do not attempt to conduct all the steps yourself. A strength of BCD is its ability to integrate professionals with diverse expertise. Do not waste the collaborative potential of the approach

Practical Example: The SuperAmma campaign in India aimed at HWWS for mothers and their children. It included a meeting with the village chairman, village and school event, a Public Commitment (T.37) by mothers through a ceremony and public display of their names, a public commitment by local leaders through a display of their pictures, meetings with pre-school teachers and animated films and skits highlighting the clean and exemplary behaviour of SuperAmma. The campaign prompted participants to reevaluate HWWS as an activity associated with being a nurturing mother. The environment was 'disrupted' by installing eye-spots in handwashing areas. Surprise was created by presenting the whole campaign as a special event.

→ **References and further reading material for this framework/approach can be found on page 303**

Communication for Behavioural Impact (COMBI)

Purpose To achieve positive behavioural results through the use of a strategic communication framework

HP Component	Response Phase	Target Group	Application Level
★ Preconditions & Enabling Factors	★ Acute Response	★★ Children	★★ Individual/Household
★ Community Engagement & Participation	★★ Stabilisation	★★ Adults	★★ Community/Municipality
★★ Assessment, Analysis & Planning	★★ Recovery	★★ Older People	★★ Institution
★★ Communication	★★ Protracted Crisis	★★ Persons with Disabilities	★★ Camp
★★ Social & Behaviour Change	★★ Development	★★ Local Leaders	★★ Rural
★★ MEAL		★★ Society as a Whole	★★ Urban



Adapted from COMBI Institute

The Communication for Behavioural Impact (COMBI) methodology is designed to produce behavioural results, not only to increase awareness and knowledge. COMBI draws on many disciplines to design communication strategies for behaviour change: marketing, advocacy, public relations, education, psychology and anthropology. It is based on successful experiences in both the public and private sectors to encourage the adoption of specific behaviours.

COMBI is a planning framework and implementation method that uses communication strategically to achieve positive behavioural and social results. Its communication programmes are designed to engage individuals, families, communities and nations and encourage them to consider and take action on specific recommended behaviours that could make a difference to the quality of their lives. COMBI involves the following ten steps:

- Step 1:** Set out the overall goal
- Step 2:** Set out preliminary, tentative, specific behavioural objectives
- Step 3:** Carry out a situational market analysis
- Step 4:** Present the communication strategy
- Step 5:** Present the COMBI plan of action
- Step 6:** Present a plan for managing the implementation of the COMBI plan
- Step 7:** Present a plan for monitoring implementation
- Step 8:** Present a plan for assessing behavioural impact
- Step 9:** Develop a calendar/timeline/implementation plan
- Step 10:** Prepare a budget

The method begins with a precise definition of the behavioural result(s) expected in relation to people's needs, wants, or desires. No communication activities are undertaken until specific behavioural objectives have been selected in step 2 and a situational market analysis (SMA) carried out in step 3. 'Market analysis' here is used in the sense of the Social Marketing (F.21) of a behaviour. The SMA involves listening to people and learning about their

perceptions of a specific behaviour. It explores factors that would constrain or facilitate the adoption of the behaviour and people's expectation of the costs (time, effort, money) compared to the value of the behaviour. COMBI integrates five communication action areas into its approach **(1)** political mobilisation, public relations and advocacy, **(2)** community mobilisation and engagement, **(3)** advertising, promotion and incentives, **(4)** personal selling, interpersonal communication and counselling and **(5)** point-of-service promotion.

Applicability: COMBI is suitable for all response phases and can be applied in a rural as well as urban context. A well-implemented COMBI process can also lead to appropriate preparedness and mitigation activities with greater support from and engagement by the concerned communities. The COMBI methodology has been widely used to identify behaviour changes related to the control of disease outbreaks and suitable actions for disease prevention. COMBI has been mostly used in the (public) health sector, including WASH-related interventions. It has also been used to achieve behavioural change objectives in a wider social development context, including in interventions that address violence against women or children's education. A potential area of COMBI application in the future may be to address behavioural issues related to an increasingly urbanised world.

Main Requirements/Investments Needed: Organisations planning to apply COMBI should allocate sufficient time and resources for the process and not rush assessments, especially the process of listening to people. Staff should be trained well in its application and provided with ongoing support.

Evidence of Effectiveness: The COMBI methodology was developed in 1994. WHO began successfully using it in 2000 in disease control programmes in developing countries worldwide. The essential prerequisite for measuring impact is having clear behavioural outcomes as programme goals. One of the most successful COMBI projects was in Cambodia where in one year UNICEF achieved a 600 % increase in the numbers of women making their first antenatal visit within 8–12 weeks of missing their period.

☺ **Do**

- Be very specific and detailed on the behaviour to be addressed with COMBI
- Plan sufficient time to apply all steps of the COMBI process
- Connect to and engage the intended target group of the behavioural change process
- Carry out market research about the desired behaviour and services (e.g. attendance at clinics providing a specific service)

☹ **Don't**

- Do not create new needs. Instead, respond to existing needs, wants and desires
- Do not make assumptions but use participatory research methods to identify the actual barriers and constraints that prevent or facilitate the adoption of healthy behaviours.

Practical Example: In Johor Bahru, Malaysia, a three-month COMBI programme resulted in 85 % of households in the sampled areas carrying out the desired dengue control-related behavioural tasks over a 12-week period. Three months later, 70 % were still maintaining the checks. COMBI has also been applied successfully in programmes where health and hygiene are interlinked e.g. a leprosy control intervention in Bihar, India where COMBI contributed to an increase in early case detection through improving the number of people self-reporting to clinics (a 73 % increase for females reporting). The COMBI methodology was also instrumental in the successful implementation of health behaviour communication in Cambodia where it was applied in the planning and implementation of a nationwide ante-natal care behaviour change communication campaign.

→ **References and further reading material for this framework/approach can be found on page 303**

FOAM and SaniFOAM

Purpose To identify and address key determinants of hygiene behaviours

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★ Communication ★★ Social & Behaviour Change ★★ MEAL 	<ul style="list-style-type: none"> ★ Acute Response ★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> ★★ Children ★★ Adults ★★ Older People ★★ Persons with Disabilities ★★ Local Leaders ★★ Society as a Whole 	<ul style="list-style-type: none"> ★★ Individual/Household ★★ Community/Municipality ★ Institution ★★ Camp ★★ Rural ★★ Urban



Adapted from WSP Worldbank 2009 and 2010

FOAM and SaniFOAM are conceptual frameworks designed to help in the development, monitoring and evaluation of handwashing (FOAM) and sanitation (SaniFOAM) behaviours but can also be useful for a range of other health-related behaviour change programmes.

Focus, Opportunity, Ability and Motivation (FOAM) begins with **Focus**: clearly defining the desired target behaviour and the target group, followed by the identification and analysis of so-called behavioural determinants – factors that can facilitate or inhibit a behaviour of interest in a certain population. Behavioural determinants can be internal (factors that take place within a person's mind, e.g. an individual's knowledge or a belief) or external (factors that happen to an individual and are beyond their control, e.g. the availability of a product or social pressure from peers). SaniFOAM applies the FOAM approach specifically to sanitation behaviours (such as ceasing open defecation, or building a latrine). The behavioural determinants for both frameworks are broadly categorised and defined as follows:

Opportunity: does the individual have the chance to perform the behaviour? This depends on determinants such as access to and availability of products and services (e.g. a public toilet may have a sink but there is no soap available), product attributes (e.g. a badly maintained and smelly toilet), social norms (e.g. a public toilet user does not clean up after using it because the previous user did not) or explicit, formal sanctions and their enforcement (e.g. fines for not having a basic sanitation facility).

Ability: is the individual capable of performing the behaviour? This depends on determinants such as knowledge (inaccurate or lack of knowledge may prevent people from engaging in appropriate hygiene practices), Social Support (T.46), skills (e.g. individuals know how to construct a toilet or empty a full latrine pit), roles and decisions (e.g. female heads of household may have the final say in hygiene matters but male heads of household decide on major household expenditures) and affordability (e.g. ability to pay for hygiene-related goods and services).

Motivation: does the individual want to perform the behaviour? This depends on determinants such as attitudes

and beliefs that may prevent an individual from adopting positive behaviours. It includes emotional, physical or social drivers (such as safety, privacy, convenience and status) or the use of Social Norms and emotional reactions (T.45) such as in the approach of Community-Led Total Sanitation (CLTS, F.2) or the willingness to pay (e.g. households might not see the benefit of a toilet in comparison to its costs).

Formative research prior to an intervention contributes to a more in-depth understanding of the most important behavioural determinants of the envisioned behaviours in that context. It enables programme planners to identify which determinants should be prioritised in the intervention.

Tools and Methods used

Typically, formative research is carried out using tools such as:

- Focus Group Discussions (T.14)
- Key Informant Interviews (T.23)
- Doer/Non-Doer Analysis (T.32)
- Observation (T.28)
- Barrier and Motivator Analysis (T.3)

FOAM also provides a useful checklist as well as a framework for organising the findings and it can be used to inform the design of questionnaires and observation tools.

Applicability: FOAM is not usually recommended during an acute response because the in-depth formative research of behavioural determinants takes time. It can be applied from the stabilisation phase onwards. FOAM was developed initially for use in resource-poor settings but can be adapted to a variety of other contexts. FOAM and SaniFOAM can assist programme managers working in hygiene promotion at all stages of their interventions from programme design through implementation to Monitoring (M.2) and Evaluation (M.3).

Main Requirements/Investments Needed: Conducting formative research on the FOAM behavioural determinants takes time. Human resources are needed to conduct interviews (T.23) or group discussions (T.14), analyse data and design (and later implement) behaviour change interventions. The time needed depends on the target behaviour and target group and the available human resources; it can take several weeks or several months.

Evidence of Effectiveness: Whilst there is evidence from research in psychology on the determinants of behaviour there is little available evidence on the application of the FOAM approach itself. A recent review indicated that the overall quality of the evidence on 'handwashing determinants' remained poor and that the literature was skewed towards reporting certain types of determinants at the expense of a more complete understanding of the routines, norms, context and the physical and biological environments and motives.

☺ Do

- Use the framework creatively to understand the Barriers and Motivators (T.3) for handwashing and sanitation
- Use this approach to conduct a formative assessment in conjunction with other methods and tools

☹ Don't

- Do not underestimate the time required to undertake a thorough formative assessment
- Do not forget to return to the findings to identify gaps and opportunities as the programme progresses

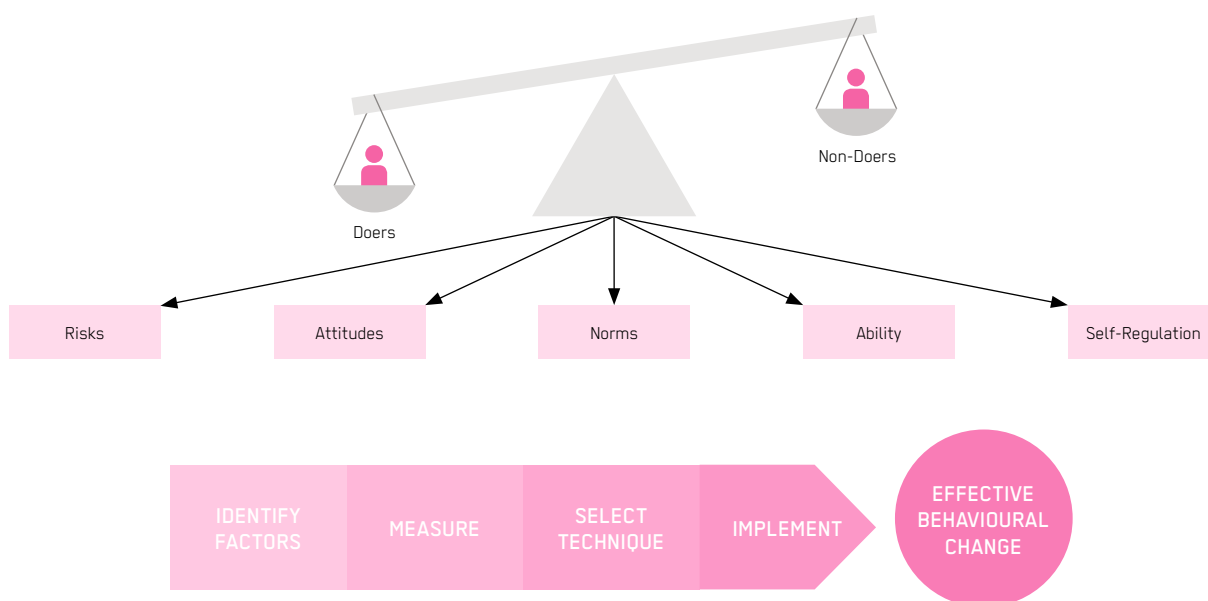
Practical Example: The CHISHPIN Project in Nigeria uses the CLTS (F.2) approach, Nigeria's national approach in the sanitation sector, but it used the SaniFOAM Framework for the baseline and KAP Survey (T.24). The survey findings helped United Purpose, the grant holder, to answer questions about sanitation behaviour, especially on the barriers and motivators for change in sanitation practice.

→ **References and further reading material for this framework/approach can be found on page 304**

Risks, Attitudes, Norms, Abilities and Self-Regulation (RANAS)

Purpose To analyse the behavioural factors of doers and non-doers and develop tailored and evidence-based behaviour change interventions

HP Component	Response Phase	Target Group	Application Level
* Preconditions & Enabling Factors	* Acute Response	** Children	** Individual/Household
* Community Engagement & Participation	* Stabilisation	** Adults	** Community/Municipality
** Assessment, Analysis & Planning	** Recovery	** Older People	** Institution
* Communication	** Protracted Crisis	** Persons with Disabilities	** Camp
** Social & Behaviour Change	** Development	** Local Leaders	** Rural
** MEAL		** Society as a Whole	** Urban



Adapted from RANAS

Risks, Attitudes, Norms, Abilities and Self-Regulation (RANAS) is a practical approach for the development of behaviour change interventions that are evidence-based and tailored to the population. The heart of the approach is a set of behavioural factors (motivators/barriers) that determine a behaviour and are grouped into risks, attitudes, norms, abilities and self-regulation factors.

The RANAS approach follows four steps that can be adapted to a context, response phase or WASH and environmental-related behaviour. The behavioural factors of the RANAS approach are: Risk factors describing the perceived risks of contracting a disease and the perceived impact on daily lives. Attitude factors include the perceived costs and benefits related to the target behaviour and the positive or negative feelings connected with it. Norm factors describe the social pressure someone experiences from influential others (e.g. religious leaders) and the social environment (e.g. family members). Ability factors describe an individual's confidence to perform the behaviour and maintain it even if problems arise. Finally,

the Self-Regulation factors describe the strength of an individual's intention to perform the behaviour, even if there are conflicting goals. Factors include remembering to perform the behaviour, action planning and action control as well as barrier planning. The four RANAS steps are:

Step 1 – Identify Factors: using short qualitative interviews, the main psychological Barriers and Motivators (T.3) relating to a target behaviour are identified along with the enabling or hindering contextual factors and characteristics of the current practices and target group.

Step 2 – Measure: depending on the response phase – but especially in stabilisation and recovery – the information from step 1 is translated into a quantitative questionnaire used to conduct approximately 150–200 household interviews. The questionnaire assesses all the RANAS factors. People who practise a specific behaviour can then be compared to those who do not (Doer/Non-Doer Analysis, T.32). Thus, the RANAS factors that are most likely to influence people's behaviour in a specific context can then be identified.

Step 3 – Select Technique: for each factor identified in Step 2, a Behaviour Change Technique (BCT) is selected using the online RANAS BCT catalogue. BCTs are based on well-established evidence from scientific research. The selected BCTs are combined to become a single campaign. The corresponding IEC (T.19) materials are then developed.

Step 4 – Implement: the campaign is implemented, monitored (M.2) and evaluated (M.3). The evaluation contributes to an understanding of whether people have changed their behaviour and why – what has changed in their minds, attitudes, feelings and beliefs that has led (or not) to behaviour change? This should lead to adaptations and improvements of the campaign.

Tools and Methods used

Potential Assessment Tools:

- Assessment Checklist (T.2)
- Barrier and Motivator Analysis (T.3)
- Focus Group Discussion (T.14)
- Household Visit (T.18)
- Key Informant Interview (T.23)
- Observation (T.28)
- Positive Deviancy and Doers/Non-Doers Analysis (T.32)
- Stakeholder Mapping (T.49)
- Transect Walks (T.52)

Potential Behaviour Change Tools:

- Beautification (T.4)
- Routine Planning and Self-Regulation (T.42)
- Involvement of Local Champions (T.22)
- Public Commitments (T.37)
- Rewards and Incentives (T.40)
- Social Support (T.46)
- WASH Committees (T.55)
- Supervised Handwashing (T.50)
- IEC Materials (T.19)

Applicability: The RANAS approach can be used in all contexts (urban, rural, camp or host communities) and in all response phases, but so far has mainly been applied in stabilisation and recovery phases. If resources are very limited, the quantitative surveys can be omitted and only qualitative interviews used. It is possible that the RANAS approach could be applied in the acute phase of the response if hygiene promoters are already familiar with it or if expertise can be rapidly sourced. Once piloted, the RANAS behaviour change campaign can be replicated in the same context and scaled up.

Main Requirements/Investments Needed: Adequate numbers of trained personnel are needed to conduct interviews and data analysis, as well as design and later implement behaviour change interventions. Depending on the available human resources, the RANAS approach can be implemented in between two and four weeks. Training must be provided to the campaign data collectors and hygiene promoters as RANAS BCTs may be new even to experienced hygiene promoters.

Evidence of Effectiveness: The effectiveness of the RANAS approach has been reported in more than 40 peer-reviewed scientific articles. For example, in the Rohingya refugee response, the approach led to a 43 % increase in habitual handwashing with soap, 34 % more women having access to private spaces for MHM, an additional 37 % of households drinking safe water, 70 % less littering and an increase of 48 % in latrines observed as clean.

😊 Do

- Do carefully read the methodology and develop context-specific tools
- Select BCTs and design a behaviour change campaign that is appropriate for the context

☹ Don't

- Do not fall back into teaching about health risks when people already have this knowledge. Instead, include BCTs that make use of other determinants of hygiene behaviour such as social norms and emotions.

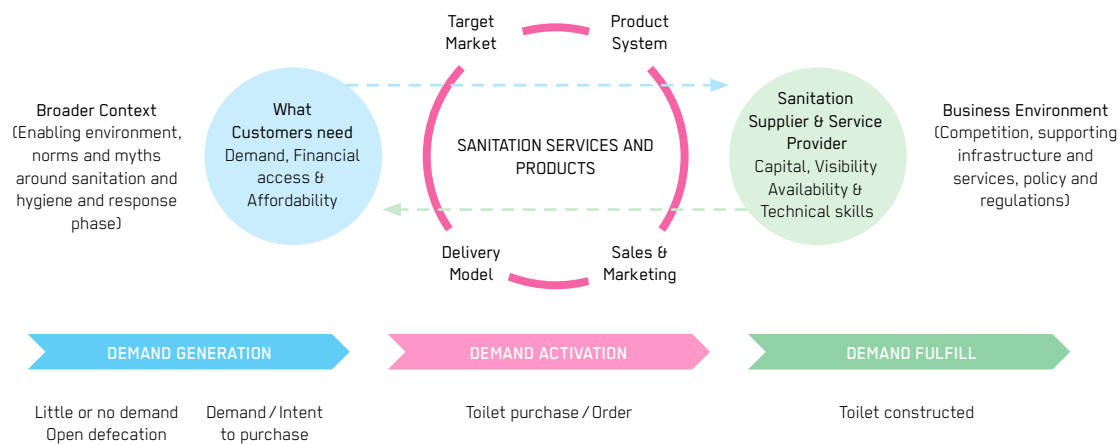
Practical Example: In the Rohingya refugee communities in Bangladesh, UNICEF and its partners implemented the RANAS approach to develop BCTs for eleven different hygiene behaviours. During steps one and two, qualitative interviews identified potential factors which were then tested in a quantitative survey of 400 people. The factors influencing latrine cleaning, for example, were identified by comparing the doers and non-doers. During step three BCTs were selected from the RANAS catalogue according to the key factors identified. The BCTs of 'Presentation of facts', 'Prompting to talk to others' and 'Describing feelings about positive consequences' were employed in user group meetings where doers talked to non-doers. In the same meetings, health promoters asked people to demonstrate latrine cleaning ('Prompt behavioural practice') and facilitated the development of detailed cleaning action plans ('Prompt specific planning') and discussed solutions to challenges ('Prompt coping with barriers'). In step 4 the interventions were evaluated using a survey of the same households to identify the positive changes in behaviour.

→ **References and further reading material for this framework/approach can be found on page 304**

Sanitation and Social Marketing

Purpose To increase sustainable access to improved household sanitation services at scale

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> ★★ Preconditions & Enabling Factors ★ Community Engagement & Participation ★★ Assessment, Analysis & Planning ★★ Communication ★★ Social & Behaviour Change ★ MEAL 	<ul style="list-style-type: none"> Acute Response ★ Stabilisation ★★ Recovery ★★ Protracted Crisis ★★ Development 	<ul style="list-style-type: none"> Children ★★ Adults ★ Older People ★ Persons with Disabilities ★ Local Leaders ★★ Society as a Whole 	<ul style="list-style-type: none"> ★★ Individual/Household ★ Community/Municipality Institution ★ Camp ★★ Rural ★★ Urban



Adapted from CRS

Sanitation Marketing aims to increase access to improved household sanitation (P.4) sustainably and at scale by developing the sanitation marketplace to better serve the needs of low-income households, supporting and stimulating the supply side of sanitation products and services and by increasing demand. It draws on Social Marketing principles that can also be applied to the promotion of other behaviours with a 'social value' such as handwashing or the use of mosquito nets.

The objective of Sanitation Marketing is that households reach satisfactory levels of latrine coverage and hygiene behaviours without extended external support. It does this by creating demand for sanitation products and services and promoting a supportive regulatory environment for establishing a market offering affordable sanitation solutions. Sanitation Marketing, like Social Marketing, is based on formative research that puts consumers at its heart – whether 'marketing' a product or a behaviour. It analyses what consumers want and are willing to invest in (demand), what markets can offer and how the policy

environment enables the approach (supply). The strategy is developed by applying the 4P's of Social Marketing: Product, Place, Price and Promotion, to which two more Ps are often added: Policies and Partnership. The formative research findings determine the marketing strategy, promoted by messages and marketing materials through key communication channels (**chapter C**). The strategy supports the development of adapted and desired sanitation products and services by engaging, supporting and training market actors (e.g. importers and wholesalers, masons, prefabricated concrete producers construction material retailers and financial service providers). Sanitation Marketing should be accompanied by a participatory hygiene promotion approach that encourages latrine use and handwashing such as Participatory Hygiene and Sanitation Transformation (PHAST, **F.6**), Wash'Em (**F.22**), Community-Led Total Sanitation (CLTS, **F.2**) or any of these in combination. Sanitation Marketing programmes must be continuously Monitored (**M.2**) to measure effectiveness, ensure the continued support of market actors and that households needs and preferences are met.

Tools and Methods used

The 4 P's Social Marketing approach:

- Product, place, price and promotion (plus policy and partnership)

Formative research:

- Site/population desk and field study research
- In-depth consumer research and interviews (both for latrine adopters and non-adopters (T.32))
- Focus Group Discussion (T.14)
- Key Informant Interview (T.23)
- Assessment Checklist (T.2)
- Household Visit (T.18)
- Observation (T.28)
- Transect Walk (T.52) with a latrine inventory (design, type, materials, quality)
- Visits and assessments of potential sanitation and other service providers
- Assessment of potential communication channels (chapter C) for promotion

Applicability: Sanitation Marketing is appropriate for households with access to markets in urban, peri-urban and rural areas. It is not fully adapted to short-term displaced households, camps or urban slum areas with limited sanitation space. It can be implemented from the early recovery phase onwards but requires a context in which national and subnational policies are favourable to the sanitation marketing approach. It may not work well if government subsidies are used to undercut the real cost of sanitation materials although it can still be used if the subsidies are redirected to the programme's sanitation services. The methodology is easy to scale up because the research information is likely to be relevant in other locations with similar sanitation supply and demand characteristics. Piloting the Sanitation Marketing approach first is, however, recommended.

Main Requirements/Investments Needed: A Sanitation Marketing project usually requires a project manager experienced in sanitation programming and business management as well as a social scientist or marketing specialist to lead the research. The manager should have access to a technical WASH team (e.g. water and sanitation engineers, public health, social behaviour change or hygiene promoters) and may require a microfinance, business development or livelihood/markets expert and an advertising and communication expert. A minimum of 12 months is recommended for the formative research, design and purchase and an additional 12 months for the Sanitation Marketing. Staff, partners, private and institutional actors may need training on the methodology. Sanitation Marketing does not require specific equipment but services such as local or regional marketing agencies and IEC (T.19) materials and information channels can enhance the approach.

Evidence of Effectiveness: Sanitation Marketing can bridge gaps between social marketing, behaviour change analysis (chapter B), market-based WASH programming (P.8) and participatory sanitation approaches. It is more sustainable than subsidised interventions as it examines sanitation from a broader perspective, considers hardware demand and supply and engages households willing to access and use a product or service and maintain it in the long term. There is limited but promising evidence for the effectiveness of social marketing in hand hygiene in Europe but there is less evidence of its application in other communicable disease areas and with disadvantaged groups.

😊 Do

- Spend time and resources on formative research
- to understand the whole context before launching any marketing activity
- Monitor (M.2) outcomes regularly and adapt the intervention to changes in the context
- Ensure inclusion during the formative research to avoid marginalising parts of the community
- Coordinate and partner with others to enhance scale and impact (P.9)

😞 Don't

- Do not implement a Sanitation Marketing programme if the formative research indicates that subsidised sanitation programming areas may jeopardise the objective
- Do not implement Sanitation Marketing in short-term projects; it needs time

Practical Example: In 2015, USAID implemented a programme in Senegal, combining CLTS (F.2) with Sanitation Marketing. The programme worked with local communities, households, masons, entrepreneurs and technical experts to design improved latrine models that were cost-effective, durable, blocked odours and flies and ensured the clients' safety, comfort and security. Different financial mechanisms (such as saving groups) were used to ensure households had access to cash. The project worked through village monitoring committees responsible for mobilising the community, promoting latrine sales, negotiating with masons and managing financial resources (e.g. latrine instalment payments collected for masons). After four years of implementation, 2347 latrines had been sold in CLTS triggered communities.

→ **References and further reading material for this framework/approach can be found on page 304**

Wash'Em

Purpose To rapidly design evidence-based and context-adapted handwashing behaviour change programmes in emergencies

HP Component	Response Phase	Target Group	Application Level
<ul style="list-style-type: none"> * Preconditions & Enabling Factors * Community Engagement & Participation ** Assessment, Analysis & Planning * Communication ** Social & Behaviour Change * MEAL 	<ul style="list-style-type: none"> ** Acute Response ** Stabilisation ** Recovery ** Protracted Crisis * Development 	<ul style="list-style-type: none"> ** Children ** Adults ** Older People ** Persons with Disabilities ** Local Leaders ** Society as a Whole 	<ul style="list-style-type: none"> ** Individual/Household ** Community/Municipality Institution ** Camp ** Rural ** Urban



1 Learn about the rapid assessment tools



2 Do the rapid assessment tools



3 Input data in Wash'Em software



4 Get context-specific hygiene program recommendations

Source: Wash'Em

The Wash'Em process enables humanitarians to rapidly design evidence-based and context-specific handwashing behaviour change programmes. It uses five rapid assessment tools to understand behavioural determinants better. The findings from the tools are entered into the Wash'Em software that provides tailored programme recommendations.

The Wash'Em process consists of five rapid assessment tools that explore different determinants of handwashing behaviour. The assessment tools are specifically designed for emergency contexts and to aid programme design. The assessment data is entered into the Wash'Em programme design software along with data about the context and programme constraints (e.g. time, budget and security). The software generates between five and nine recommended hygiene promotion activities. The Wash'Em software contains 80 handwashing promotion activities each with step-by-step instructions, tips and guidance on budgeting, procurement and implementation. Typically, the full Wash'Em process can be completed in less than

a week. Despite being a rapid process, Wash'Em places a strong focus on holistically understanding behaviour and ensuring that crisis-affected communities are at the heart of programme design. The Wash'Em tools have been developed over several years as part of a consortium of researchers, humanitarian practitioners and experts in learning and software development. The Wash'Em process and activities draw on multiple behavioural theories and are the output of literature reviews, interviews with humanitarians and in-depth qualitative research in several humanitarian settings. Wash'Em has been used to prevent and respond to outbreaks (including COVID-19, cholera and Ebola) and in droughts, flooding and typhoon response. Wash'Em has also been used in a range of conflict-affected settings with internally displaced people and refugees who are living in either camps or informal settlements.

Tools and Methods used

Assessment: Wash'Em uses five rapid assessment tools with interactive activities to learn about the enabling environment, disease perceptions, motives, potential delivery channels and people's broader experiences of the crisis. It includes tools and methods such as Demonstration (T.10), Focus Group Discussion (T.14) and individual Interviews (T.23).

Implementation: covers infrastructural improvements to handwashing facilities (P.2), community engagement (chapter E), household-level activities and motivational stories. The activities are designed to go beyond hygiene education and use behaviour change techniques (chapter B) to make people think differently about handwashing, motivate people to take action, make handwashing convenient and desirable, reward good behaviour and make handwashing normative.

Applicability: The Wash'Em process was designed primarily for use in emergencies but it can also be applied in longer-term stabilisation and recovery contexts. It is rapid, requires few staff and targets the determinants that are most important in a crisis. Wash'Em has been used in more than 80 crises and has been iteratively improved to strengthen its validity and reliability. All the tools are qualitative and aim to capture as much diversity in the sampling as possible. Wash'Em can only be used for handwashing promotion. Users may be able to adapt the tools and recommendations to incorporate other behaviours. It works best when it is incorporated into proposals during the onset of a crisis and used to guide programme design. It can also be used to adapt longer-term programmes. Wash'Em is designed to explore handwashing practices at the community level and may not be the best approach for schools or health centres as there are often different determinants driving behaviour within institutions.

Main Requirements/Investments Needed: The Wash'Em process was developed to be quick and easy to complete requiring, on average, a week to implement when used for the first time. This includes one day to familiarise with the training resources, one-to-two days to train and practise with the team, two-to-three days to collect the data and one day to summarise the data and generate recommendations. A minimum of six people (three groups of two) is recommended for data collection. The process requires access to a computer and access to devices that can record video. No prior knowledge of behaviour theory is needed.

Evidence of Effectiveness: Existing evidence and Behavioural Theory (B.2) have been used to inform all stages of the development of Wash'Em. The approach welcomes consultations with humanitarians and continuous feedback to iteratively improve the process. Wash'Em is a new approach (launched in 2020) but has already been tested by more than 50 organisations in 80 crises. Case studies of its use can be found on the Wash'Em website. An evaluation to better understand its effectiveness is ongoing and recommendations for monitoring and evaluating Wash'Em-designed programmes are available.

😊 Do

- Focus on the goal of people washing their hands with soap more frequently rather than more thoroughly
- Work with other organisations during Wash'Em training, data collection and sharing results
- Ask for support or give feedback: support@washem.info
- Allocate appropriate funding to allow the implementation of Wash'Em activities

😞 Don't

- Do not assume that knowledge will make people more likely to wash their hands with soap
- Do not undermine the importance of handwashing infrastructure and products in your handwashing promotion programme

Practical Example: Several case studies from organisations that have used Wash'Em are available. In the Philippines, Wash'Em was used by the WASH Cluster (including ACF, Oxfam, Samaritan's Purse and UNICEF) for a Super Typhoon Ompong recovery. Ten WASH programme managers and members of the government were trained. The data collection took 2.5 days. Since then, Cluster partners have repeated the process in the conflict-affected region of Mindanao and as part of the COVID-19 response. A video and case study about their experience is available.

→ **References and further reading material for this framework/approach can be found on page 304**

Accountability to Affected Population (AAP)

Purpose To ensure that humanitarian organisations are held to account by the people they are seeking to assist

HP Component	Response Phase	Target Group	Application Level
★ Preconditions & Enabling Factors	★★ Acute Response	★★ Children	★★ Individual/Household
★★ Community Engagement & Participation	★★ Stabilisation	★★ Adults	★★ Community/Municipality
★★ Assessment, Analysis & Planning	★★ Recovery	★★ Older People	★★ Institution
★★ Communication	★★ Protracted Crisis	★★ Persons with Disabilities	★★ Camp
★ Social & Behaviour Change	★★ Development	★★ Local Leaders	★★ Rural
★★ MEAL		★★ Society as a Whole	★★ Urban

THE FIVE DIMENSIONS OF ACCOUNTABILITY TO AFFECTED POPULATION (AAP)



Adapted from GWC 2009

Accountability (M.4) to Affected Population (AAP) is essential for all WASH programmes at any stage of humanitarian action. It includes five dimensions: (1) participation of the affected population to voice concerns and express preferences, (2) transparency about the humanitarian WASH response through timely and interactive communication, (3) accessibility and inclusiveness of feedback and complaints mechanisms, (4) monitoring and evaluation of the WASH interventions and (5) staff competencies and attitudes.

AAP is 'an active commitment by humanitarian actors and organizations to use power responsibly by taking account of, giving account to and being held to account by the people they seek to assist'. This means that individual organisations and humanitarian sectors must explain and take responsibility for what they do and do not do. They must provide accessible and timely information about their actions and decisions to affected women, men and children. They must ensure ongoing dialogue with affected people and welcome and act upon their feedback and

complaints. They should identify opportunities to enable affected people to make decisions about WASH interventions, Monitor (M.2) user satisfaction and learn from their work (M.6, M.7, M.8). This means enabling the affected population to exercise its rights. They include the right to safe, fair and equitable access to quality services and accurate, reliable and relevant information, the right to share their views and opinions on the quality and effectiveness of programmes and to participate in decisions that affect them. This requires building trusting relationships between humanitarian organisations and vulnerable people and communities based on mutual respect, transparency, two-way Communication (chapter C) and Engagement (chapter E).

Tools and Methods used

- Community Mapping (T.7)
- Exchange Visits (T.12)
- Feedback Mechanism (T.13)
- Focus Group Discussion (T.14)
- Photo Voice and Participatory Video (T.30)
- Observation (T.28)
- Transect Walk (T.52)
- More information can also be found in the Community Engagement and Participation (E) and MEAL (M) chapters

Applicability: AAP is not a stand-alone activity but an integrated approach aimed at improving programme quality, effectiveness and accountability. It must be implemented from the outset of an emergency and integrated into all phases of the humanitarian programme cycle and all response phases. Sectoral coordination mechanisms may already have an established AAP system; it is important to contribute to or incorporate these existing systems.

Main Requirements/Investments Needed: AAP requires the whole WASH team to be trained in Participatory Communication (C.4) and active listening. It requires human resource staff and senior management to establish measures designed to ensure that staff are competent and can communicate respectfully and effectively. Collaboration with other stakeholders and sectors (P.9) is also required. Organisations that establish their own feedback mechanism should allocate an appropriate budget and, if required, dedicated and skilled staff.

Evidence of Effectiveness: The overall evidence for the impact and effectiveness of AAP is limited. However, it is a requirement and commitment in humanitarian programmes. Research is needed to identify the most effective strategies, approaches and tools.

😊 Do

- Monitor (M.2) and Evaluate (M.3) how AAP is being integrated into the WASH programme
- Use standards such as Sphere and the Core Humanitarian Standard as a framework for accountability, ensuring the programme responds to the needs of the affected community
- Ensure that information about the organisation and programme are shared with the community in a format and language they understand
- Ensure that all WASH staff are sufficiently trained and skilled (especially in active listening) to be able to integrate AAP into their work

😞 Don't

- Do not consider the population as a homogeneous group but promote the recognition of individuals with diverse needs and capacities and use a variety of communication and feedback mechanisms

Practical Example: Several case studies from organisations that have used Wash'Em are available. In the Philippines, Wash'Em was used by the WASH Cluster (including ACF, Oxfam, Samaritan's Purse and UNICEF) for a Super Typhoon Ompong recovery. Ten WASH programme managers and members of the government were trained. The data collection took 2.5 days. Since then, Cluster partners have repeated the process in the conflict-affected region of Mindanao and as part of the COVID-19 response. A video and case study about their experience is available.

→ **References and further reading material for this framework/approach can be found on page 304**

Community Perception Tracker (CPT)

Purpose To collect and use community perceptions during a disease outbreak

HP Component	Response Phase	Target Group	Application Level
Preconditions & Enabling Factors	** Acute Response	Children	** Individual/Household
** Community Engagement & Participation	** Stabilisation	** Adults	** Community/Municipality
** Assessment, Analysis & Planning	** Recovery	** Older People	** Institution
** Communication	** Protracted Crisis	** Persons with Disabilities	** Camp
* Social & Behaviour Change	** Development	** Local Leaders	** Rural
** MEAL		** Society as a Whole	** Urban



Adapted from Oxfam

The Community Perception Tracker (CPT) is an approach to enable staff and partners to capture, analyse and understand the perceptions of communities during disease outbreaks. The qualitative data is analysed, correlated with epidemiological data, used to inform and adjust programming and provide an evidence base for advocacy and influencing.

The CPT is part of a Community Engagement (**chapter E**) approach developed by Oxfam in 2018. It was trialled in the Democratic Republic of Congo during the Ebola outbreak. CPT enables the systematic and ongoing collection of perceptions throughout the response. Perceptions are the concerns, questions, beliefs or practices of crisis-affected communities about the disease outbreak. By listening to people's perceptions and understanding their priorities and challenges, they can be supported to make informed choices during a disease outbreak. CPT can lead to meaningful programmatic changes that can play an important role in building trust with communities. It is not a stand-alone approach but should supplement wider

WASH and other programme activities. There are six steps to complete the CPT process:

1. As part of their existing programme activities, an organisation's staff or their partners listen to community members and capture the perceptions on phones or tablets. The information is uploaded to a server.
2. The real-time data is analysed and triangulated with epidemiological data and any relevant programme and contextual information
3. Regular team or partners' meetings are held to discuss the findings and prioritise key actions.
4. The findings and data are shared and triangulated with others to extend the reach of the collected information.
5. Activities are adapted, or teams advocate for change and bring concerns to the attention of other actors.
6. Activities and changes in perceptions are monitored and the evidence documented.

7. A key aspect of CPT is that the process creates space for all teams (across sectors) and partners to come together and regularly discuss real-time data and trends and make coordinated recommendations and actions.

Tools and Methods used

Information gathering:

- The perceptions are collected while personnel are conducting regular participatory programme activities such as:
- Community Group Meetings
- Individual discussions and Key Informant Interviews (T.23)
- Household Visit (T.18)
- Focus Group Discussions (T.14)

Data collection and analysis:

- Data collection can be done face to face or remotely using a phone. The data is uploaded to a server and extracted for analysis which is shared in teams/partners group discussions. The analysis is fed-back to the community (T.13), using existing information channels.

Applicability: The CPT can be used in all contexts and response settings. It is exclusively designed for use during disease outbreaks but may be adapted in the future to suit other types of emergency responses. Ideally, the CPT should be set up at the outset of a programme to capitalise on the ability of the process to shape and adapt activities based on the analysis of the captured data. CPT users must be engaged in the process, receive feedback about the quality of the data collected and take an active part in the decisions taken to adjust the programming or advocate for change. The data also serves as evidence to advocate (P.10) on behalf of communities in coordination fora and with donors. The CPT can be implemented in stages, starting in one project or area and scaled up as needed.

Main Requirements/Investments Needed: CPT requires the dedicated time of a 'focal person' or group of people to oversee the process, lead on the analysis of the data and facilitate regular team meetings. All staff, including managers, must be trained (online or face to face) and supported, especially in the CPT's first few weeks. CPT also needs support from monitoring and evaluation staff for data validation and extraction. Mobile phones, tablets or pads are required for data collection as well as a digital platform to send and store data (e.g. Survey CTO, Kobo).

Evidence of Effectiveness: A research project was conducted by the London School of Hygiene and Tropical Medicine, Action Contre la Faim in Zimbabwe and Oxfam in Lebanon. It aimed to establish whether the CPT approach is effective at helping COVID-19 response organisations adapt their interventions so that projects are of good quality, relevant and acceptable to the communities. The findings will be available on the Oxfam and Elhra websites following publication in 2022.

😊 Do

- Ensure that managers understand and support the approach
- Train the team and partners and ensure that all CPT users are part of the CPT process not just for data collection (this has a significant impact on the quality of data collected).
- Feedback the results of the data analysis to communities

😞 Don't

- Do not implement the CPT as a stand-alone project but as an integrated programme approach
- Do not use the CPT to analyse information from social media platforms as the data may not enable perceptions to be disaggregated (e.g. by gender and age)

Practical Example: Since 2020 the CPT has been used in Oxfam's COVID-19 responses in more than 12 countries. It has highlighted different patterns of perception on the existence and origin of the virus, preventative measures and treatment and revealed how COVID-19 affects people's lives including their livelihoods, protection and education. It has helped to adjust programme activities and, where Oxfam and its partners were not able to respond to the concerns, led to advocacy for other organisations to respond.

In Lebanon, in early 2021, perceptions were gathered about the COVID-19 vaccines. Concerns, questions and beliefs were captured about the vaccine, its efficacy and potential side effects as well as access to the vaccine. Refugees shared their perspectives over several months helping to design a new vaccination promotion project that included transport fees to vaccination centres, support for registration on government platforms and the use of testimonies from vaccinated people.

→ **References and further reading material for this framework/approach can be found on page 304**

Appendix

Glossary

A

AAP: Accountability to the Affected Population (F.23)

ABCD: Approach Focused on Behaviour Change Determinants (F.16)

Accountability: Accountability as defined by the OECD as the obligation to demonstrate that work has been conducted in compliance with agreed rules and standards. Sphere describes accountability as the process of using power responsibly, taking account of and being held accountable by different stakeholders and primarily those who are affected by the exercise of such power. It helps ensure that resources are used appropriately and transparently, that WASH responders take responsibility for their work and that communities benefit from efficient and effective programming (M.4)

Assessment: Assessment is an ongoing process of enquiry that enables a deeper and broader understanding of the situation to facilitate a more effective response (chapter A)

B

Baseline: Baselines determine the starting point for subsequent monitoring. The term 'baseline' can refer to the situation before the emergency or provide initial data to compare with an 'endline' survey (A.3)

BCC: Behaviour Change Communication

BCD: Behaviour Centred Design (F.17)

BCT: Behaviour Change Technique

Behavioural Determinants: The social, environmental, psychological and cultural factors that influence behaviour

C

CCCM: Camp Coordination and Camp Management

CHAST: Children's Hygiene and Sanitation Training (F.9)

CHC: Community Health Club (F.1)

CHS: Core Humanitarian Standard

CLTS: Community-Led Total Sanitation (F.2)

COMBI: Communication for Behavioural Impact (F.18)

Community: A group of people sharing something in common

Community Engagement: Community engagement connects the community and other stakeholders so that people affected by crisis can participate and have more control over the response and its impact on them (chapter E)

Community Profile: A WASH Community Profile aims to understand community structures and dynamics and determine which individuals and groups are vulnerable to which WASH-related risks and why (A.7)

CPT: Community Perception Tracking (F.24)

CVA: Cash and Voucher Assistance (P.8)

D

DHS: Demographic and Health Survey

DRR: Disaster Risk Reduction

E

Environmental Hygiene: All behaviours that ensure a clean and safe household and community environment. It includes proper waste collection, transport and disposal, drainage, potential site improvements and vector control measures

Evaluation: An Evaluation is the systematic and objective examination of a humanitarian intervention to determine the worth or significance of an activity, policy or programme and intended to draw lessons to improve policy and practice and enhance accountability. The key evaluation criteria are relevance, effectiveness, efficiency, impact, sustainability and coherence (M.3)

F

FIT: Fit for School (F.10)

FOAM: Focus, Opportunity, Ability, Motivation (F.19)

Food Hygiene: Conditions and practices that prevent food contamination and corresponding food-borne illness. It includes the safe handling, storage and preparation of food prior to consumption at home, or in public places such as communal kitchens and canteens. Safe handling and preparation include maintaining a hygienic food preparation or processing environment, working with clean hands as well as washing and safe cooking or reheating of food. Correctly stored food should be covered and protected from flies. Drinking vessels and cooking utensils should be clean when used and covered when stored. Food hygiene also encompasses safe and appropriate infant and young children feeding practices including breastfeeding

Formative Assessment: Process of in-depth enquiry into a specific situation

FRC: Free Residual Chlorine

G

GBV: Gender-Based Violence

Gender Analysis: Gender analysis aims to understand the relationships between men and women, their access to resources, their activities, the constraints they face relative to each other and how this might affect WASH programming (A.7 and E.3)

GWC: Global WASH Cluster

H

Hand Hygiene: General term referring to any action of cleaning one's hands with soap and water (or equivalent materials such as alcohol-based hand sanitiser) to remove pathogens like viruses, bacteria and other micro-organisms as well as dirt, grease or harmful and unwanted substances stuck to the hands

HCWM: Health Care Waste Management (P.5)

HP: Hygiene Promotion

HPC: Humanitarian Programme Cycle

HWWS: Handwashing with Soap

I

IASC: Inter-Agency Standing Committee

IDP: Internally Displaced People

IEC: Information, Education and Communication (T.19)

Inclusion: The policy and practice of ensuring equal access to opportunities and resources for those who are often excluded or marginalised (E.5)

Indicators: Indicators are the 'signals' that enable measurement of progress and objectives and therefore of change (M.2)

J

JMP: Joint Monitoring Program

K

KAP: Knowledge, Attitude and Practice (T.24)

KPC: Knowledge, Practice and Coverage

L

LGBTQI+: Lesbian, Gay, Bisexual, Transgender and Genderqueer or Questioning and Intersex

Likert Scale: A rating scale often used in questionnaires to measure attitudes, perceptions and opinions by using a continuum ranging from e.g. strongly agree to strongly disagree and asking participants to specify their level of agreement

LQAS: Lot Quality Assurance Sampling: a survey methodology originally used in manufacturing for quality control that uses small sample sizes

M

M&E: Monitoring and Evaluation (**M.2** and **M.3**)

MBP: Market-Based Programming (**P.8**)

Menstrual Health and Hygiene (MHH): Menstrual Health and Hygiene encompasses both menstrual hygiene management (MHM) and the systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, dignity, and rights. The systematic factors include accurate and timely knowledge; available, safe, and affordable materials; informed and comfortable professionals; referral and access to health services; sanitation and washing facilities; positive social norms; safe and hygienic disposal; and advocacy and policy (**P.7**)

Menstrual Hygiene Management (MHM): Menstrual Hygiene Management includes the provision of adequate, appropriate and quality menstrual supplies, access to sanitation facilities to manage menstruation and access to information and education on menstruation (**P.7**)

Menstrual Products: Products to manage menstruation. These include disposable pads and tampons, reusable menstrual products such as reusable pads, menstrual cups, period underwear or clean cloth and may vary according to the context (**P.7**)

MICS: Multi-Indicator Cluster Survey

MMH: Mum's Magic Hands (**F.5**)

MoE: Ministry of Education

Monitoring: Monitoring measures progress and checks whether a programme or intervention is working according to plan. It is the planned, systematic and continuous checking of the hygiene promotion intervention to ensure it is doing what was intended, that allocated funds are being used effectively, that feedback is heard and acted upon and that strengths, weaknesses and gaps are identified, so that changes can be made as needed (**M.2**)

M00C: Massive Open Online Course

N

NGO: Non-Governmental Organisation

Non-Food Items: Essential items, other than food, that people affected by humanitarian crises may need, including items to enable hygiene such as soap, buckets, razors or potties (**P.6**)

O

O&M: Operation and Maintenance

OD: Open Defecation

ODF: Open Defecation Free

OPD: Organisation of Persons with Disabilities

ORS: Oral Rehydration Solution

P

Participation: Participation aims to empower people and involve them in decisions that affect their lives (**chapter E**)

PCMA: Pre-Crisis Market Assessment (**P.8**)

Personal Hygiene: Behaviours associated with maintaining the cleanliness of the body and clothing to preserve overall health and wellbeing. It can include regular washing and bathing with soap to enhance a sense of wellbeing and to remove potential pathogens, dirt and bacteria that cause body odour or skin irritations. It can refer to dental hygiene such as regular tooth brushing, male genital hygiene where it is an issue, regular handwashing with soap or washing clothing and bedding

PHAST: Participatory Hygiene and Sanitation Transformation (**F.6**)

PPE: Personal Protective Equipment

Primary Audience: People who are most affected by an issue and who are the key target of social and behaviour change communications
Primary Data: Information that is collected directly from the affected population, usually through fieldwork or by carrying out an assessment (**A.4**)

Primary Stakeholders: Those who hold a direct interest in the project e.g. affected communities (**A.1** and **T.49**)

Proxy Indicators: Substitute indicators (or signals) that measure change indirectly using a more measurable variable. This allows for an assumption of WASH impact when direct measurement is unrealistic

Q

QIVC: Quality Improvement Verification Checklist

Qualitative Data: Information related to qualities or characteristics. It is usually descriptive and asks how and why (**A.4**)

Quantitative Data: Information related to quantities. It is numerical and asks how many, how much, or how often (**A.4**)

R

RANAS: Risks, Attitudes, Norms, Abilities and Self-Regulation (**F.20**)

RCCE: Risk Communication and Community Engagement – is an evolving approach and refers to the processes used to systematically consult, engage and communicate with communities who are at risk specifically during outbreaks of disease (**C.9**)

S

Sanitation-Related Behaviours: Set of behaviours associated with safe excreta management including the use, by all, of sanitation facilities at all times, routine operation and maintenance of toilets, the use of culturally appropriate anal cleansing materials, the safe collection, management, treatment and disposal of faeces, the safe disposal of baby and child faeces, the use of items like potties or diapers and the use of incontinence materials and facilities and toilet training for children. It may also refer to the prevention of indiscriminate/open defecation and the potential clean-up of an already contaminated environment where no toilets are available. It always implies handwashing after toilet use and after contact with children's excreta

SBM: School-Based Management

Secondary Audience: This audience is not necessarily the primary target for change, but may be able to influence others

Secondary Data: Information that has been collected previously (**A.4**)

Secondary Stakeholders: Those who have an indirect influence on the project (**A.1** and **T.49**)

SLTS: School-Led Total Sanitation (**F.2**)

SMA: Situational Market Analysis (**P.8**)

Supportive Menstrual Material: Includes underwear, extra laundry and bathing soap, a container with a lid for storing and soaking of reusable menstrual pads, cloth or dirty clothes, or rope and pegs for drying (**P.7**)

SWM: Solid Waste Management (**P.5**)

T

Tippy Tap: A simple handwashing device that uses a container that can be tipped up to release water

TMG: Toilets Making the Grade (**F.12**)

Triangulation: Compares several different data sources and methods to cross check and confirm findings, helping to reduce bias (**A.1**)

TSA: Three Star Approach (**F.11**)

U

UN-CRPD: UN Convention on the Rights of Persons with Disabilities

W

WASH: Water, Sanitation and Hygiene

WASHaLot: Group handwashing facility consisting of a pipe with easy-to-operate water outlets that allows several people to wash their hands at the same time. The water outlets release water only when touched

Water-Related Behaviours: Set of behaviours needed to ensure that the clean water provided at the point of supply remains uncontaminated until the point of use. It may include the protection of the water source, the safe transport of the water, the regular cleaning of water containers and safe water storage at household level. If further treatment at the household level is needed, it may also require the use and maintenance of household water treatment options. It may also call for (community-led) water quality monitoring at regular intervals

WinS: WASH in Schools

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All listed references are also available at and can be downloaded from the Emergency WASH Knowledge Hub online platform and the Sustainable Sanitation Alliance (SuSanA) library.

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P.3 Access to Water Supply Facilities

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P.5 Access to Solid Waste Management (SWM), Health Care Waste Management (HCWM) and Vector Control

Standards and indicators for SWM, HCWM and vector control:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Page 121-138. Switzerland

Practical guidelines for managing solid waste:

- IFRC (2020): Managing Solid Waste: Sector-Specific Guidelines for the Red Cross Red Crescent. Switzerland

Examples of waste recycling, reuse and upcycling of bio-waste:

- Zurbrugg, C. (2017): Biowaste Management: The Key to Sustainable Municipal Solid Waste Management. Eawag. Switzerland
- WasteAid (undated): Projects. UK

Information on medical and HCWM:

- Chartier, Y., Emmanuel, J. et al. (2014): Safe Management of Wastes from Health-Care Activities. 2nd Edition. WHO. Switzerland
- ACF (2017): Medical Waste Management for WASH Practitioners. Incinerators and Sharps Management. France

Guidance on how to respond to malaria outbreaks in emergencies:

- WHO (2013): Malaria Control in Humanitarian Emergencies. Switzerland
- Malaria Consortium (2018): A Guide to Implementing the Community Dialogue Approach

P.6 Access to Hygiene Items

Sphere minimum standards related to hygiene items:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Page 99-101. Switzerland

Guidance on Market-Based Programming:

- Allen, J., Brown, J. (2021): Market-Based Programming in WASH. Technical Guidance for Humanitarian Practitioners. 2nd Edition. GWC. Switzerland

- IFRC (2019): Using Cash and Voucher Assistance for Menstrual Hygiene. (Available in different languages). Switzerland

Guidance on faecal and urinary incontinence:

- Rosato-Scott, C., Barrington, D. et al. (2020): Incontinence: We Need to Talk About Leaks. *Frontiers of Sanitation*. Issue 16. IDS. UK
- Rosato-Scott, C., Barrington, D. et al. (2020): How to Talk About Incontinence: A Checklist. IDS. UK

P.7 Menstrual Health and Hygiene (MHH)

Sphere minimum standards related to MHH:

- Sphere Association (2018): *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. 4th Edition. Page 102-104 and 115-118. Switzerland

Emergency MHH guidance and toolkits in different languages:

- Sommer, M., Schmitt, M. et al. (2017): *A Toolkit for Integrating MHH into Humanitarian Response*. Columbia University, Mailman School of Public Health and IRC. (English, Arabic, French)
- IFRC (2019): *Addressing Menstrual Hygiene Management (MHH) Needs. Guide and Tools for Red Cross and Red Crescent Societies*. (Available in different languages). Switzerland
- Columbia University, IRC (2020): *Menstrual Disposal, Waste Management and Laundering in Emergencies. A Compendium*
- UNICEF (2019): *Guidance on Menstrual Health and Hygiene*
- Gruer, C., Utami, D. et al. (2020): *Guidance Note. Integrating Menstrual Hygiene Management (MHH) into Ebola Response*. Columbia University. USA
- UNICEF, UNFPA, UNHCR (undated): *Global Quality Specifications for Menstrual Products*
- UNICEF (2020): *Guidance Note. Menstrual Health and Hygiene for Girls and Women with Disabilities*
- Allen, J., Brown, J. (2021): *Market-Based Programming in WASH. Technical Guidance for Humanitarian Practitioners*. 2nd Edition. GWC. Switzerland

Practical MHH recommendations and case studies:

- IFRC (2020): *Learning from Other National Societies. Global Menstrual Hygiene Management Experiences*

MHH in Emergencies Working Group:

- For resources, guidance and support on addressing menstruation in emergencies, please reach out to the global Menstrual Hygiene Management in Emergencies working group. Contact: Adrian Dongus dongus@unfpa.org

P.8 Market-Based Programming (MBP)

Guidance and position papers on Market-Based Programming:

- Allen, J., Brown, J. (2021): *Market-Based Programming in WASH. Technical Guidance for Humanitarian Practitioners*. 2nd Edition. GWC. Switzerland
- Barbiche, J., Collins, O. (2020): *Evidence-Building for Cash and markets for WASH in Emergencies. Practices in Market-Based Programming in the Hygiene Sub-Sector*. GWC. Switzerland
- GWC (2019): *Guidance on Market Based Programming for Humanitarian WASH Practitioners*. Switzerland
- GWC (2016): *Cash and Markets in the WASH Sector. A GWC Position Paper*. Switzerland

Minimum expenditure basket decision tool:

- Klein, N., Baizan, P. (2020): *Minimum Expenditure Basket (MEB) Decision Making Tools*. CaLP

Overview of cash learning resources with the possibility to select sector, theme, type of transfer, or payment methods:

- CaLP (undated): *CaLP Library*

P.9 Coordination and Collaboration with other WASH Stakeholders and Sectors

Collection of resources to support effective WASH coordination along the humanitarian programme cycle:

- GWC (undated): *Global WASH Cluster Coordination Toolkit (CTK)*. Global WASH Cluster Advisory and Strategic Team (GWC CAST). Switzerland

Sphere WASH minimum standards including information on coordination:

- Sphere Association (2018): *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. 4th Edition. Switzerland

P.10 Advocacy for WASH and Community Priorities

Available guidance and toolkits on advocacy in emergencies:

- UNHCR (undated): *Emergency Handbook. Advocacy in Emergencies*. Switzerland
- CARE (undated): *Emergency Toolkit. Advocacy*. Switzerland
- Make Rights Real (undated): *Putting the Human Rights to Water and Sanitation into Practice – At Local Level*

E.1 Key Concepts and Good Practice

Overview and description of community engagement:

- WHO (2020): *Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People*. Switzerland

Standards for humanitarian response and WASH emphasising the need for community engagement in all sectors:

- Sphere Association (2018): *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. 4th Edition. Switzerland

Guidance on community engagement:

- UNHCR (2008): *A Community Based Approach in UNHCR Operations*. Switzerland
- Oxfam (undated): *Community Engagement in Humanitarian WASH Responses*. UK
- CDAC Network (2019): *Collective Communication and Community Engagement in Humanitarian Action. How to Guide for Leaders and Responders*. UK
- IFRC (2021): *A Red Cross Red Crescent Guide to Community Engagement and Accountability*. Switzerland
- IFRC (undated): *Community-Based Health and First Aid (eCBHFA). Teaching Guides and Tools*. Switzerland

Short films on community engagement and consultation:

- Oxfam (2020): *Community Engagement in WASH. How it Works in Practice*. UK
- Oxfam (2019): *Sanitation in Emergencies. How to Consult the User*. UK

E.2 Levels of Engagement and Participation

Overview and guidance on community engagement and participation:

- WHO (2020): *Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People*. Switzerland
- WHO (2021): *Voice, Agency, Empowerment. Handbook on Social Participation for Universal Health Coverage*. Switzerland
- Oxfam (2018): *Community Engagement in Humanitarian WASH Response*. UK

Summary paper on community engagement in emergencies:

- Brown, D., Donini, A. et al. (2014): *Engagement of Crisis-Affected People in Humanitarian Action. Background Paper. ALNAP 29th Annual Meeting 11–12 March 2014, Addis Ababa*. ALNAP, ODI. UK

E.3 Gender Issues

Guidance on why and how to collect disaggregated data in an emergency:

- Mazurana, D., Benelli, P. et al. (2011): *Sex and Age Matter. Improving Humanitarian*

Response in Emergencies. Feinstein International Center, Tufts University. USA

Guidance on exploring gender in WASH programmes:

- Water Aid (2016): Exploring Gender Aspects of Community Water, Sanitation and Hygiene. A Manual for Facilitating Dialogue between Women and Men in Communities. UK

Guidance on gender for all sectors including WASH:

- IASC (2018): The Gender Handbook for Humanitarian Action. IASC Reference Group on Gender and Humanitarian Action
- IFRC (2021): Protection, Gender and Inclusion in Water, Sanitation and Hygiene Promotion – Leaving No-one Behind in WASH. (Available in different languages). Switzerland

Practical guidance focusing on involving men and boys in sanitation and hygiene:

- Cavill, S., Mott, J. et al. (2018): Engaging Men and Boys in Sanitation and Hygiene Programmes. Frontiers of CLTS. Issue 11. IDS. UK

Practical monitoring tool:

- Plan International Australia (2014): Gender and WASH Monitoring Tool. Australia

Film on GenCap advisors work on WASH:

- IASC GenCap (2011): Gender in Humanitarian Action: WASH

E.4 Working with Babies, Children and Young People

WASH guidance with a focus on children:

- Save the Children UK (2019): Global Humanitarian WASH Guidance 2019–2021. UK

Briefing paper with practical examples of working with children:

- Oxfam (undated): Working with Children in Humanitarian WASH Programmes

Practical examples of how to work with children with disabilities:

- UNICEF (2017): Including Children with Disabilities in Humanitarian Action. WASH. USA

Child protection standards:

- Child Protection Working Group (2020): Minimum Standards for Child Protection in Humanitarian Action. The Alliance for Child Protection in Humanitarian Action

Practical guidance on Baby WASH:

- World Vision (2017): Baby WASH Toolkit. Version 1

UNICEF film on Baby WASH in Ethiopia:

- UNICEF Ethiopia (2019): UNICEF Ethiopia Baby WASH Interventions. Ethiopia.

Children's participation:

- Hart, R. (1992): Children's Participation: from Tokenism to Citizenship. UNICEF. Italy

E.5 Working with Persons with Disabilities and Older People

World disability report and charter on inclusion:

- WHO, World Bank (2011): World Report on Disability, Summary. Switzerland
- WHS, CBM (2016): Charter on Inclusion of Persons with Disabilities in Humanitarian Action

Comprehensive guidance aimed at emergency response:

- IASC (2019): Guidelines. Inclusion of Persons with Disabilities in Humanitarian Action

Humanitarian standards:

- ADCAP (2018): Humanitarian Inclusion Standards for Older People and People with Disabilities (WASH Chapter). A Sphere Companion Standard. Pages 120–139

Practical suggestions for responding to disability with a focus on the use of CLTS:

- Wilbur, J., Jones, H. (2014): Disability: Making CLTS Fully Inclusive. Frontiers of CLTS. Issue 3. IDS. UK

Practical ideas with illustrations for making facilities and services more accessible:

- Wilbur, J., Jones, H. (2014): Compendium of Accessible WASH Technologies. WEDC, WaterAid, Share. UK

Practical examples of how to work with children with disabilities:

- UNICEF (2017): Including Children with Disabilities in Humanitarian Action. WASH

Tool for disaggregating data by disability:

- Washington Group on Disability Statistics (2020): The Washington Group Short Set on Functioning (WG-SS)

Mobile app for humanitarian response to promote inclusion in all sectors including WASH:

- CBM (undated): Humanitarian Hands-On Tool (HhOT). Step-By-Step Practical Guidance on Inclusive Humanitarian Fieldwork. Germany

Guidance on gender and disability:

- CBM (2019): Disability and Gender Analysis Toolkit. Germany

Guidance on faecal and urinary incontinence:

- Rosato-Scott, C., Barrington, D. et al. (2020): Incontinence: We Need to Talk About Leaks. Frontiers of Sanitation. Issue 16. IDS. UK

- Rosato-Scott, C., Barrington, D.J. et al. (2020): How to Talk About Incontinence: A Checklist. IDS. UK

E.6 Hygiene Promotion in Schools

Guidance and example picture sets for use in emergencies:

- Sahin, M. (2011): Water, Sanitation and Hygiene for School Children in Emergencies. A Guidebook for Teachers. UNICEF

Collection of resources and case studies about WASH in Schools:

- IRC (undated): WASH in Schools Website
- Wendland, C., Rieck, C. et al. (2014): Making WASH in Schools more Sustainable. Case Stories from SuSanA Partners. SuSanA. Germany
- Panesar, A., Roach, E. et al. (2015): Making WASH in Schools more Sustainable Vol. 2. Case Stories from SuSanA partners. SuSanA. Germany

E.7 Ownership and Management of Facilities

Information sheet on WASH committees:

- Oxfam (2009): Public Health Briefing Paper: Working with Community Committees

Overview of operation and maintenance in emergencies with further reading and web links:

- SSWM (undated): Ensuring Appropriate Operation and Maintenance Services. Switzerland

Training manual on community management:

- Castro, V., Msuya, N. et al. (2009): Sustainable Community Management of Urban Water and Sanitation Schemes. A Training Manual. WSP World Bank. Kenya

Research into community ownership:

- Ambuehl, B., Tomberge, V. et al. (2021): The Role of Psychological Ownership in Safe Water Management: A Mixed-Methods Study in Nepal. Water 2021, 13(5), 589
- Contzen, N., Marks, S. (2018): Increasing the Regular Use of Safe Water Kiosk Through Collective Psychological Ownership: A Mediation Analysis. Journal of Environmental Psychology. Vol. 57. Pages 45–52
- ELRHA (undated): Psychological Ownership and Handwashing-Device Functionality During the COVID-19 Crisis

Involvement of communities in design of facilities:

- Oxfam (2018): Sani Tweaks. Best Practices in Sanitation. UK

E.8 Hygiene Promotion in Institutions and Other Settings

Overview of health promotion in different settings:

- Bloch, P., Toft, U. et al. (2014): Revitalizing the Setting Approach. Supersettings for Sustainable Impact in Community Health Promotion. International Journal of Behavioral Nutrition and Physical Activity 11, 118

WASH in prisons:

- Nembrini, P.G. (2013): Water, Sanitation, Hygiene and Habitat in Prisons. ICRC. Switzerland.

Health Promotion and tackling misinformation through faith leaders:

- Kraft, K., Kaufmann, A. (2021): Faith in Action. Power of Faith Leaders to Fight a Pandemic. World Vision
- Marshall, K. (2016): Case Study: Responding to the Ebola Epidemic in West Africa: What Role Does Religion Play? Georgetown University. USA

E.9 Community Capacity Strengthening

Information on adult learning principles and training using participatory methods:

- Pretty, J., Gijlt, I. et al. (1995): Participatory Learning and Action. A Trainer's Guide. IIED. UK
- SSWM (undated): Adult Learning Principles. Switzerland

How to carry out a learning needs assessment:

- SSWM (undated): Learning Needs Analysis. Switzerland

Working with communities and strengthening capacity and self-reliance:

- Hope, A., Timmel, S. (1995): Training for Transformation. A Handbook for Community Workers. Vol. 1-3. Practical Action Publishing. UK
- GWC (2009): Hygiene Promotion. Training for Community Mobilisers. Switzerland

CARE Groups training manual:

- TOPS (2016): Care Groups: A Reference Guide for Practitioners. USA

Visual aids for working with communities:

- IFRC (undated): Watsan Mission Assistant
- UNICEF (2012): Visual Aids for Emergencies and Development. USA

E.10 Community Engagement at a Distance

Online briefing paper with practical tips for working remotely:

- Palmer, J. (2020): Summary Report on Doing Community Engagement at a Distance. COVID-19 Hygiene Hub. UK

Guidance on community engagement in relation to COVID-19:

- GOARN, IFRC, UNICEF, WHO (2020): Tips for Engaging Communities during COVID-19 in Low-Resource Settings, Remotely and In-Person

Short guide on communication at a distance:

- BBC Media Action (2020): Community Engagement from a Distance – Guide. Bangladesh

A.1 Key Concepts and Good Practice

General and technical standards in relation to carrying out assessments (including a WASH checklist):

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Short online training introduction to needs assessments in emergencies:

- Kaya Humanitarian Leadership Academy (undated): Introduction to Needs Assessment in Emergencies. Humanitarian Leadership Academy

Methods for carrying out needs assessments with affected communities:

- Groupe URD (2009): Participation Handbook for Humanitarian Field Workers. Chapters 1–7

A.2 Risks and Influences affecting Health and Hygiene

Overview of different emergency sectors and interventions:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Description of public health risks in emergencies and how to respond effectively:

- Johns Hopkins University, IFRC (2008): The Johns Hopkins and Red Cross Red Crescent Public Health Guide in Emergencies. 2nd Edition. Switzerland

Overview of hygiene promotion assessment and link to public health:

- UNHCR (2017): UNHCR Hygiene Promotion Guidelines. Switzerland

Information on key behavioural determinants of health and hygiene:

- Petit, V. (2019): The Behavioural Drivers Model. A Conceptual Framework for Social and Behaviour Change Programming. UNICEF

Information on the links between WASH and nutrition:

- UNICEF (2016): Nutrition-WASH Toolkit

A.3 Assessment Planning and Process

Guidance on carrying out a needs assessment for field staff:

- Curron, P. (2014): Humanitarian Needs Assessment. The Good Enough Guide. Practical Action Publishing. ACAPS, ECB. UK

A.4 Data Collection Methods and Analysis

Qualitative and quantitative research techniques to collect, collate, analyse, and synthesise information for humanitarian needs assessment:

- ACAPS (2012): Qualitative and Quantitative Research Techniques for Humanitarian Needs Assessment. An Introductory Brief. Switzerland

Practical guidance on assessment and data collection:

- Curron, P. (2014): Humanitarian Needs Assessment. The Good Enough Guide. Practical Action Publishing. ACAPS, ECB. UK

Practical manual on hygiene promotion including information on assessment and planning:

- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK

Guidance on designing questionnaires and sampling:

- ACAPS (2016): Questionnaire Design. How to Design a Questionnaire for Needs Assessments in Humanitarian Emergencies. Switzerland
- Impact Initiatives (2020): Research Design Guidance: Sampling. Switzerland

A.5 Assessment Content and Scope

General and technical standards in relation to carrying out assessments (including a WASH checklist):

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Assessment checklists:

- CAWST (2021): Behaviour Change Checklist. Canada
- Rosato-Scott, C., Barrington, D.J. et al. (2020): How to Talk About Incontinence: A Checklist. IDS. UK
- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. WASH Assessment Checklist. Pages 139–143. Switzerland

Qualitative and quantitative research techniques to collect, collate, analyse, and synthesise information for humanitarian needs assessment:

- ACAPS (2012): Qualitative and Quantitative Research Techniques for Humanitarian Needs Assessment. An Introductory Brief. Switzerland

How to guides for barrier analysis using doer/non doer method:

- Kittle, B. (2017): A Practical Guide to Conducting a Barrier Analysis. 2nd Edition. Helen Keller International. USA
- Davis, J., Thomas, P. (2010): Barrier Analysis Facilitator's Guide: A Tool for Improving Behavior Change Communication in Child Survival and Community Development Programs. Food for the Hungry. USA

A.6 Existing Capacity

Standards for humanitarian response:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Overview of assessment process with descriptions of key assessment tools to support community participation:

- UNHCR (2006): UNHCR Tool for Participatory Assessment in Operations. 1st Edition. Switzerland

Practical information about enabling community participation and supporting local capacity:

- UNHCR (2008): A Community Based Approach in UNHCR Operations. Switzerland

A.7 Community Profile

Checklist for social demographics:

- IFRC (2013): Sociocultural Assessment Tool for Water, Sanitation and Hygiene Programmes. Page 35–36. Switzerland

Overview of assessment process and key participatory methods:

- UNHCR (2008): A Community Based Approach in UNHCR Operations. Switzerland

How to identify protection, gender and inclusion issues in the assessment:

- IFRC (2021): Protection, Gender and Inclusion in Water, Sanitation and Hygiene Promotion – Leaving No-one Behind in WASH. (Available in different languages). Page 15–16. Switzerland

Information on how to do a gender analysis and identify gender indicators in a WASH programme:

- CARE Australia (2014): Gender Equality Programming. Guidance Note WASH. Ensuring Gender Equality Programming in Water Supply, Sanitation and Hygiene Promotion.

A.8 Conducting Quantitative Surveys

Guidance on how to conduct questionnaire surveys:

- ACAPS (2016): Questionnaire Design. How to Design a Questionnaire for Needs Assessments in Humanitarian Emergencies. Switzerland
- Impact Initiatives (2020): Research Design Guidance: Sampling. Switzerland
- Médecins du Monde (2012): The KAP Survey Model. Knowledge, Attitude and Practices. Steps and Rules for the Preparation and Implementation of Quantitative Surveys. France
- ACF (2013): Conducting KAP Surveys: A Learning Document Based on KAP Failures

Washington Group short set of disability questions:

- Washington Group on Disability Statistics (2020): The Washington Group Short Set on Functioning (WG-SS). USA

Lot Quality Assurance Sampling (LQAS) training guide:

- Valadez, J., Weiss, W. et al. (2001): A Trainers Guide for Baseline Surveys and Regular Monitoring. Using LQAS for Assessing Field Programs in Community Health in Developing Countries. USA

A.9 Planning Frameworks

Guidance and examples on the Logical Framework Approach (T.25):

- Jensen, G. (2010): The Logical Framework Approach. How to Guide. Bond

Short film on humanitarian logframes:

- Save the Children (2018): Humanitarian Logframes. UK

Problem tree analysis process:

- TolaData (2019): Step 1: Identifying the Focal Issue with 'Problem Tree Analysis' Technique

Guidance and examples of stakeholder analysis:

- SSWM (undated): Stakeholder Identification. Switzerland
- WYG International (2009): Summary Stakeholder Analysis. Water Supply and Sanitation Services ADB TA 7240-UZB
- GWC (2009): Training for Hygiene Promoters and HP Coordinators. Part 3 of 3. Stakeholder Analysis. Page 148–150

Sphere handbook with minimum standards and indicators that support planning:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Programme design process for a handwashing programme:

- Global Handwashing Partnership (undated): The Handwashing Handbook. Chapter 3

C.1 Key Concepts and Good Practice

Basic concepts in communication:

- Spring Arbor University (2019): Fundamentals of Communication: 8 Basic Concepts and Definitions. USA

Communication during emergencies:

- CDAC Network (2019): Collective Communication and Community Engagement in Humanitarian Action. How to Guide for Leaders and Responders
- World Bank (2020): Communication during Disaster Recovery. Disaster Recovery Guidance Series. USA
- Barrantes, S., Rodriguez, M. et al. (2009): Information Management and Communication in Emergencies and Disasters. Manual for Disaster Response Teams. PAHO, WHO. USA
- Cabañero-Verzosa, C. (2005): Counting on Communication: The Uganda Nutrition and Early Childhood Development Project. World Bank Working Paper No. 59. World Bank. USA

Short video on communication in emergencies:

- Infoasaid (2011): Communication is Aid

Online training on communication:

- Kaya Humanitarian Leadership Academy (undated): Online CDAC e-learning course: Communication is Aid

C.2 Communication Skills

Communications skills for emergencies:

- World Bank (2020): Communication during Disaster Recovery. Disaster Recovery Guidance Series. USA

Information on motivational interviewing theory and practice:

- Fuller, C., Taylor, P. (2008): A Toolkit of Motivational Skills. Encouraging and Supporting Change in Individuals. John Wiley and Sons. England

Short films on active listening and the community dialogue approach:

- Spunout (2015): Six Tips for Active Listening

- Malaria Consortium (2019): The Community Dialogue Approach. Social and Behaviour Change for Promoting Healthy Communities

C.3 Audience Profile and Inclusive Communication

Inclusive communication strategies and principles (including audience profiling):

- WHO (2017): WHO Strategic Communications Framework for Effective Communications. Switzerland
- Compass (2013): How to Do an Audience Analysis. USAID. USA

Audience segmentation, profiling and communication channels:

- Health Communication Capacity Collaborative (2016-2020): SBCC for Emergency Preparedness I-Kit. USA

Communication with neglected groups during an emergency:

- Inter-Agency Coordination Lebanon (2020): Communication and Engagement with Older Persons, Persons with Disabilities, Persons with Underlying Medical Conditions and their Caregivers during COVID-19 Response. UN

C.4 Participatory Communication

Practical guidelines in participatory communication:

- Tufte, T., Mefalopulos, P. (2009): Participatory Communication. A Practical Guide. World Bank Working Paper No. 170. World Bank. USA
- CDAC Network (2019): Collective Communication and Community Engagement in Humanitarian Action. How to Guide for Leaders and Responders. UK

Designing participatory communication:

- Mefalopulos P., Kamlongera, C. (2004): Participatory Communication Strategy Design. A Handbook. FAO. Italy

Methods used in participatory communication:

- IDS (undated): Participatory Methods. UK

C.5 Mass Communication

Concise overviews for different mass communication tools:

- SSWM (undated): Media Campaigns – Radio. Switzerland
- SSWM (undated): Media Campaigns – Posters and Flyers. Switzerland
- SSWM (undated): Media Campaigns – Internet and Emails. Switzerland

Online guide on the media and tele-communication landscape in various countries:

- CDAC (undated): Media Landscape Guides. UK

Guidance on developing effective radio spots :

- Shafritz, L., Cowan, C. (2005): Spot on Malaria: Facilitator's Manual for Workshops on Adapting, Developing and Producing Effective Radio Spots. CHANGE Project. USA

C.6 Community Perspectives and Rumours

A practical overview of how to manage rumours in an emergency context:

- Bugge, J. (2017): Rumour has it: A Practice Guide to Working with Rumours. CDAC Network. UK

Information on Oxfam's systematic approach to identifying perceptions and rumours:

- Oxfam (undated): Community Perception Tracker. UK

Practical tips on how to set up a feedback mechanism:

- IFRC (2020): Tool 15. Feedback Starter-Kit. Switzerland

Guidance on how to conduct regular perception surveys:

- IFRC, Ground Truth Solutions (2019): How to Establish and Manage a Systematic Community Feedback Mechanism. Switzerland

Guidance on rumour tracking:

- Internews (undated): Rumour Tracking

C.7 Language and Cultural Considerations

Key principles for designing effective communication:

- Barrantes, S., Rodriguez, M. et al. (2009): Information Management and Communication in Emergencies and Disasters. Manual for Disaster Response Teams. PAHO, WHO. USA
- WHO (2017): WHO Strategic Communications Framework for Effective Communications. Switzerland

Cultural considerations for communication:

- Translators without Borders, Oxfam (2021): Six Tips for Humanitarians Working with Interpreters on Sensitive Topics
- Mental Health First Aid Australia (2008): Cultural Considerations and Communication Techniques. Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person. Australia

Video guides on culture sensitive communication:

- Speak First (2009): Cultural Diversity – Tips for Communicating with Cultural Awareness

C.8 Remote Communication

Detailed information about the strengths and limitations of different remote delivery channels:

- Jain, A. (2020): Summary Report on Maximising Different Delivery Channels for Communicating About COVID-19. COVID-19 Hygiene Hub. UK

Things to consider when developing communication content:

- Hasund Thorseth, A. (2020): Summary Report on the Production and Distribution of Communications Materials. COVID-19 Hygiene Hub. UK

Key principles for designing effective communication:

- WHO (2017): WHO Strategic Communications Framework for Effective Communications. Switzerland

Communications guidance for working in humanitarian settings, including links to useful tools and guidance:

- UNHCR (2021): Communicating with Communities. Switzerland

Rapid way of assessing the acceptability and reach of different delivery channels:

- Wash'Em (2020): The Touchpoints Tool

C.9 Risk Communication and Community Engagement (RCCE)

Introduction and overview on risk communication:

- CDC (2018): CERC Crisis and Emergency Risk Communication. Introduction. USA
- CDC (2019): CERC Crisis and Emergency Risk Communication. Psychology of a Crisis. USA
- RCCE (undated): Handout 1. What it Is and Why it Matters

RCCE strategy for COVID-19 response:

- IFRC, UNICEF, WHO (2020): COVID-19 Global Response Risk Communication and Community Engagement (RCCE) Strategy

Training resources:

- WHO (2015): Effective Communications. Participant Handbook. Switzerland
- WHO (undated): Risk Communication Essentials: Get social! Switzerland

Films on risk communication:

- Frost, M. (2020): Risk Communication and Community Engagement. WHO. Switzerland
- Media/Pool (2020): What is Risk Communication?

Country specific guides on available media and telecommunications (including radio stations, newspapers, mobile phone networks, languages used and national legislation):

- CDAC Network (undated): Media Landscape Guides. UK

C.10 Communication Plan

Overview of how to compile a crisis communication plan:

- CDC (2014): CERC: Crisis Communication Plans. USA

B.1 Key Concepts and Good Practice

Guidance on social and behaviour change:

- Schmied, P. (2019): Social and Behaviour Change. Insights and Practice. GIZ. Germany
- Pezzullo, L., Corna, F. et al. (2013): ABC – Assisting Behaviour Change. Designing and Implementing Programmes in ACF Using an ABC Approach. Part 1. Theories and Models. ACF. France
- Schmied, P. (2017): Behaviour Change Toolkit for International Development Practitioners. Enabling People to Practice Positive Behaviours. People in Need. Czech Republic

Introductory video on HP in humanitarian contexts with an emphasis on the RANAS approach :

- Mosler, H. (2018): Hygiene Promotion in Humanitarian Contexts. Using a Systematic Approach to Behavior Change. Introduction to Public Health Engineering in Humanitarian Contexts. ICRC, Eawag, EPFL. Switzerland

Guidance on how to do BCC for WASH programmes:

- SNV (2016): Behaviour Change Communication Guidelines. The Netherlands

Online webinar about systematic approaches in HP with a focus on the Behaviour Centred Design (BCD) approach:

- IRC (2018): Webinar Discussion: Systems Approaches to Hygiene Behavior Change: Lessons Across WASH, Health and Education. USA

Introduction to social and BCC in emergency situations:

- Breakthrough Action (undated): Social and Behaviour Change Communication (SBCC) website

CAWST training and collection of resources on behaviour change including assessment of determinants of behaviour:

- CAWST (undated): Explore Behaviour Change. Canada
- CAWST (2021): WASH Resources. Canada

B.2 Behaviour Change Models and Theories

Introduction to social and behaviour change theories:

- Petit, V. (2019): The Behavioural Drivers Model. A Conceptual Framework for Social and Behaviour Change Programming. UNICEF
- Schmied, P. (2019): Social and Behaviour Change. Insights and Practice. GIZ. Germany
- Schmied, P. (2017): Behaviour Change Toolkit for International Development Practitioners. Enabling People to Practice Positive Behaviours. Pages 5–6. People in Need. Czech Republic
- US Department of Health and Human Services (2005): Theory at a Glance. A Guide for Health Promotion Practice. 2nd Edition. USA
- Norman, P., Conner, P. (2005): Predicting Health Behaviour: Research and Practice with Social Cognition Models. 2nd Edition. Open University Press. UK

Information and short films about models and theories of behaviour change used in health and hygiene promotion:

- Bedoya, D. (2020): The Health Belief Model
- Smith, N. (2013): Trans-Theoretical Model of Behaviour Change

B.3 Motivators and Barriers: Knowledge

Activities to use the F-diagram to impart health and action knowledge:

- IFRC (undated): Disease Transmission (Chain of Contamination) Instructions. (Available in different languages). Switzerland

RANAS catalogue proposing several BCTs to target health and action knowledge:

- Eawag, Helvetas, SDC (2016): Catalogue of Behavior Change Techniques (BCTs). Version 1.0. Switzerland

B.4 Motivators and Barriers: Ability and Self-Efficacy

Theoretical introduction to self-efficacy:

- Petit, V. (2019): The Behavioural Drivers Model. A Conceptual Framework for Social and Behaviour Change Programming. Page 34. UNICEF
- Bandura, A. (1977): Self-Efficacy: Toward a Unifying Theory of Behavioral Change. Psychological Review, 84(2). Pages 191–215

Short film on self-efficacy:

- Burditt, R. (2015): Self Efficacy

Details about behaviour change techniques to target self-efficacy:

- Mosler, H., Contzen, N. (2016): Systematic Behavior Change in Water, Sanitation and Hygiene. A Practical Guide Using the RANAS Approach. Version 1.0. Eawag. Switzerland

B.5 Motivators and Barriers: Motivation, Attitudes and Beliefs

Social and behaviour change guides containing more information on attitudes:

- Pezzullo, L., Corna, F. et al. (2013): ABC – Assisting Behaviour Change. Designing and Implementing Programmes in ACF Using an ABC Approach. Part 1. ACF. France
- Petit, V. (2019): The Behavioural Drivers Model. A Conceptual Framework for Social and Behaviour Change Programming. Pages 32–33. UNICEF

A list of practical techniques to tackle attitudes:

- Mosler, H., Contzen, N. (2016): Systematic Behavior Change in Water, Sanitation and Hygiene. A Practical Guide Using the RANAS Approach. Version 1.0. Eawag. Switzerland

B.6 Motivators and Barriers: Social Influence, Norms and Group Affiliation

Practical guide on including social norms in behaviour change programming:

- Petit, V., Zalk, T. (2019): Everybody Wants to Belong: A Practical Guide to Tackling and Leveraging Social Norms in Behavior Change Programming. UNICEF, PENN SoNG. Jordan

Definition of social norms and how to change them:

- Bicchieri, C. (2016): Norms in the Wild. How to Diagnose, Measure, and Change Social Norms. Oxford University Press. UK

Information on targeting gender norms:

- Marcus, R., Harper, C. (2014): Gender Justice and Social Norms – Processes of Change for Adolescent Girls. Towards a Conceptual Framework 2. Overseas Development Institute. UK

A list of practical behaviour change techniques to tackle social norms:

- Mosler, H., Contzen, N. (2016): Systematic Behavior Change in Water, Sanitation and Hygiene. A Practical Guide Using the RANAS Approach. Version 1.0. Eawag. Switzerland

B.7 Motivators and Barriers: Cues and Habit Formation

Details about Behaviour Change Techniques (BCTs) to support habit formation:

- Mosler, H., Contzen, N. (2016): Systematic Behavior Change in Water, Sanitation and Hygiene. A Practical Guide Using the RANAS Approach. Version 1.0. Eawag. Switzerland

Details about BCTs to support habit formation with a focus on latrine use:

- Neal, D., Vujcic, J. et al. (2016): Nudging and Habit Change for Open Defecation: New Tactics from Behavioral Science. WSP World Bank. USA

Guidance on how to use nudges for handwashing promotion:

- Global Handwashing Partnership (2017): FAQ: Using Nudges to Encourage Handwashing with Soap

B.8 Overview of Behaviour Change Approaches

Overview of hygiene and sanitation approaches:

- Peal, A., Evans, B. et al. (2010): Hygiene and Sanitation Software. An Overview of Approaches. WSSCC. Switzerland

M.1 Key Concepts and Good Practice

Standards and indicators for Hygiene Promotion:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Page 96-138. Switzerland

Tool for disaggregating data by disability:

- Washington Group on Disability Statistics (2020): The Washington Group Short Set on Functioning (WG-SS). USA

Definitions of accountability and practical examples and case studies on putting accountability into practice:

- GWC (2009): WASH Accountability Resources. Ask, Listen, Communicate. Switzerland

Definition and explanation on how to conduct evaluations:

- Cosgrave, J., Buchanan-Smitz, M. et al. (2016): Evaluation of Humanitarian Action Guide. ALNAP, ODI. UK

Guidance on knowledge management and learning:

- Cranston, P., Chandak, A. (2016). Strengthening Learning and Knowledge Management: Review of WaterAid's Approach to Knowledge Management. Briefing Paper 2549. 39th WEDC International Conference, Kumasi, Ghana. UK

M.2 Monitoring

Hygiene Promotion standards and indicators:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Page 96-138. Switzerland
- UNICEF (2007): Indicators for Monitoring Hygiene Promotion in Emergencies. Best Practice Materials Produced Through the WASH Cluster HP Project

Guidance on how to establish a WASH monitoring plan:

- GWC (undated): Global WASH Cluster Coordination Toolkit (CTK). Global WASH Cluster Advisory and Strategic Team (GWC CAST). Switzerland

- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Chapter 4 on HP Monitoring and Evaluation. Practical Action Publishing. UK

Multi-sectoral guide to monitoring and evaluation with definitions, methods and guidance:

- ACF (undated): Multi-Sectoral Monitoring and Evaluation Guidelines. (Available in English and French). France

General and COVID-19 specific information and resources on monitoring and evaluation:

- Majorin, F., Watson, J., et al. (2020): Summary Report on Remote Data Collection. COVID-19 Hygiene Hub. UK
- Freeman, M., White, S. et al. (2020): Summary Report on General Principles for Monitoring and Evaluating COVID-19 Prevention Projects. COVID-19 Hygiene Hub. UK

Monitoring community satisfaction:

- Oxfam (2018): An Introduction to Community Engagement in WASH. UK

M.3 Evaluation

Definition and explanation of evaluations:

- Cosgrave, J., Buchanan-Smitz, M. et al. (2016): Evaluation of Humanitarian Action Guide. ALNAP, ODI. UK

Basic guideline covering key aspects of evaluation for Hygiene Promotion:

- Mooijman, A. (2003): Evaluation of Hygiene Promotion. DFID Resource Centre for Water, Sanitation and Health. WEDC. UK
- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Chapter 4 on HP Monitoring and Evaluation. Practical Action Publishing. UK

Practical guidelines evaluating hygiene at all stages of a programme; assessment, planning, evaluation:

- Almedom, A., Blumentahl, U. et al. (1997): Hygiene Evaluation Procedures. Approaches and Methods for Assessing Water- and Sanitation-Related Hygiene Practices. ODA, INFDC, LSHTM, UNICEF

Information on involving communities and using participatory tools for WASH evaluations:

- Narayan D. (1993): Participatory Evaluation. Tools for Managing Change in Water and Sanitation. World Bank Technical Paper No. 207. USA

Hygiene Promotion minimum standards and indicators:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Suggestions for multi-sectoral evaluations and links to field examples of evaluations:

- GWC (undated): Global WASH Cluster Coordination Toolkit (CTK). Response Evaluation. Global WASH Cluster Advisory and Strategic Team (GWC CAST). Switzerland

Remote data collection and how to protect participants and data collectors:

- Majorin, F., Watson, J. et al. (2020): Summary Report on Remote Data Collection. COVID-19 Hygiene Hub. UK

General and COVID-19 specific information and resources on monitoring and evaluation:

- Freeman, M., White, S. et al. (2020): Summary Report on General Principles for Monitoring and Evaluating COVID-19 Prevention Projects. COVID-19 Hygiene Hub. UK
- Majorin, F., Hasund Thorseth, A. et al. (2020): Summary Report on Remote Quantitative and Qualitative Approaches for Understanding COVID-19 related Behaviours and Perceptions. COVID-19 Hygiene Hub. UK

M.4 Accountability

Internationally agreed WASH minimum standards, the Core Humanitarian Standard and the Code of Conduct:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Definitions of accountability and practical examples, case studies for putting accountability into practice:

- GWC (2009): WASH Accountability Resources. Ask, Listen, Communicate. Switzerland

Guidance on incorporating accountability into humanitarian programmes including WASH:

- IFRC (2021): A Red Cross Red Crescent Guide to Community Engagement and Accountability. Switzerland
- Oxfam (2007): The Good Enough Guide. Impact Measurement and Accountability in Emergencies. Emergency Capacity Building Project. UK

Overview about ethical considerations and guidelines in data collection and field research:

- Majorin, F., Watson, J. et al. (2020): Summary Report on Ethics, Consent, Protection and Risk. COVID-19 Hygiene Hub. UK

Information about remote data collection and how to protect participants and data collectors:

- Majorin, F., Watson, J. et al. (2020): Summary Report on Remote Data Collection. COVID-19 Hygiene Hub. UK

M.5 Participatory Monitoring, Evaluation, Accountability and Learning

Practical advices and suggestions for managers on issues related to participatory evaluation:

- USAID (2011): Performance Monitoring and Evaluation. Tips. Conducting a Participatory Evaluation. USA

Information on participatory processes and indicators that can be used to involve community members and other stakeholders:

- Narayan D. (1993): Participatory Evaluation. Tools for Managing Change in Water and Sanitation. World Bank Technical Paper No. 207. USA

How to use the Most Significant Change Approach to Monitoring and Evaluation:

- Davis, R., Dart, J. (2005): The 'Most Significant Change' (MSC) Technique. A Guide to Its Use

M.6 Learning: Process and Key Elements

Discussion paper on organisational and institutional learning:

- Van Brabant, K. (1997): Organisational and Institutional Learning in the Humanitarian Sector. Opening the Dialogue. ALNAP. UK

Review of learning and knowledge sharing practices:

- Cranston, P., Chandak, A. (2016): Strengthening Learning and Knowledge Management: Review of WaterAid's Approach to Knowledge Management. Briefing Paper 2549. 39th WEDC Conference, Kumasi, Ghana. UK

Proposed methodology to improve the rigour of research methods :

- Dillon, N., Campbell, L. (2018): Lessons Papers: A Methods Note. ALNAP. UK

Monitoring and evaluation principles and practical ways of applying these to hygiene during the COVID-19 response:

- Freeman, M., White, S. et al. (2020): Summary Report on General Principles for Monitoring and Evaluating COVID-19 Prevention Projects. COVID-19 Hygiene Hub. UK
- Majorin, F. (2020): What Tools are Available to Aid Organisations in Acting Ethically While Learning from Communities? COVID-19 Hygiene Hub. UK

M.7 Learning: Research and Evidence

Study on research methods used in humanitarian settings, with a specific focus on the utilisation of adaptive or innovative approaches:

- Smith, J., Blanchet, K. (2020): Research Methodologies in Humanitarian Crises. R2HC, ELRHA. UK

Information on the use of the case study method, a method often practiced but little understood:

- Gerring, J. (2004): What Is a Case Study and What Is It Good for? American Political Science Review, Vol. 98(2). USA

Quantitative and qualitative data collection methods, with a specific focus on the COVID-19 pandemic:

- Majorin, F., Hasund Thorseth, A. et al. (2020): Summary Report on Remote Quantitative and Qualitative Approaches for Understanding COVID-19 related Behaviours and Perceptions. COVID-19 Hygiene Hub. UK

Practical examples and case studies on putting accountability into practice:

- GWC (2009): WASH Accountability Resources. Ask, Listen, Communicate. Switzerland

Information on participatory processes and indicators that can be used to involve community members and other stakeholders:

- Narayan D. (1993): Participatory Evaluation. Tools for Managing Change in Water and Sanitation. World Bank Technical Paper No. 207. USA

How to use the Most Significant Change Approach to Monitoring and Evaluation:

- Davis, R., Dart, J. (2005): The 'Most Significant Change' (MSC) Technique. A Guide to Its Use

M.8 Learning: Knowledge Management

Review of learning and knowledge sharing practices:

- Cranston, P., Chandak, A. (2016): Strengthening Learning and Knowledge Management: Review of WaterAid's Approach to Knowledge Management. Briefing Paper 2549. 39th WEDC Conference, Kumasi, Ghana. UK

Online module from Ethiopia on Learning and Sharing in the WASH Sector:

- Ethiopia's One WASH national programme (undated): Study Session 11: Learning and Sharing in the WASH Sector. Ethiopia

T.1 Accessibility and Safety Audit

In-depth information and checklists on accessibility and safety audits:

- WEDC, WaterAid (2013): Accessibility and Safety Audit of Water and Sanitation Facilities. Facilitators Notes. UK
- WEDC, WaterAid (2013): Accessibility and Safety Audit. Latrine Checklist. UK

Ideas for designing WASH facilities for people with disabilities:

- Jones, H., Reed, R. (2005): Water and Sanitation for Disabled People and

other Vulnerable Groups: Designing Services to Improve Accessibility. WEDC, Loughborough University. UK

Case study from Ethiopia:

- WRC (2012): In Search of Safety and Solutions: Somali Refugee Adolescent Girls at Sheder and Aw Barre Camps, Ethiopia

T.2 Assessment Checklist

WASH assessment checklist in the Sphere handbook:

- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. WASH Initial Needs Assessment Checklist. Page 139–143. Switzerland

Implementation guide, including links to checklists in Sphere:

- Sphere (2021): Sphere in Context for Assessments, Monitoring, Evaluation and Learning. Sphere Unpacked. Switzerland

Example of an observation checklist:

- UN OCHA (2012): Multi Cluster Initial Rapid Assessment Observation Checklist. USA

Checklist for hygiene promotion review:

- UNHCR (2017): UNHCR Hygiene Promotion Guidelines. Switzerland

General assessment guide and how to use a checklist:

- IFRC (2005): Guidelines for Emergency Assessment. Switzerland
- British Red Cross (2006): Sanitation and Hygiene Checklist. Mass Sanitation Module Emergency Response Unit. London

T.3 Barrier and Motivator Analysis

Explanation of Barriers and Motivators and how to start assessing these:

- IFRC (2018): IFRC WASH Guidelines for Hygiene Promotion in Emergency Operations. Step 3. (Available in different languages). Switzerland

How to guides for barrier analysis using doer/non-doer method:

- Kittle, B. (2017): A Practical Guide to Conducting a Barrier Analysis. 2nd Edition. Helen Keller International. USA
- Davis, Jr., Thomas, P., (2010): Barrier Analysis Facilitator's Guide. A Tool for Improving Behaviour Change Communication in Child Survival and Community Development Programs. Food for the Hungry. USA
- TOPS Program (2014): Barrier Analysis Questionnaire. FSN Network

Barrier Analysis case studies:

- PIN (2017): The Barriers to Improve Hygiene and Sanitation Practices in Rural Ethiopia. People in Need. Czech Republic
- WaterAid (2020): Removing Barriers to the Practice of Hygiene in Southern Africa. Summary of Formative Research Findings in Five Countries. UK

T.4 Beautification

Guide to Beautification of WASH facilities:

- IFRC (2021): A Guide to Community Muralisation. Switzerland
- UNICEF, GIZ (2016): Scaling Up Group Handwashing in Schools. Compendium of Group Washing Facilities Across the Globe
- Cion, I. (2006): A Refugee Camp Beautification Proposal that Seeks to Uplift both Environment and Spirits. Pages 40–41
- GIZ (2015): WASHaLOT Field Guide. Prefabricated Group Washing Facility for Schools. Germany

Examples related to Beautification:

- SBM Gramin (2019): Swachh Sundar Shauchalaya Contest. India
- Sharma, P. (2018): These New York Artists Are Bringing Colours and Smiles to Rohingya Camps. News 18

T.5 Care Groups

Care Group training manual:

- FSN Network – Social and Behavioral Change Task Force (2014): Care Groups: A Training Manual for Program Design and Implementation. USA
- TOPS (2016): Care Groups: A Reference Guide for Practitioners. USA

World Vision Nurturing Care Group (NCG):

- World Vision (2020): Nurturing Care Groups Project Model
- Herrick, M., Tidwell, B. et al. (2021): Behavior Change: Practical Implementation Guidance for Programs. Page 22. World Vision

Selected resources on the use of the Care Group approach:

- Behaviour Change (undated): Care Group Website

Film describing ENRICH Care Group program in four countries:

- World Vision (undated): Care Group Model – World Vision ENRICH Project

T.6 Community Drama, Cinema and Puppet Theatre

Guidance on how to do street theatre and puppet shows:

- GWC (2009): Training for Hygiene Promoters and HP Coordinators. Part 2 of 3. Useful to Know. USA

- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK
- OM (2020): Puppetry and Animation Used to Educate Children about COVID-19 in Ethiopia
- Oxfam (undated): Working with Children in Humanitarian WASH Programmes. UK
- SSWM (undated): Child Hygiene and Sanitation Training (CHAST). Switzerland
- World Vision (2017): Sesame Street. World Vision Partnership Expands to 11 Countries with Lifesaving Hygiene Lessons
- Sesame Street International Social Impact (2017): WASH UP! How Raya is Helping Syrian Refugee Children Stay Healthy

T.7 Community Mapping

General overview and step by step guidance on the principles of PLA (incl. Community Mapping):

- Pretty, J., Guijt, I. et al. (1995): Participatory Learning and Action. A Trainer's Guide. UK

Guidance on Community Mapping in WASH for community organising and decision making:

- SSWM (undated): Participatory Mapping for Decision Making. Switzerland
- Roaf, V. (2005): Community Mapping: A Tool for Community Organising. Guidelines for WaterAid partners. WaterAid. UK

Details on how to use a variety of participatory tools and for training facilitators (focused on HIV/AIDS but easily adaptable to WASH):

- International HIV Aids Alliance (2006): Tools Together Now: 100 Participatory Tools to Mobilize Communities on HIV/AIDS. UK.

Case study from Southern Gobi:

- Hawkins, R., Marmer, P. et al. (2006): Participatory Rural Appraisal in the Southern Gobi. York University. UK

T.8 Competition

Competition case studies from various countries:

- GTO (2019): Toilets Making the Grade in Uganda. Germany
- Abel, M. (2017): Clean Hands, Good Toilet, Happy Family! Hygiene Promotion Guidelines & Tools. Western Pacific Sanitation Marketing and Innovation Project. Australia
- Agarwal, P. (2018): Now, Toilets of Govt Schools to Compete in Beauty Contest. The Times of India. India
- World Vision MEERO (2017): GIZ Water Conservation 2017 – Implemented by World Vision International

T.9 Cues and Nudges

Practical examples of Cues and Nudges:

- Global Handwashing Partnership (2017): FAQ: Using Nudges to Encourage Handwashing with Soap
- Dreibelbis, R., Kroeger, A. et al. (2016): Behavior Change without Behavior Change Communication: Nudging Handwashing among Primary School Students in Bangladesh. International Journal of Environmental Research and Public Health
- Neal, D., Vujcic, J. et al. (2016): Nudging and Habit Change for Open Defecation: New Tactics from Behavioural Science. WSP World Bank. USA

T.10 Demonstration, Show and Tell

Evidence on handwashing Demonstration:

- Goel, S., Chandrashekar, B. R. (2020): Evaluating the Efficacy of Handwashing Demonstration on Hand Hygiene Among School Students. An Interventional Study. Journal of Education and health Promotion. India

Information on HWTS Demonstration in emergencies:

- Oxfam (2012): Hygiene Promotion for Household Water Treatment and Safe Storage in Emergencies UK

T.11 Events

Advocacy and planning guides for different world days:

- MH Day Alliance International Secretariat (2016): Menstrual Hygiene Day Planning Guide. WASH United. Germany. URL: <https://www.susana.org/en/knowledge-hub/resources-and-publications/library/details/4614>
- WHO, UNICEF, WSSCC (2008): Celebrating World Water Day 2008. Theme: Sanitation Matters! – An Advocacy Guide. WHO. Switzerland. URL: <https://www.susana.org/en/knowledge-hub/resources-and-publications/library/details/4555>

Reports and case studies related to global handwashing day:

- Global Handwashing Partnership (2021): 2020 Global Handwashing Day Report
- Rulashe, P. (2012): Sudanese Refugees Embrace Global Handwashing Day for Disease Control. UNHCR. Switzerland
- White, S. (2020): Global Handwashing Day Report: What Have we Learned About Promoting Hand Hygiene During the COVID-19 Pandemic. COVID-19 Hygiene Hub. UK

T.12 Exchange Visit

General information on Exchange Visits:

- Matras F., Sidi, F. et al. (2013): Exchange Visits: Advice for Improving the Impact. Knowledge Management and Gender. FAO. Italy

T.13 Feedback Mechanism

Guides and toolkits on Feedback

Mechanisms:

- Plan International (2018): Child Friendly Feedback Mechanisms: Guide and Toolkit. UK
- Bonino, F., Warner, A. (2014): What Makes Feedback Mechanisms Work? ALNAP. UK

Tools, tips and templates for setting up and running a simple Feedback Mechanism:

- IFRC (2020): Tool 15. Feedback Starter Kit. Switzerland

Feedback Mechanism case studies:

- Bonino, F., Jean, I. et al. (2014): Humanitarian Feedback Mechanisms: Research, Evidence and Guidance. ALNAP, ODI. UK

T.14 Focus Group Discussion (FGD)

Details of how to do FGDs (incl. sample questions, checklists and training materials)

- IFRC, UNICEF (2020): Guide to Run Focus Group Discussions with Community Volunteers. Risk Communication and Community and Community Engagement for the New Coronavirus
- IFRC (undated): Focus Group Discussions. EVCA Toolbox. Switzerland
- SSWM (undated): Focus Groups. Switzerland
- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK
- GWC (2009): Training for Hygiene Promoters and HP Coordinators. Part 1 of 3. Essential to Know. USA

Suggested questions for a FGDs with women about menstrual hygiene:

- IFRC (2019): Focus Group Discussion Guide – Assessment. Menstrual Hygiene Management in Emergencies. (Available in different languages). Switzerland

FGD guidance with key points to consider before, during and after and with focus on COVID-19:

- IFRC, UNICEF (2020): Focus Group Discussion Guide for Communities. Risk Communication and Community Engagement for the New Coronavirus

T.15 Games and Toys

Research and case studies using

Surprise Soap:

- LSHTM (2018): Innovative 'Surprise Soap' gets Children Washing Hands in Emergencies, with Lifesaving Implications. UK
- Watson, J., Dreibelbis, R. et al. (2019): Child's Play: Harnessing Play and Curiosity Motives to Improve Child Handwashing in a Humanitarian Setting. International Journal of Hygiene and Environmental Health, Vol. 222(2). Page 177–182

'My School Loo' sanitation and hygiene educational games and materials:

- GTO (2021): My School Loo. Germany

'Snake and Ladder' case study from India:

- Kamala Devi, C. (2016): Effect of Snake and Ladder Game on Knowledge regarding Personal Hygiene among School Children at Selected Schools, Coimbatore. India

E-Gaming case study from South Africa:

- Unilever (2020): Gaming and E-learning Offer Fresh Take on Schools Hygiene Programme

Use of story mat, snakes and ladders games for hygiene messaging:

- Stanford University, World Vision, Sesame Street (undated): WASH UP! Factsheet. USA

T.16 Gender Analysis

Handbook and practical guidance on integrating gender equality into humanitarian action across sectors:

- IASC (2018): The Gender Handbook for Humanitarian Action. IASC Reference Group on Gender and Humanitarian Action

Toolkit to mainstream gender in emergencies with practical examples in WASH:

- CARE (undated): Rapid Gender Analysis. UK

Guidance on Protection, Gender and Inclusion (PGI) in WASH (in different languages):

- IFRC (2021): Protection, Gender and Inclusion in Water, Sanitation and Hygiene Promotion - Leaving No-one Behind in WASH. (Available in different languages). Switzerland

Guidance note to increase gender awareness among WASH practitioners:

- CARE Australia (2014): Gender Equality Programming. Guidance Note WASH. Ensuring Gender Equality Programming in Water Supply, Sanitation and Hygiene Promotion. Australia

Case study from Nepal:

- Oxfam (2015): Gender Analysis in WASH. Recovery Assistance to Earthquake Affected Communities of Sindhupalchok. Nepal

T.17 Health Surveillance Data

General reference for all sectors covering the importance of using disaggregated data – including surveillance data in emergencies:

- Mazurana, D., Benelli, P. et al. (2011): Sex and Age Matter. Improving Humanitarian Response in Emergencies. Feinstein International Center, Tufts University. USA

Health information systems:

- WHO (undated): Early Warning, Alert and Response Systems (EWARS)
- WHO (undated): WHO Toolkit for Routine Health Information Systems Data

Data sources:

- DHS (undated): Demographic Health Surveys by Country. USA
- UNICEF (2019): Reports of Multi Indicator Cluster Surveys (MICS) by country
- UN DESA (undated): World Population Prospects 2019. Online Edition. Rev. 1

T.18 Household Visit

Guidance on how to do Household Visits for hygiene promotion:

- WEDC (2014): Guide 13. Managing Hygiene Promotion in WASH Programmes. Loughborough University. UK
- UNHCR (2017): UNHCR Hygiene Promotion Guidelines. Switzerland
- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK
- CAWST (2017): Community WASH Promotion Trainer Manual. Canada

T.19 Information, Education and Communication (IEC)

MOOC training on IEC in WASH emergencies:

- Oxfam (undated): Information, Education and Communication (IEC) in WASH Emergencies. Online Course

General information on posters and flyers as part of media campaigns:

- SSWM (undated): Media Campaign. Poster and Flyer. Switzerland

IEC material examples:

- IFRC (undated): IEC Materials for Health Promotion in Water, Sanitation and Hygiene. Resilience Library Southeast Asia Resources. Laos
- CDC (undated): Posters for the Prevention and Control of Cholera. USA
- CDC (undated): Hygiene-Related Posters. USA

T.20 Institutional Checklist

Checklist for monitoring WASH systems in refugee schools:

- UNHCR (2020): WASH in Schools Checklist. Switzerland

Survey checklist for WASH safety planning in Kiribati schools:

- UNICEF (undated): Sanitary Survey Checklists. WASH Safety Planning. Technical Toolkit for Kiribati Schools

WASH in schools checklist to manage COVID-19 response:

- WASH in Schools Network (2020): WASH in Schools Checklists to Manage COVID-19 Response. Checklists for School Entrances, Classrooms and Toilets. GIZ, UNICEF, WaterAid, Save the Children

T.21 Integrated Behavioural Model (IBM) for WASH

Academic paper describing the model and how it came about:

- Dreibelbis, R., Winch, P. et al. (2013): The Integrated Behavioural Model for WASH: A Systematic Review of Behavioural Models and a Framework for Designing and Evaluating Behaviour Change Interventions in Infrastructure-Restricted Settings. BMC Public Health 13:1015

Academic paper illustrating a case study from Bangladesh:

- Hulland, K., Leontsini, E. et al. (2013): Designing a Handwashing Station for Infrastructure-Restricted Communities in Bangladesh Using the Integrated Behavioural Model for Water, Sanitation and Hygiene Interventions (IBM-WASH). BMC Public Health 13:877

T.22 Involvement of Local Champions

General information on the use of Local Champions:

- IFRC (2020): Learning from Other National Societies. Global Menstrual Hygiene Management Experiences. (Available in different languages). Switzerland
- WHO (1996): Factsheet 4.5. Selecting Target Groups for Hygiene Education. Switzerland
- Marshall, K. (2016): Case Study: Responding to the Ebola Epidemic in West Africa: What Role Does Religion Play? Georgetown University. USA

T.23 Key Informant Interview

Description of Key Informant Interviews and semi-structured Interviews with example set of questions:

- Almedom, A., Blumenthal, U. et al. (1997): Hygiene Evaluation Procedures,

Approaches and Methods for Assessing Water- and Sanitation-Related Hygiene Practices. ODA, INFDC, LSHTM, UNICEF

Details about how to do Key Informant Interviews:

- ACAPS (2011): Technical Brief: Direct Observation and Key Informant Interview Techniques, for Primary Data Collection During Rapid Assessments. Switzerland
- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK
- SSWM (undated): Semi-Structured Interviews. Switzerland

T.24 Knowledge, Attitude and Practice (KAP) Survey

Guidance on how to conduct KAP Surveys and lessons learned:

- ACF (2005): Water, Sanitation and Hygiene for Populations at Risk. Pages 570–576. France
- Médecins du Monde (2012): The KAP Survey Model. Knowledge Attitude and Practices. Steps and Rules for the Preparation and Implementation of Quantitative Surveys. France
- ACF (2013): Conducting KAP Surveys: A Learning Document Based on KAP Failures. France

KAP Survey case study from Za'atari camp, Jordan:

- UNICEF, REACH (2018): WASH Knowledge, Attitude and Practice (KAP) Survey in Za'atari Camp. Jordan

T.25 Logical Framework Analysis and Problem Tree

General description of the Problem Tree method:

- IFRC (undated): Problem Tree. EVCA Toolbox. Switzerland

Short film on humanitarian logframes:

- Save the Children (2018): Humanitarian Logframes. UK

Simple guides and tools:

- Garbutt, A., Simister, N. (2017): The Logical Framework. Intrac. UK
- Tools4dev (undated): Logical Framework (Logframe) Template
- DFID (2011): Guidance on Using the Revised Logical Framework. UK

Example plan of action:

- IFRC (undated): Water, Sanitation and Hygiene Promotion (WASH) Logframe/Plan of Action (POA) Template. Switzerland

T.26 Most Significant Change (MSC)

Guidance and manuals on how to use Most Significant Change:

- Davis, R., Dart, J. (2005): The 'Most Significant Change' (MSC) Technique. A Guide to Its Use
- Lennie, J. (2011): The Most Significant Change Technique. A Manual for M&E Staff and Others at Equal Access

Case study from Nepal:

- USAID, Suahara (undated): Most Significant Change (MSC) Stories

T.27 Motivational Interviewing

Guidance on MI theory and practice incl. details about how to use numerous tools to support MI:

- Fuller, C., Taylor, P. (2008): A Toolkit of Motivational Skills. Encouraging and Supporting Change in Individuals. John Wiley and Sons. UK. ISBN: 978-0-470-51658-4

Research paper on use of MI in promoting household water treatment:

- Thevos, A., Olsen, S. et al. (2002): Social Marketing and Motivational Interviewing as Community Interventions for Safe Water Behaviors: Follow-up Surveys in Zambia. International Quarterly of Community Health Education. Vol. 21, Issue 1

T.28 Observation

Example training exercise for observing:

- GWC (2009): Hygiene Promotion. Training for Community Mobilisers. USA. URL: <https://www.susana.org/en/knowledge-hub/resources-and-publications/library/details/4473>

General description and practical tips on how to do observations:

- IFRC (undated): Direct Observation. EVCA Toolbox. Switzerland.
- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK. ISBN: 978-1853396410.

Example MHM Observation checklists for latrines, bathing areas and solid waste facilities:

- IFRC (2019): Addressing Menstrual Hygiene Management (MHM) Needs. Guide and Tools for Red Cross and Red Crescent Societies. (Available in different languages). Switzerland

Outline of how to do observations:

- ACAPS (2011): Technical Brief: Direct Observation and Key Informant Interview Techniques, for Primary Data Collection During Rapid Assessments. Switzerland.

Examples of how observation can be used with monitoring indicators:

- UNHCR (2017): UNHCR Hygiene Promotion Guidelines. Switzerland

Wash'Em handwashing demonstration tool:

- Wash'Em (undated): Rapid Assessments

T.29 Peer Education (Child-to-Child)

Guide to engaging children in emergencies:

- UNICEF East Asia and Pacific Regional Office (2007): The Participation of Young People and Children in Emergencies. A Guide for Relief Agencies, Based Largely on Experiences in the Asian Tsunami Response

Child-to-Child case study:

- Child to Child (undated): INEE Global Meetup: How Can Children Take an Active Role in Education in Emergencies?

Guide to Child-to-Child approach:

- Gibbs, S., Mann, G. et al. (2002): Child-to-Child: A Practical Guide. Empowering Children as Active Citizens. Child-to-Child. UK

Guide to working with children:

- Oxfam (undated): Working with Children in Humanitarian WASH Programmes. UK

T.30 Photo Voice and Participatory Video

Research, guidance and examples of using the Photo Voice tool:

- Wang, C., Yi, W. et al. (1998): Photovoice as a Participatory Health Promotion Strategy. Health Promotion International. Vol. 13, Issue 1. Oxford University Press
- Photovoice (undated): Photovoice Website
- Save the Children (2014): Photovoice Guidance. 10 Simple Steps to Deliver and Facilitate Children's Participation in Needs Assessments. UK
- Walker, A., Early, J. (2010): "We Have to Do Something for Ourselves": Using Photovoice and Participatory Action Research to Assess the Barriers to Caregiving for Abandoned and Orphaned Children in Sierra Leone. International Electronic Journal of Health Education

Participatory Video:

- Indaba (undated): Indaba Participatory Video Guide
- IFRC (2020): Indaba: Participatory Video Monitoring on a WASH in Indonesia

T.31 Pocket Chart Voting

Useful guidance and manuals:

- Dayal, R., van Wijk, C. et al. (2000): MetGuide. Methodology for Participatory Assessments with Communities, Institutions and Policy Makers. Linking Sustainability with Demand, Gender and Poverty. IRC. The Netherlands
- House, S., Ferron, S. et al. (2014): Violence, Gender and WASH. A Practitioner's Toolkit. Toolset 4-E Methodologies for Working With Communities. Pocket Chart Voting and Participatory Ranking. WaterAid, SHARE. UK
- Srinivasan, L. (1990): Tools for Community Participation: A Manual for Training Trainers in Participatory Techniques. PROWESS/UNDP Technical Series. UNDP PROWESS. USA. ISBN: 0-912917-20-2

T.32 Positive Deviancy and Doer/Non-Doer

Case studies and guidance from different sectors:

- CORE Group (2003): Positive Deviance / Hearth Materials: A Resource Guide for Sustainably Rehabilitating Malnourished Children. USAID. USA
- Kittle, B. (2013): A Practical Guide to Conducting a Barrier Analysis. Helen Keller International. USA
- Save the Children (2018): First 1000 Days Project: Barrier Analysis Report and Social and Behaviour Change Strategy. UK

T.33 Print Media

General information on the use of Print Media:

- IFRC (2021): Community Engagement and Accountability Toolkit. Tool 8: Communication Channels. Switzerland
- SSWM (undated): Media Campaigns: Posters and Flyers. Switzerland
- IFRC (2020): Learning from Other National Societies. Global Menstrual Hygiene Management Experiences. (Available in different languages). Switzerland

T.34 Proportional Piling

General overview of different participatory assessment tools including Proportional Piling:

- IFRC (2005): Guidelines for Emergency Assessment. Switzerland
- IFRC (2006): How to Conduct a Food Security Assessment. A Step-by-Step Guide for National Societies in Africa. Switzerland
- Adebo, S. (2000): Training Manual on Participatory Rural Appraisal. Ethiopia

Case Study:

- Watson, C. (1994): Proportional Piling in Turkana: A Case Study. RRA Notes, Vol. 20. Pages 131–132. IIED. UK

T.35 Protection Mainstreaming

Tool kit developed for WASH practitioners working in development, humanitarian and transitional contexts:

- House, S., Ferron, S. et al. (2014): Violence, Gender and WASH. A Practitioner's Toolkit. WaterAid, SHARE. UK

Safe programming in humanitarian responses:

- Oxfam (undated): Safe Programming in Humanitarian Responses. A Guide to Managing Risks. UK

Tool kit on protection mainstreaming in humanitarian response:

- Global Protection Cluster (undated): Protection Mainstreaming Toolkit. Field Testing Version

Example protection checklist from the Occupied Palestinian Territory:

- OHCHR (undated): Checklist for Mainstreaming Protection in WASH Programmes. Protection and WASH Cluster. Occupied Palestinian Territory

Guidance on Protection, gender and inclusion:

- IFRC (2021): Protection, Gender and Inclusion in Water, Sanitation and Hygiene Promotion – Leaving No-One Behind in WASH. (Available in different languages). Switzerland

T.36 Public Announcement

General information on risk communication:

- CDC (undated): Crisis and Emergency Risk Communication. Manual and Tools. USA
- Ford, C., Khajehpour, S. (undated): Preparing the Ground for Better Dialogue, Better Information, Better Action. Lessons on Communicating With Communities in Emergencies. CDAC Network. UK
- CDAC Network, ACAPS (2014): Assessing Information and Communication Needs: A Quick and Easy Guide for Those Working in Humanitarian Response

T.37 Public Commitment

Catalogue of behaviour change techniques (incl. Public Commitments):

- Eawag, Helvetas, SDC (2016): Catalogue of Behavior Change Techniques (BCTs). Version 1.0. Page 7. Switzerland

Case study from Zimbabwe:

- UNHCR, World Vision, RANAS, SDC (2021): Designing a Theory and Evidence-based COVID-19 Prevention Programme that is Feasible within a Refugee Camp. COVID-19 Hygiene Hub. UK

Research on Public Commitments to promote handwashing during drought response:

- Contzen, N., Inauen, J. (2015): Social-Cognitive Factors Mediating Intervention Effects on Handwashing: A Longitudinal Study. *Journal of Behavioral Medicine* 38. Pages 956–969

T.38 Radio and Television (TV)

General information on the use of Radio and TV:

- IFRC (2021): Community Engagement and Accountability Toolkit. Tool 8: Communication Channels. Switzerland
- SSWM (undated): Media Campaigns – Radio. Switzerland
- SSWM (undated): The Radio News Story. Switzerland
- SSWM (undated): The Radio Lead-In. Switzerland
- SSWM (undated): The Telephone Interview for Radio Broadcast. Switzerland
- SSWM (undated): The TV Interview for Water Reporting. Switzerland

T.39 Ranking

General overview of different participatory assessment tools including Ranking:

- IFRC (undated): Enhanced VCA Toolbox Including a Variety of Participatory Tools. Switzerland
- SSWM (undated): Problem and Preference Ranking. Switzerland
- Ager, A., Stark, L. et al. (2010): Participative Ranking Methodology: A Brief Guide. ALNAP. Columbia University. USA

Practical examples:

- House, S. (2019): Strengthening the Humanity in Humanitarian Action in the Work of the WASH Sector in the Rohingya Response. Gender, GBV and Inclusion Audit of the Work of the WASH Sector and Capacity Development Assessment
- House, S. (2018): Guidance and Tips for Learning from People Who May Be Most Disadvantaged During the Programme Process. WSSCC Global Sanitation Fund

T.40 Rewards and Incentives

Definitions and an economic perspective on incentives:

- MasterClass (2021): Understanding Incentives in Economics: 5 Common Types of Economic Incentives

Case study from Zimbabwe using incentives to promote practice and talking about SODIS:

- Kraemer, S., Mosler, H. (2011): Effectiveness and Effects of Promotion Strategies for Behaviour Change: Solar Water Disinfection in Zimbabwe. *Applied*

Psychology: An International Review. Vol. 61(3). Pages 392–414

T.41 Role Play

Tips on how to use Role Play to explore WASH, gender and violence related issues:

- House, S., Ferron, S. et al. (2014): Violence, Gender and WASH. A Practitioner's Toolkit. TS4-D: Videos, Role Plays and Drama. WaterAid, SHARE. UK

Video on the use of role play that can be adapted to WASH:

- The Bell Foundation (undated): Great Idea: Drama and Role Play

T.42 Routine Planning and Self-Regulation

Guide to changing habits:

- UNC (undated): Changing Habits. USA

T.43 Seasonal Calendar

General overview of different participatory tools including Seasonal Calendars:

- IFRC (undated): Seasonal Calendar. EVCA Toolbox. Switzerland
- Oxfam (2015): Market Analysis Application in WASH Response. UK
- IFRC (2005): Guidelines for Emergency Assessment. Switzerland

Short description of Seasonal Calendars as an evaluation tool:

- BetterEvaluation (undated): Seasonal Calendars

Example Seasonal Calendar used as part of the Zika response in the Americas:

- IFRC (2017): Zika, Dengue and Chikungunya Toolkit: Adaptation for Latin America and the Caribbean. The Netherlands

T.44 Social Media and Text Messaging

Guide to using Social Media in emergencies:

- Lugo, T. (2017): How to Use Social Media to Better Engage People Affected by Crises. A Brief Guide for Those Using Social Media in Humanitarian Organizations. ICRC, IFRC, OCHA
- Lallucci, A., Barrow, G. (2013): 101 Seminar Report: Social Media in Emergencies. CDAC Network, BBC Media Action

Social Media toolkits:

- Global Handwashing Partnership (2021): Global Handwashing Day 2021 Social Media Toolkit
- AMREF (2020): COVID-19 Africa Social Media Toolkit

Social Media outreach example:

- WaterAid Zambia (2020): Handwashing Campaign Twitter Post

T.45 Social Norms and the Use of Shame and Disgust

Overview of practice of using Social Norms and common pitfalls:

- Cislighi, B., Heise, L. (2018): Theory and Practice of Social Norms Interventions: Eight Common Pitfalls. *Globalization and Health*, Vol. 14 (83)
- Petit, V., Zalk, T. (2019): Everybody Wants to Belong: A Practical Guide to Tackling and Leveraging Social Norms in Behavior Change Programming. UNICEF, PENN SoNG. Jordan

General information and research on shame and disgust:

- Otieno, P. (2012): The 'Shame Question' in CLTS. CLTS Knowledge Hub
- Brewis, A., Wutich, A. (2019): Why We Should Never Do It: Stigma as a Behavior Change Tool. *BMJ Global Health* 4(5)
- Harvey, P. (2011): Community-Led Total Sanitation, Zambia: Stick Carrot or Ballon? *Waterline*, Vol. 30(2)
- Lawrence, J., Yeboah-Antwi, K. et al. (2016): Beliefs, Behaviors, and Perceptions of CLTS and Their Relation to Improved Sanitation in Rural Zambia. *American Journal of Tropical Medicine and Hygiene*, Vol. 94(3). Pages 553–562
- Bolton, L., Kanguru, L. (2013): Helpdesk Report: Community-Led Total Sanitation in Africa. HEART
- Gonzales, L., Güllemann, H. et al. (2010): Community-Led Total Sanitation in the Red Cross / Red Crescent Movement. Discussion Paper. IFRC, Swiss Red Cross, French Red Cross

Detailed description of the CLTS approach incl. shame and disgust and experiences in post-emergency and fragile contexts:

- Kar, K., Chambers, R. (2008): Handbook on Community-Led Total Sanitation. IDS, Plan International. UK
- Greaves, F. (2016): CLTS in Post-Emergency and Fragile States Settings. *Frontiers of CLTS*. Issue 3. IDS. UK

T.46 Social Support

General information on Social Support:

- House, J. (1987): Social Support and Social Structure. *Sociological Forum*, Vol. 2(1). Pages 135–146
- Glanz, K., Rimer B. et al. (2008): Health Behavior and Health Education. Theory, Research and Practice. John Wiley and Sons. USA

- Sclar, G., Mosler, H. (2021): Caregiver Social Support and Child Toilet Training in Rural Odisha, India: What Types of Support Facilitate Training and How? Applied Psychology : Health and Well-Being. Pages 1–21

T.47 Songs and Stories

Guidance and tips on using Songs and Stories for hygiene promotion:

- Oxfam (undated): Working with Children in Humanitarian WASH Programmes. UK
- Sarom, M. (2018): Going Viral to Promote Hygiene: Four Tips to Get a Million People Dancing to a Handwashing Song. WaterAid. UK
- Postma, L., Getkate, R. et al. (2004): Life Skills-Based Hygiene Education. IRC, UNICEF. The Netherlands

Case studies from Bangladesh and Guinea-Bissau:

- Reidy, K. (2020): Rohingya Children Become Hygiene Promotion Ambassadors During COVID-19 Response in Cox's Bazar. UNICEF
- Da Gama, W. (2016): In Guinea-Bissau, Teenagers Sing the Praises of Handwashing. UNICEF

T.48 Spidergram

Brief description of Spidergrams:

- Guijt, I. (2014): Participatory Approaches. Methodological Briefs. Impact Evaluation No. 5. UNICEF Office of Research. Italy

Examples of Spidergrams for community participation in WASH programmes:

- Oxfam (2018): An Introduction to Community Engagement in WASH. UK

Spidergrams to monitor level of community participation and satisfaction:

- Niederberger, E., Glanville-Wallis, T. (2019): Community Engagement in WASH Emergencies: Understanding Barriers and Enablers Based on Action Research from Bangladesh and the Democratic Republic of Congo (DRC). Water, Vol. 11(4)

The use of Spidergrams for a disability self-assessment:

- WaterAid (2018): Toolkit. Understanding and Addressing Equality, Non-Discrimination and Inclusion in Water, Sanitation and Hygiene (WASH) Work. Part of Our Global Strategy 2015–2020. UK

T.49 Stakeholder Mapping

Guidance on Stakeholder Mapping:

- Miro (undated): Complete Stakeholder Mapping Guide
- SSWM (undated): Stakeholder Importance and Influence. Switzerland

- Grassroots Collective (undated): Tools for Project Planning in Community Development. Using a Stakeholder Analysis to Identify Key Local Actors

Example Stakeholder Mapping dashboard from Cox's Bazaar, Bangladesh:

- Communications with Communities Working Group (2020): Stakeholder Mapping 2020. Ukhiya and Teknaf Upazila, Cox's Bazar Bangladesh
- Malteser International (undated): Mapping of Stakeholders and Initiatives on Early Warning Systems in Myanmar

T.50 Supervised Handwashing

Guide to Supervised Handwashing in schools:

- Pizzacalla, K., Nantume, G. (2019): Guide to WASH in Schools. WinS Models that Work. GLZ. Germany
- Monse, B., Naliponguit, E. et al. (2014): Manual for Teachers for the Implementation of the Essential Health Care Program in Schools. Fit for School Inc. Philippines
- Fit for School (2014): School Community Manual Indonesia. GLZ. Indonesia

Supervised Handwashing case study from Fiji:

- Akvo (2017): Emergency Support to WASH in Schools. Fiji

T.51 Three-Pile Sorting

Explanation card and picture cards, divided by continents:

- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK. ISBN: 978-1853396410.

Detail description of Three-Pile Sorting and how it can be used:

- IFRC (2018): Three-Pile Sorting (Good and Bad Behaviours) Instructions. IFRC Standard HP-Box Tools. Switzerland
- CAWST (2009): Three Pile Sorting Instructions. WASH Education and Training Resources. Canada

Adapting Three-Pile Sorting to discuss reducing vulnerabilities to violence :

- House, S., Ferron, S. et al. (2014): Violence, Gender and WASH. A Practitioner's Toolkit. Toolset 4–6 Methodologies for Working With Communities. Three-Pile Sorting. SHARE. UK

Session plan for training community mobilisers (incl. for Three-Pile Sorting):

- GWC (2009): Hygiene Promotion Training Package. Training for Community Mobilisers. Switzerland

T.52 Transect Walk

General information on Transect Walks:

- IFRC (undated): Transect Walk. EVCA Toolbox. Switzerland
- SSWM (undated): Factsheet: Transect Walk. Switzerland
- World Bank (2015): Transect Walk

Transect Walk and observation guide:

- IFRC (undated): Transect Walk and Observation Guide. Switzerland

Case study from Peru:

- Kramer, H., Krauss, M. et al. (2020): A Transect Walk to Observe Water and Sanitation Infrastructure Undertaken in the Rural Municipality San Andrés de Tupicocha in the Peruvian Andes. University of Stuttgart, TRUST. Germany

Handbook on the CLTS approach including Transect Walks:

- Kar, K., Chambers, R. (2008): Handbook on Community-Led Total Sanitation. IDS, Plan International. UK

T.53 Transmission Routes and Barriers (F-Diagram)

Short summary and description of the F-Diagram:

- Sphere Association (2018): The Sphere Handbook. Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. WASH Chapter Appendix 2. Page 144. Switzerland
- WHO (2005): Section One: Sanitation and Hygiene Promotion – General Principles. Page 10. Switzerland
- WEDC (undated): Fun with the 'F' Diagram. Loughborough University. UK
- WEDC (undated): Poster 04. The 'F' Diagram. Loughborough University. UK

Use of the faecal transmission pathways exercise as part of CLTS:

- Kar, K., Chambers, R. (2008): Handbook on Community-Led Total Sanitation. IDS, Plan International. UK

T.54 Venn Diagram

Detailed description of Venn Diagrams and how to use them:

- IFRC (undated): Venn Diagram. EVCA Toolbox. Switzerland
- IFRC (2007): VCA Toolbox with Reference Sheets. Geneva, Switzerland
- Ferron, S., Morgan, J. et al. (2007): Hygiene Promotion. A Practical Manual for Relief and Development. Practical Action Publishing. UK
- SSWM (undated): Venn Diagrams. Switzerland

T.55 WASH Committee

Guidelines on WASH Committees:

- UNICEF, RSPN (undated): Guiding Booklet for Village Sanitation Committee. Pakistan Approach to Total Sanitation (PATS). UNICEF'S Sanitation Programme at Scale in Pakistan (SPSP-Rural). Pakistan
- Uckrow, K., Stephan, Y. (2012): Structure and Functions of WASH Committees in Rural Areas. A Guideline. arche noVa. Germany
- Oxfam (2009): Public Health Briefing Paper: Working with Community Committees

F.1 Community Health Club (CHC)

CHC training and materials:

- Africa AHEAD (undated): CHC Training Courses including Tool Kit of Visual Aids and Manual. South Africa, Zimbabwe
- CHC AHEAD (undated): Registry of CHCs for Implementing Organisations

Quick guideline for implementing CHCs:

- Waterkeyn, J. (2006): District Health Promotion Using the Consensus Approach. Africa Ahead, WELL

Guidance on WASH communication incl. case studies on CHCs:

- WHO (undated): Guidance on Communication with Respect to Safe Drinking Water and Household Hygiene. Literature Review, Interviews and Case Studies. John Hopkins Bloomberg School of Public Health, Cranfield University. USA

Text book on the CHC approach:

- Waterkeyn, J. (2010): Hygiene Behaviour Change Through the Community Health Club Approach: A Cost Effective Strategy to Achieve the Millenium Developments Goals for Improved Sanitation in Africa. Lambert Academic Publishing. Germany. ISBN: 978-3-8383-4491-1

Theory of the CHC model:

- Waterkeyn, J., Waterkeyn, A. (2013): Creating a Culture of Health: Hygiene Behaviour Change in Community Health Clubs Through Knowledge and Positive Peer Pressure. Journal of Water, Sanitation and Hygiene for Development. Vol. 3(2). Pages 144–155. IWA Publishing. UK

Evidence of impact and cost-effectiveness:

- Rosenfeld, J., Berggren, R. et al. (2021): A Review of the Community Health Club Literature Describing Water, Sanitation, and Hygiene Outcomes. International Journal of Environmental Research and Public Health 18(4)

- Waterkeyn, J., Cairncross, S. (2005): Creating Demand for Sanitation and Hygiene Through Community Health Clubs: A Cost-Effective Intervention in Two Districts in Zimbabwe. Social Science & Medicine 61. Pages 1958–1970. UK
- Waterkeyn, J., Matimati, R. et al. (2009): ZOD for all - Scaling up the Community Health Club Model to Meet the MDGs for Sanitation in Rural and Urban Areas: Case Studies from Zimbabwe and Uganda. Africa Ahead, Zimbabwe Ahead. South Africa, Zimbabwe
- Waterkeyn J., Matimati, R. et al. (2019): Comparative Assessment of Hygiene Behaviour Change and Cost-Effectiveness of Community Health Clubs in Rwanda and Zimbabwe. IntechOpen
- Waterkeyn, J., Waterkeyn, A. et al. (2020): The Value of Monitoring Data in a Process Evaluation of Hygiene Behaviour Change in Community Health Clubs to Explain Findings from a Cluster-Randomised Controlled Trial in Rwanda. BMC Public Health 20:98
- Whaley, L., Webster, J. (2011): The Effectiveness and Sustainability of Two Demand-Driven Sanitation and Hygiene Approaches in Zimbabwe. Journal of Water, Sanitation and Hygiene for Development. Vol. 1(1). Pages 20–36. IWA Publishing. UK

F.2 Community-Led Total Sanitation (CLTS)

Detailed description of the CLTS approach:

- Kar, K., Chambers, R. (2008): Handbook on Community-Led Total Sanitation. IDS, Plan International. UK

Guide to strengthen equality and non-discrimination principles into CLTS programmes:

- House, S., Cavill, S. et al. (2017): Equality and Non-Discrimination (EQND) in Sanitation Programmes at Scale. Frontiers of CLTS. Issue 10. IDS. UK

Overview of experiences applying CLTS in post-emergency and fragile contexts:

- Greaves, F. (2016): CLTS in Post-Emergency and Fragile States Settings. Frontiers of CLTS. Issue 9. IDS. UK

CLTS case studies and field notes from different countries:

- Balfour, N., Mutai, C. et al. (2014): CLTS in Fragile and Insecure Contexts: Experience from Somalia and South Sudan. UNICEF
- UNICEF (2017): UNICEF Field Notes on Community Approaches to Total Sanitation. Learning From Five Country Programmes. USA
- IFRC (2018): Integrating CLTS and PHAST in Kenya. Case Study. (Available in English and French). Kenya

A research report on the impact of CLTS:

- USAID (2018): An Examination of CLTS's Contributions Toward Universal Sanitation. USA

Facilitator's guidance for School-led Total Sanitation (SLTS):

- MoE Malawi, UNICEF (2014): School-Led Total Sanitation: School Facilitator Training Guide. Malawi

F.3 Emergency Community Health Club (eCHC)

CHC documentation, training and materials:

- Africa AHEAD (undated): CHC Training Materials. South Africa, Zimbabwe

Guideline for implementing CHCs:

- Waterkeyn, J., Waterkeyn, A. (2013): Creating a Culture of Health: Hygiene Behaviour Change in Community Health Clubs Through Knowledge and Positive Peer Pressure. Journal of Water, Sanitation and Hygiene for Development. Vol 3(2). Pages 144–155. IWA Publishing. UK
- Waterkeyn, J. (2006): District Health Promotion Using the Consensus Approach. Africa Ahead, WELL

Guidance on WASH communication including CHCs:

- WHO (undated): Guidance on Communication with Respect to Safe Drinking Water and Household Hygiene. Literature Review, Interviews and Case Studies. John Hopkins Bloomberg School of Public Health, Cranfield University. USA

Case study summarising the CHC approach used in camps in Uganda:

- Waterkeyn, J., Okot. P. et al. (2005): Rapid Sanitation Uptake in the Internally Displaced People Camps of Northern Uganda Through Community Health Clubs. 31st WEDC Conference. Uganda

Case study on the adaptation of CHCs for Haiti:

- Brooks, J., Adams, A. et al. (2015): Putting Heads and Hands Together to Change Knowledge and Behaviours: Community Health Clubs in Port-au-Prince, Haiti. Waterlines 34(4). Pages 379–396
- Rosenfeld, J. (2019): Social Capital and Community Health Clubs in Haiti. University of North Carolina. USA

F.4 IFRC's 8 Steps for Hygiene Promotion in Emergencies

IFRC Hygiene Promotion Guideline:

- IFRC (2018): IFRC WASH Guidelines for Hygiene Promotion in Emergency Operations. (Available in different languages). Switzerland

IFRC e-learning module for the eight steps for hygiene promotion in emergencies (available in different languages):

- IFRC (undated): IFRC Online Learning Platform (Open Access, Anyone can Register and Log-In). Switzerland

IFRC online repository for WASH:

- IFRC (undated): Watsan Mission Assistant. Switzerland

Hygiene promotion box:

- IFRC, ICRC (undated): Standard Products Catalogue Website. Hygiene Promotion Boxes. Switzerland

F.5 Mum's Magic Hands (MMH)

General MMH overview:

- Mum's Magic Hands (undated): Mum's Magic Hands. Hygiene Promotion to Save Lives. UK

MMH field guide (for emergencies and long-term situations):

- Oxfam (2018): Mum's Magic Hands. A Field Guide for Rapid Implementation of Hand-washing Promotion in Emergencies. UK

MMH training materials and story boards:

- Oxfam (2018): Mum's Magic Hands. Training Guide. UK38
- Oxfam (2018): Mum's Magic Hands. Global Storyboard. UK
- Oxfam (2018): Mum's Magic Hands. Asia Storyboard. UK
- Oxfam (2018): Mum's Magic Hands. Africa Storyboard. UK

F.6 Participatory Hygiene and Sanitation Transformation (PHAST)

PHAST step-by-step guidance:

- Sawyer, R., Simpson-Hérbert, M. et al. (1998): PHAST Step-by-Step Guide: A Participatory Approach for the Control of Diarrhoeal Disease. WHO. Switzerland

Research on effectiveness of different sanitation and hygiene approaches incl. PHAST:

- Nzioki, M., Korir, A. (2020): Effective Methods for Community Sanitation and Hygiene Promotion in the Developing World: A Scoping Review. Africa Journal of Technical and Vocational Education and Training, Vol. 5(1). Pages 175–185

PHAST case studies from Uganda, Kenya and Eritrea:

- Gonzalez, L., Kabura, R. (2006): Using PHAST for In-Country Disease Outbreaks Response. Uganda Red Cross Emergency Response During the Cholera Outbreak. IFRC. Switzerland
- IFRC (2018): Integrating CLTS and PHAST in Kenya. Case Study. (Available in English and French). Kenya

- IFRC (2018): CLTS and PHAST in Eritrea. Case Study. Eritrea. (Available in English and French)

- Faster PHAST cases study from the Philippines:
- Philippine Red Cross (2018): PHASTER Report. Participatory Hygiene and Sanitation Transformation in Emergency Response. Barangay Mangsee, Palawan. Philippines

F.7 Sani Tweaks

Sani Tweaks tools and materials:

- Oxfam (2018): Sani Tweaks. Best Practices in Sanitation. UK
- Oxfam (undated): Sani Tweaks. Theory of Change. UK
- Oxfam (2018): Sani Tweaks. Best Practices in Sanitation. Booklet. UK
- Oxfam (2018): Sani Tweaks. Minimum Requirements in Sanitation Programming for all PHEs and PHPs. Checklist. UK
- Oxfam (2021): Best Practices in Emergency Sanitation – Sani Tweaks. UK
- Oxfam (2020): In Her Shoes – The True Story of Emergency Sanitation. UK
- Oxfam (2019): Ask Andy Episode 1. Spotlight on Safety. UK

Original research and key findings which led to Sani Tweaks:

- Oxfam (2018): Shining a Light. How Lighting In or Around Sanitation Facilities Affects the Risk of Gender-Based Violence in Camps. Oxfam, WEDC, ELRHA. UK
- Hastie, R. (2019): We Must Do More to Make Emergency Sanitation Safer. Oxfam. UK

F.8 Blue Schools

General information on the Blue

Schools approach:

- SWSC (undated): SWSC Website. Switzerland

Blue Schools kit, including concept brief, catalogue of practical exercises and technologies (available in different languages):

- SWSC (2018): Blue Schools Kit (English Download). Switzerland
- Leclert, L., Moser, D. et al. (undated): Blue Schools – Linking WASH in Schools with Environmental Education and Practice. 1st Edition. SWSC, Caritas Switzerland, Helvetas, Terre des hommes, Eawag. Switzerland

Blue Schools case study from Cambodia and Benin:

- Khin, S., Zuber, B. (2021): Caritas Switzerland's Blue Schools in Cambodia – A Success Story. SWSC. Switzerland
- SWSC (2015): Fact Sheet on Blue Schools. Switzerland

F.9 Children's Hygiene and Sanitation Training (CHAST)

Caritas Switzerland's CHAST kit:

- Leclert, L., Wanjihia, C. et al. (2019): The CHAST Kit. Children's Hygiene and Sanitation Training. Methodology Outline. Caritas. Switzerland
- Leclert, L., Wanjihia, C. et al. (2019): The CHAST Kit. Children's Hygiene and Sanitation Training. Facilitator's Guide. Caritas. Switzerland
- Leclert, L., Wanjihia, C. et al. (2019): The CHAST Kit. Children's Hygiene and Sanitation Training. Flipchart. Caritas. Switzerland

Red Cross Red Crescent CHAST adaptations and resources in different languages:

- IFRC (undated): Watsan Mission Assistant. WASH in Schools. CHAST Manuals and Resources
- IFRC (undated): Toolkit for Adapting CHAST to a New Context. French Red Cross and Solomon Islands Red Cross Societies

WASH in schools roadmap incl. CHAST:

- Leclert, L., Affolter, J. et al. (2018): From Awareness Raising to Sustainable Behaviour Change in School: The WASH in School Road Map. 41st WEDC International Conference. Egerton University. Kenya

General information in CHAST:

- SSWM (undated): Child Hygiene and Sanitation Training (CHAST). Switzerland

CHAST case study from Ethiopia:

- Caritas Schweiz (2019): Ethiopia: Children's Hygiene and Sanitation Training and Blue Schools

F.10 Fit for School (FIT)

General information on FIT:

- Fit for School (undated): Fit for School Website

FIT case studies and evidence from different countries:

- Philippines Department of Education (2020): Wins Monitoring Results. School Year 2017/18 to School Year 2019/2020
- Duijster, D., Monse, B. et al. (2017): 'Fit for School' – A School-Based Water, Sanitation and Hygiene Programme to Improve Child Health: Results from a Longitudinal Study in Cambodia, Indonesia and Lao PDR. BMC Public Health 17:302

F.11 Three Star Approach (TSA)

Case study from the Philippines:

- Philippines Department of Education (2020): Wins Monitoring Results. School Year 2017/18 to School Year 2019/2020

Case study from India:

- Schlenk, J., Pizzacalla, K. et al. (2019): Digital Monitoring Approaches to Trigger Action – Making WASH in Schools more Sustainable (Volume III). SuSanA. Germany

Sample tools developed to support TSA implementation:

- Philippines Department of Education (undated): WASH in Schools Resources. Philippines

F.12 Toilets Making the Grade (TMG)

TMG web portal:

- GTO (undated): Toilets Making the Grade. Website. Germany

TMG case study from Uganda and Pakistan:

- GTO (undated): Toilets Making the Grade in Uganda. Website. Germany
- GIZ (2021): Sanitation for Millions. Factsheets Jordan, Uganda and Pakistan. Germany

WASH in schools case studies including TMG implementation in Germany:

- Wendland, C., Rieck, C. et al. (2014): Making WASH in Schools More Sustainable. Case Stories from SuSanA Partners. SuSanA. Germany

F.13 Baby WASH

Baby WASH guidelines and toolkits from different organisations:

- Dominguez, E. (2017): Baby WASH and the 1,000 Days. A Practical Package for Stunting Reduction. Contributing to Malnutrition Reduction Through a Multi-Sector Approach. ACF. France
- World Vision International (2017): Baby WASH Toolkit. Version 1

Baby WASH evidence and learning:

- World Vision (2017): Baby WASH Overview and Evidence Summary
- UNICEF Eastern and Southern Africa (2020): Learning Note. Baby WASH Programming. Integrating Water, Sanitation and Hygiene Interventions Across Sectors to Impact Child Health Outcomes

F.14 IFRC's 8 Steps for Menstrual Hygiene Management (MHM) Action

8 Steps for MHM guideline and tools:

- IFRC (2019): Addressing Menstrual Hygiene Management (MHM) Needs. Guide and Tools for Red Cross Red Crescent Societies. (Available in different languages). Switzerland

Compilation of MHM case studies and experiences:

- IFRC (2020): Learning from Other National Societies. Global Menstrual Hygiene Management Experiences. (Available in different languages). Switzerland

F.15 WASH Social Architecture

Background information on WASH Social Architecture and case study from Bangladesh:

- Schmitt, M., Wood, O. et al. (2021): Innovative Strategies for Providing Menstruation-Supportive Water, Sanitation and Hygiene (WASH) Facilities: Learning from Refugee Camps in Cox's Bazar, Bangladesh. Conflict and Health 15, 10
- Farrington, M. (2019): Social and Feminist Design in Emergency Contexts: The Women's Social Architecture Project, Cox's Bazar, Bangladesh. Oxfam

Final report of the first phase of the Oxfam Social Architecture project:

- Farrington, M. (2018): Women's Social Architecture Project – Phase 1 Final Report. Oxfam Rohingya Response. Cox's Bazar, Bangladesh. Oxfam

Case study (incl. definition and description of the process):

- Bourne, S. (2019): User-Centred Design and Humanitarian Adaptiveness. ALNAP, ODI. UK

F.16 Approach Focused on Behaviour Change Determinants (ABCD)

Handbook with ABCD principles and tools (and without imposing a rigid methodology):

- Cardon, A. (2015): The ABCD Approach. Handbook and Tools. Approach Focused on Behaviour Change Determinants. Solidarités International. France

Documents on different behaviour change models and approaches ABCD originated from:

- Auger, R., Curtis, V. (2014): The Evo-Eco Approach to Behaviour Change. Applied Evolutionary Anthropology. Pages 271–295
- FHI360 (2002): Behaviour Change: A Summary of Four Major Theories. USA
- Glanz, K., Rimer, B. et al. (2008): Health Behavior and Health Education. Theory, Research and Practice. John Wiley and Sons. ISBN: 978-0787996147.
- Mosler, H. (2012): A Systematic Approach to Behavior Change Interventions for the Water and Sanitation Sector in Developing Countries: A Conceptual Model, a Review, and a Guideline. International Journal of Environmental Health Research 22(5). Pages 431–449

F.17 Behaviour Centred Design (BCD)

General information on the BCD approach and the underlying behaviour change theory:

- Auger, R., Curtis, V. (2016): Behaviour Centred Design: Towards an Applied Science of Behaviour Change. Health Psychology Review 10(4). Pages 425–446. URL: <https://www.susana.org/en/knowledge-hub/resources-and-publications/library/details/2771>

Case study from India (SuperAma Campaign):

- Biran, A., Schmidt, W. et al. (2014): Effect of a Behaviour-Change Intervention on Handwashing With Soap in India (SuperAma): A Cluster-Randomised Trial. The Lancet Global Health, Vol. 2(3). Pages 145–154

Research findings for various target behaviours and contexts (Zambia, Nepal, Indonesia):

- Greenland, K., Chipungu, J. et al. (2016): Theory-Based Formative Research on Oral Rehydration Salts and Zinc Use in Lusaka, Zambia. BMC Public Health 16:312
- Gautam, O., Schmidt, W. et al. (2017): Trial of a Novel Intervention to Improve Multiple Food Hygiene Behaviors in Nepal. American Journal of Tropical Medicine and Hygiene 96(6). Pages 1445–1456
- White, S., Schmidt, W. et al. (2016): Can Gossip Change Nutrition Behaviour? Results of a Mass Media and Community-Based Intervention Trial in East Java, Indonesia. Tropical Medicine and International Health 21(3). Pages 348–364

F.18 Communication for Behavioural Impact (COMBI)

General information on COMBI:

- WHO (2012): A Brief History of COMBI. Switzerland
- WHO (2012): Impact Series #5. Communication-for-Behavioural Impact (COMBI) in the Field. Switzerland
- WHO (2002): COMBI Design Process. Switzerland
- The COMBI Institute (undated): Basics of Communication for Behavioral Impact
- Zimmerman, R., DiClemente, R. et al. (2016): Introduction to Global Health Promotion. SOPHE, Jossey-Bass. USA. ISBN: 978-1-118-89779-9

COMBI Toolkit:

- WHO, UNICEF, FAO (2012): COMBI Toolkit. Field Workbook for COMBI Planning Steps in Outbreak Response. Switzerland

COMBI case studies:

- WHO (2012): Applying COMBI to Ebola Control in Yambio, Southern Sudan

F.19 FOAM and SaniFOAM

FOAM and SaniFOAM frameworks:

- Devine, J. (2009): Introducing SaniFOAM: A Framework to Analyze Sanitation Behaviors to Design Effective Sanitation Programs. WSP World Bank. USA
- Coombes, Y., Devine, J. (2010): Introducing FOAM: A Framework to Analyze Handwashing Behaviors to Design Effective Handwashing Programs. WSP World Bank. USA

Evidence review:

- White, S., Dreifelbis, R. et al. (2020): The Determinants of Handwashing Behaviour in Domestic Settings: An Integrative Systematic Review. International Journal of Hygiene and Environmental Health. Vol. 227

F.20 Risks, Attitudes, Norms, Abilities and Self-Regulation (RANAS)

RANAS guideline:

- Mosler, H., Contzen, N. (2016): Systematic Behavior Change in Water, Sanitation and Hygiene. A Practical Guide Using the RANAS Approach. Version 1.0. Eawag. Switzerland

RANAS methodological factsheets:

- Contzen, N., Mosler, H. (2015): RANAS (Risks, Attitudes, Norms, Abilities, and Self-Regulation) Methodological Fact Sheets – 6 Methodological Factsheets on Behavior Change. Eawag. Switzerland

RANAS BCT catalogue:

- Eawag, Helvetas, SDC (2016): Catalogue of Behavior Change Techniques (BCTs). Version 1.0. Eawag. Switzerland

RANAS examples and project updates:

- RANAS (undated): RANAS Website. Switzerland
- Friedrich, M. (2016): Design, Implementation and Evaluation of a Handwashing Campaign in Harare, Zimbabwe. A Case Study Applying the Practical Guide Systematic Behavior Change in Water, Sanitation and Hygiene. Eawag. Switzerland
- Inauen, J., Mosler, H. (2016): Mechanisms of Behavioural Maintenance: Long-Term Effects of Theory-Based Interventions to Promote Safe Water Consumption. Psychology and Health 31(2). Pages 166-183

F.21 Sanitation and Social Marketing

Social Marketing:

- AED (2008): Social Marketing Behavior: A Practical Resource for Social Change Professionals. USA

Sanitation Marketing guidance documents:

- Devine, J., Kullmann, C. (2011): Introductory Guide to Sanitation Marketing. WSP World Bank
- Nabembezi, D., Nabunya, H. (undated): Sanitation Marketing: A Handbook for Sanitation Managers and Private Sector Players. Plan International, MoH Uganda. Uganda
- USAID (2010): Sanitation Marketing for Managers: Guidance and Tools for Program Development. USA
- UNICEF (2020): Guidance for Market-Based Sanitation. USA
- USAID (2018): Scaling Market-Based Sanitation. Desk Review on Market-Based Rural Sanitation Development Programs. USA

Sanitation Marketing case studies:

- Sijbesma, C., Truong, T. et al. (2010): Case Study on Sustainability of Rural Sanitation Marketing in Vietnam. World Bank Water and Sanitation Program
- World Bank Water and Sanitation Program (2008): Sanitation Demand and Supply in Cambodia
- World Bank Water and Sanitation Program (2004): The Case for Marketing Sanitation. Kenya
- USAID (2020): Promoting Latrine Sales in CLTS Interventions through Integrated Sanitation Marketing. USA

F.22 Wash'Em

Wash'Em website with key information and resources:

- Wash'Em (undated): Wash'Em Website. URL: <https://washem.info>

Summary of the process used to develop Wash'Em:

- White, S., Heath, T. et al. (2018): Designing Evidence-Based and Context-Specific Hygiene Programs in Emergencies: Could There be an App for That? WEDC, Loughborough University. UK

Webinars on the Wash'Em process and software:

- White, S. (2019): Wash'Em Webinar: Doing Hygiene Programming Better. CAWST. Canada
- Mills, O., White, S. et al. (2019): Wash'Em Launch Webinar. CAWST. Canada

Literature review on handwashing determinants that helped inform Wash'Em:

- White, S., Dreifelbis, R. et al. (2020): The Determinants of Handwashing Behaviour in Domestic Settings: An Integrative Systematic Review. International Journal of Hygiene and Environmental Health 227. UK

Lessons learned during the COVID-19 pandemic and how Wash'Em has adapted:

- Wash'Em (2021): Wash'Em and the COVID-19 Response. LSHTM, ACF, CAWST

Key recommendations for handwashing programme design:

- White, S. (2021): How Can Implementers Use Evidence to Inform Their Handwashing Programme Design? LSHTM, ACF, CAWST

F.23 Accountability to Affected Population (AAP)

WASH Accountability Resources:

- GWC (2009): WASH Accountability Resources. Ask, Listen, Communicate. Switzerland
- Sphere Association (2018): The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th Edition. Switzerland

Case study from Kurdistan Region Iraq:

- UNICEF (2014): Joint WASH Assessment. In Nine Official Refugee Camp Settlements Across Three Governorates in the Kurdistan Region of Northern Iraq

F.24 Community Perception Tracker (CPT)

General information on the CPT (in different languages):

- Oxfam (2020): Community Perception Tracker. UK

Case study on the use of the CPT in Ebola outbreak in DRC:

- Oxfam (2020): Why Capture Community Perceptions During a Disease Outbreak? Learnings from the Democratic Republic of Congo (DRC). UK

Interviews with practitioners on the usefulness of the CPT:

- Oxfam (2021): Can the Community Perception Tracker (CPT) Transform a Humanitarian Response? Spotlight on Venezuela in the Context of COVID-19. UK
- Azzalini, R., Oxfam Team in Venezuela (2021): Tracking Community Perceptions in Venezuela during COVID-19. Forced Migration Review. Issue 67. Pages 23-25

Case study on tracking and responding to community perceptions about the COVID-19 pandemic in Zimbabwe:

- ACF, Nutrition Action Zimbabwe, Africa AHEAD (2021): Tracking and Responding to Community Perceptions about the COVID-19 Pandemic in Zimbabwe. COVID-19 Hygiene Hub

On-going research project on the usefulness of using the CPT during humanitarian crisis:

- ELRHA, ACF, LSHTM, Oxfam (undated): Tracking Community Perceptions: Curbing the Spread of COVID-19


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The Compendium of Hygiene Promotion in Emergencies is also available as an interactive online version.

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Graphic Design, Layout, Photo Credits:

Jan-Hendrik Schmidt, germantoilet.org (Layout)

Jana Evers, datamadevisual.de (Icons)

© Marco Fischer (Picture of Luise Amtsberg)

Editing:

Peta Sandison, Suzanne Ferron, Robert Gensch

First Edition:

2,000 Copies

Printed by:

Buch- und Offsetdruckerei H. Heenemann,
Berlin, Germany

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The Compendium of Hygiene Promotion in Emergencies is the third volume of the ‘Emergency WASH Compendium’ series, complementing the already existing compendia on sanitation and water supply technologies in emergencies and addressing the third pillar of the WASH triad – Hygiene Promotion.

Using a similar approach, it provides a comprehensive and systematic compilation of the most relevant and sector-reviewed components, tools, methods and approaches to design and implement successful Hygiene Promotion interventions. It draws on the latest initiatives, materials and evidence, disaggregating Hygiene Promotion into its functional components, clarifying terminology and providing guidance on the most appropriate solutions in a given context. It is not intended to be a ‘How To’ guide but to provide a single source of the available guidance and to summarise key concepts and good practice.

The Compendium is primarily a capacity strengthening tool and a reference book and supports planning, implementation and decision making for specific Hygiene Promotion interventions. It provides a systematic starting point to access relevant summarised information on Hygiene Promotion with details and links to additional practical guidance and information as well as publications, case studies, videos and training materials where available.

The development of the Compendium has been a collaborative effort of Global WASH Cluster partners, coordinated by the German WASH Network and with contributions and support from a multitude of international WASH experts, organisations and institutions.

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