7. Hygiene Promotion

Overcrowding, a lack of access to basic water and sanitation services and a lack of hygiene materials, such as soap, can result in poor hygiene which can rapidly facilitate the transmission of disease. Hygiene promotion is an essential activity in refugee settings to ensure the population has the knowledge, resources, willingness and practice to prevent WASH related disease transmission and live with dignity.

Introduction

The importance of hygiene promotion in refugee settings

1. During refugee emergencies, overcrowding, a lack of access to basic water and sanitation services, difficult living conditions, and a lack of basic hygiene items (for example soap, or water containers) can cause a rapid increase in water and sanitation related diseases. In some cases there may be a risk of disease outbreaks which can put many lives at risk. Hygiene promotion is an essential activity not only to ensure the population has the knowledge, resources, willingness and practice to prevent WASH related disease transmission but also to create the conditions for life with dignity.

Figure 7-1 Public Health Messages

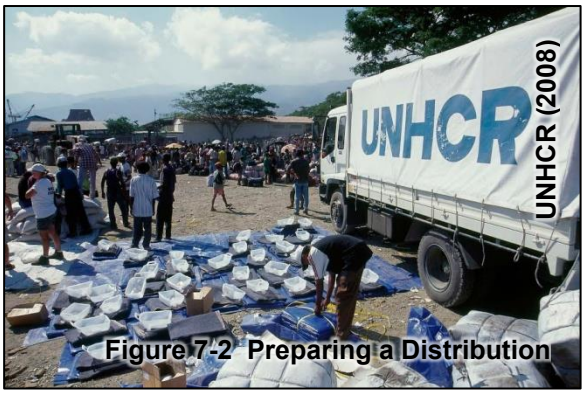

Figure 7-2 Preparing a Distribution

2. Promoting improved hygiene practices in particular handwashing with soap, safe disposal of excreta, safe water management, and safe food handling, can have a significant impact on preventing disease transmission. This includes diarrhoeas and dysenteries such as Amoebic Dysentery, Cholera, Cryptosporidiosis, Giardiasis, Rotavirus Diarrhoea, Salmonellosis and Shigellosis - in addition to enteric fevers such as Typhoid, Paratyphoid, Poliomyelitis, Hepatitis and Leptospirosis. Promoting handwashing with soap and regular bathing and laundering can significantly reduce the transmission of infectious skin and eye diseases such as Scabies and Trachoma. Handwashing with soap has also been shown to reduce the transmission of respiratory infections. Use of insecticide treated bed nets can also prevent the transmission of diseases spread by mosquitoes including Malaria.

"Hygiene promotion is the planned, systematic approach to enable people to take action to prevent and/or mitigate water, sanitation and hygiene-related diseases."

SPHERE Minimum Standards in Humanitarian Response (2011)

3. Enabling the refugee population to regularly launder and dry their clothes and bedding, in addition to the use of insecticide treated bed nets, can reduce the transmission of diseases spread by vectors including human body lice, ticks, fleas and mites including Typhus. A more detailed description of all of the different water, sanitation and hygiene related diseases along with their transmission routes and prevention strategies can be found in **Chapter 2**.

Figure 7-3 Poor Planning for Laundering

Hygiene promotion as part of a comprehensive public health approach

4. The primary objective of hygiene promotion programmes is the reduction of WASH related disease transmission. Therefore, it is absolutely essential that all hygiene promotion related activities are closely coordinated, or run in collaboration, with health programmes. Any disease related information campaigns should provide a balance of messages related to hygiene, messages related to curative health, and messages related to health seeking behaviour. For example, campaigns related to diarrhoeal disease should not only include key messages related to safe water, latrine use, handwashing with soap and food safety - but may also include a diarrhoea case definition, the importance of seeking early medical attention and treatment in the case of small children, and the importance of rapid rehydration using oral rehydration solutions.
5. Hygiene promotion activities are of particular importance for high-risk groups including mothers with small infants, pregnant women, people living with HIV/AIDS are their carers, malnourished children and their carers, and primary school and pre-school children.

Figure 7-4 Child Bathing

6. In all refugee settings it is essential that there is effective coordination and collaboration between the Community Health, Nutrition, HIV/AIDS, Education, Community Services and WASH programmes to avoid overlaps and gaps. At the refugee community, school, and household level, there should be a clear division of responsibilities between the activities of Community Health Workers, Teachers and Hygiene Promoters.

Ensuring the refugee population has the resources and knowledge to carry out key hygienic practices is an essential contribution to the health, dignity and morale of the refugee population. The psychological benefits of being able to live in a clean and hygienic way should not be underestimated.

Hygiene promotion as practical mechanism for community mobilisation

7. Hygiene promotion also provides a practical mechanism for the active mobilisation of the refugee

population to take action related to WASH services and conditions. Hygiene promoters play an essential role in ensuring there is equality of access to WASH services. They also play an important role in ensuring that the community is fully involved in the use and management of WASH facilities and that users have an input into the design of services; in particular that they are safe, secure, comfortable, culturally appropriate and adequately managed. In addition, hygiene promotion ensures there is an effective mechanism for accountability, protection and feedback. Hygiene promoters are also the primary point of community contact for the mobilisation of the population (for example during clean up campaigns).

The importance of seeking expert professional advice

8. Designing and implementing hygiene promotion programmes incorporating elements of hygiene related behaviour change is not easy. Even if the population has access to hygiene resources and facilities, and are provided with key hygiene messages, it does not mean that they will have the willingness to carry out improved behaviours. Factors related to changing hygiene practice can be varied and complex and in all settings UNHCR and WASH actors must take time to fully investigate the main motivations and barriers for certain risk practices. In all settings, it is essential to have expert support from professionals who are familiar with hygiene promotion programmes and the local context. Assistance can be sought locally from sources such as government departments, the UN system, NGOs, or universities. If these cannot meet the need, UNHCR Headquarters assistance should be requested.

The importance of respecting UNHCR's WASH philosophy and principles

9. In addition to the guidance in this chapter, all hygiene promotion programmes must be designed and carried out in full accordance with UNHCR's general WASH principles including (please click the links below or consult the relevant section in Chapter 2 for more information).

- Safety and protection
- A timely and adequate response
- Participation of stakeholders
- Universal access
- Child friendly facilities
- Designs and construction that meet minimum quality standards
- Value for money and cost effectiveness
- Appropriate technology selection
- Durable solutions
- Reinforcing the capacity of stakeholders
- Monitoring the effectiveness of WASH interventions
- Protecting the environment
- Planning for contingencies

Priority actions

Immediate distribution of basic hygiene items

10. UNHCR and WASH actors must ensure that the refugee population

is provided with basic hygiene materials including soap, water containers and women's menstrual materials (see box below) on immediate arrival at the refugee setting and consistently throughout the emergency. It is essential that this distribution is organised as rapidly as possible as the refugee population may arrive without possessions.

11. How the basic hygiene kit is distributed should be carefully coordinated, especially if the hygiene items are included as part of a general distribution with other items such as blankets, or cooking equipment. Whichever way the distribution takes place, the WASH team must take direct responsibility for ensuring the type, quality and timeliness of the hygiene items including any post-distribution monitoring. If hygiene items are distributed by the WASH team, then UNHCR and WASH actors should follow UNHCR best practice for commodity distributions which includes ensuring that the population is well informed of the time, place and type of distribution, and that the distribution is carried out in a secure, orderly, efficient and transparent manner. More guidance can be found in the UNHCR publication *"Commodity Distribution: A Practical Guide for Field Staff" UNHCR (1997).*

12. Additional items to facilitate laundering of clothes and bedding, bathing, management of children's faeces, water treatment, and compound cleanliness may be considered if appropriate, locally available, and the basic hygiene needs have been met (see box below). If these products are readily available on the local market, the use of a cash based approach (i.e. vouchers) is highly recommended in order to prevent undermining of local suppliers and stimulate the local market economy.

Box: Recommended hygiene items for distribution

Basic hygiene items

- ☐ Water containers - 10l per person
- ☐ Hand soap - 250g/person/month (Note this should be doubled during outbreaks)
- ☐ Laundry soap (or powder if appropriate) - 200g/person/month
- ☐ Acceptable material for menstrual hygiene, e.g. washable cotton

Additional optional hygiene items

- ☐ Toothpaste - 75ml/100g
- ☐ Toothbrush - 1 per person
- ☐ Shampoo - 250ml per HH
- ☐ Bathing towel – 1 per HH
- ☐ Disposable razor - 1 per HH
- ☐ Underwear for women and girls of menstrual age - 1 per person
- ☐ Laundry basin – 1 x 40l per HH
- ☐ Washing line – 40m per HH
- ☐ Washing pegs – 80pc per HH
- ☐ Hairbrush / comb - 1 per HH
- ☐ Nail clippers - 1 per HH
- ☐ Hair scissors – 1 per HH
- ☐ Nappies (diapers) and potties (dependent on household need)
- ☐ Nappy rash lotion - 250ml per HH
- ☐ Small yard brush – 1 per HH
- ☐ Small dustbin – 1 x 40l per HH

Notes:
Quantities for approximate guidance only. Alternative items may be considered in consultation with the population.

13. As soon as is possible, the hygiene team should plan to undertake focus group discussions (see **Chapter 9**) to ensure that the


Olyset® Net
Do not eat after touching the Olyset® net. Wash your hands first.
UNHCR

hygiene items being distributed are relevant and appropriate to the culture and context - in particular those related to menstrual hygiene, bathing, hand washing and management of children's excreta.

Figure 7-5 WASH NFI Distribution

14. Additional Care should be taken to avoid distributing products that may be unfamiliar. UNHCR and WASH actors should ensure that beneficiaries receive a visual practical demonstration in the safe use of hygiene items that are unfamiliar to them. This is particularly important if any household water treatment (for example PUR, aquatabs, or household water filters) or disease vector control products (for example bed nets) are being distributed.

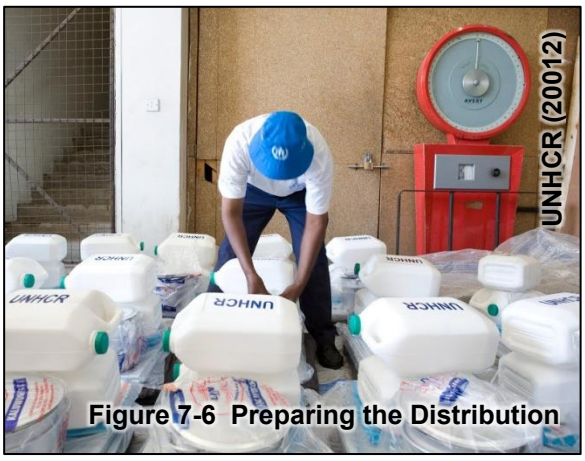

Figure 7-6 Preparing the Distribution

15. Post distribution monitoring is an essential activity after every major distribution to not only ensure that the distribution was carried out correctly and the hygiene items were received by the population, but also to ensure that the distributed items are being used, the population is satisfied with the quality and usefulness of the products, and the population has the opportunity to provide feed-back on the hygiene items and the distribution activity. The post-distribution monitoring activity should take no longer than one day and may include a rapid randomized household survey and several focus group discussions (see **Chapter 9**).

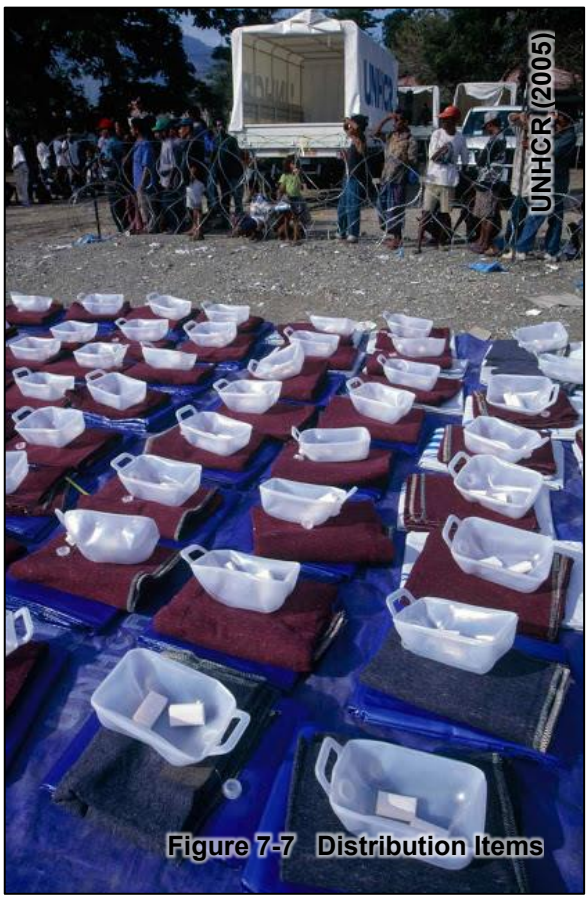

Figure 7-7 Distribution Items

Immediate mobilisation of the community to take action

16. The refugee population should clearly understand that they are not just passive recipients of

humanitarian aid but they have the rights, capacity and means to manage and dictate the direction of their daily affairs, including their sanitary environment. The degree to which the refugee population can be mobilised depends upon the context and the capacity of the refugees. However in all settings, UNHCR and WASH actors should aim to support individuals or organisations to mobilise the larger refugee community to take action concerning WASH related problems in the refugee setting e.g. the safe disposal of excreta, clean up and safe management of wastes, contamination of water resources, or management of disease vector breeding sites.

Figure 7-8 Community Mobilisation

Immediate dissemination of key hygiene promotion messages

17. UNHCR and WASH actors must ensure that the refugee population is provided with clear hygiene messages on immediate arrival at the refugee settings and consistently throughout the refugee emergency. The messages must be in their own native language, and must target the most critical hygiene risk practices for the current displaced context that are responsible for disease transmission, in addition to the key interventions to prevent them. Targeting too many messages can be confusing and can dilute the most important messages. All messages provided to the refugee population should aim to be positive (rather than scare mongering) with a focus on providing key facts.

Figure 7-9 Hygiene Promotion Poster

18. Examples of generic key hygiene messages for hygiene practices can be found in the box on the following page. However, it is essential to review these messages and carefully tailor them to the local culture, customs and context. At all times the emphasis should be on taking as much of an interactive approach as possible and mobilising people to take practical action either themselves or as groups (e.g. clean up campaings). Additional messages may be needed depending upon the context and any critical hygiene risks that are present.

19. In the early stages of a refugee emergency, UNHCR and WASH actors should use a mixture of mass media messaging to ensure that as many people as possible receive important information about reducing health risks. A mixture of approaches is especially important to reinforce messages through different communication channels and to also ensure that all sections of the refugee community are

Key hygiene messages for refugee settings

Handwashing with soap

- ☐ To prevent diarrhoea, always wash hands with water and soap or ash, after defecation, after contact with faeces, before touching or preparing food, before eating and before feeding children.
- ☐ Young children frequently put their hands in their mouths so it is important to keep the household clean and for children to wash their hands regularly, especially after defecating and before eating.

Toilet use

- ☐ To prevent diarrhoea, use a toilet and ensure that all faeces, including those of infants and young children, is disposed of in a toilet or buried. Afterwards, hands should always be washed with water and soap or ash.

Safe water

- ☐ To prevent diarrhoea, always drink water from a safe water source.
- ☐ To prevent re-contamination, store water in a clean, closed water container with a narrow opening.

Food hygiene

- ☐ Prepare and thoroughly cook food just before eating. Food left standing can collect germs that can cause diarrhoea. After two hours, cooked foods are not safe unless they are kept very hot or very cold.
- ☐ Wash fruits or vegetables that are eaten raw thoroughly with safe water.

Diarrhea

- ☐ Diarrhoea kills children by draining liquid from the body, which dehydrates the child. As soon as diarrhoea starts, it is essential to give the child extra fluids along with regular foods and fluids.
- ☐ If the child passes several watery stools in one hour and vomits, there is cause for alarm – these are possible signs of cholera. Cholera can kill children in a matter of hours. Medical help should be sought immediately and the child should continue to receive ORS solution and zinc.
- ☐ Cholera can spread throughout the community quickly through contaminated water or food. Make sure your water and food are safe and follow good hygiene practices.

Vector control

- ☐ Flies that settle on faeces and then on food transmit the germs that cause Diarrhea. To prevent the spread of germs from flies: (1) cover food and drinking water, (2) dispose of faeces in a properly designed latrine or toilet, (3) keep the latrine or toilet clean, (4) reduce fly breeding sites by burying, burning or safely disposing of food refuse at the waste collection point.
- ☐ Malaria, which is transmitted through mosquito bites, can be fatal. Wherever malaria is present, people should sleep under insecticide-treated bed nets; any child with a fever should be examined by a health worker.

Source: Facts for Life (4th Edition, 2010) – WHO, UNICEF, UNDP, WFP

reached, including men, women, children, teenagers, different ethnic groups, different religious groups, and sections of the refugee population that are non-literate or have communication difficulties (deaf, blind, elderly, ill or infirm).

20. Efforts should be made to use any existing mass media communication infrastructure that exists. For example, in urban refugee contexts, there may be an existing network of media outlets, radio stations, television stations and newspaper networks. In many settings the use of popular media (drama, songs, street theatre, dance, etc.) has been shown to be effective - however the provision of basic messages (for example broadcasting messages with loudspeakers or over a public address system) is better than delayed provision spent developing more popular media.

Immediate assessment of hygiene related risks

21. A rapid assessment of hygiene behavioural risks should be carried out within the first few days of any refugee emergency. This is best achieved in collaboration with members of the Health programme and using a combination of observation walks, key informant interviews and focus group discussions (see **Chapter 9**). Following the rapid assessment a prioritised hygiene promotion action plan should be developed that includes short, medium and long term strategies to reduce hygiene behavioural related risks. The risk assessment should be analysed taking into account current prevalence of WASH related diseases in addition to those that have the potential to cause rapid epidemics (see **Chapter 2**). Seasonal diseases should also be taken into account, particularly those linked to seasonal rain, temperature, and harvest seasons and hygiene promotion messages and activities.

Ensuring women's menstrual hygiene management needs are met

22. During a refugee emergency it is possible that the populations may have fled with very few possessions. Therefore, UNHCR and WASH actors must ensure that all women on reproductive age (10-45) have immediate access to sufficient quantities of culturally appropriate Menstrual Hygiene Management (MHM) materials (sanitary cloth, reusable pads, disposable pads, soap, spare underwear) and WASH services (water supplies, bathing, laundering and drying facilities) to practice good menstrual hygiene management. Good MHM reduces risk of infection to girls and women and also gives them the empowerment to engage in daily activities and survival in an emergency refugee context. WASH facilities must allow all women and girls to change, soak, wash and dry MHM cloths with complete security and dignity.

23. UNHCR and WASH actors must ensure that the types and quantities of MHM materials that are distributed are decided in close consultation with women from the refugee population through the use of Focus Group Discussions and Key Informant Interviews. It is essential to understand what

materials were commonly used in the refugee population's place of origins, in addition to any taboos, or specific cultural or religious considerations.

Box: UNHCR sanitary protection standards for women and girls

Indicator: Percentage of needs met for sanitary materials

Standard: 100%

Rationale: To meet the basic and protection needs of refugee women and girls to uphold their dignity and self esteem.

Notes: This group includes girls and women 13-49 years old. The sanitary material kit includes either disposable napkins (12 per person per month) or reusable, absorbent cotton material (two metres long per person per six months), six underpants per person per year, and a 250g bar of soap per person per month (in addition to soap provided to the whole population).

Practical Guide to the Systematic Use of Standards and Indicators (UNHCR, 2006)

Universal access to hygiene promotion messages and activities

24. Hygiene promotion messages, activities and supplies should be accessible to all sections of the populations including older persons, pregnant women, people with disabilities and children. Efforts should be undertaken to ensure that deaf (or hard of hearing), or blind (or partially sighted) persons are able to access hygiene information and participate in activities. Hygiene materials should match the levels of literacy of the displaced population. Particular care should be taken when designing hygiene promotion posters, or materials, for populations that are visually illiterate (cannot recognize pictures or symbols – commonly used in hygiene promotion images).

Approaches to hygiene promotion in refugee settings

25. Hygiene promotion refers to a range of approaches that systematically ensure that children, women and men have the knowledge, resources, willingness and practice to prevent or mitigate water and sanitation related disease transmission. Hygiene promotion seeks to stimulate and facilitate people to practice water and sanitation related hygiene behaviours, by building on what they already know, do and want. The focus of hygiene promotion is to motivate changes in behaviour taking into account that people are not “empty” vessels and are complex individuals with their own customs, perceptions, wants and desires. The emphasis of hygiene promotion interventions is on enabling people to take action to mitigate health risks by adhering to safe hygiene practices in addition to raising awareness about the causes of water and sanitation related disease.

26. UNHCR and WASH actors must ensure that hygiene promotion and water and sanitation hardware interventions are complementary. In order to be able to carry out improved hygiene practices, the displaced population must have access to sufficient numbers of functional latrines, handwashing stations, water collection points, laundry points, soap, water


Natural Feminine Protection
makapads
from sustainable papyrus
UNHCR
German Development Cooperation
UNHCR-BMZ Partnership Program
implemented by
gtz

containers, bathing cubicles, clothes drying facilities, children's potties and mosquito nets. All water and sanitation hardware must be culturally acceptable, comfortable, clean, functional, convenient and accessible to all users including persons with limited mobility. Mechanisms must be in place to ensure that facilities are kept in good working order and are regular maintained and do not deter use.

A phased approach to hygiene promotion

27. The hygiene promotion approach taken to mobilise the refugee community should be adapted to the phase of the emergency. During the emergency phase the priority focus should be saving lives and reducing risks of WASH related disease and should include:

- ☐ Ensuring that refugee populations have the necessary resources (soap, jerry cans etc.) to carry out good hygiene practices.
- ☐ Mobilisation of the community to take action concerning WASH related problems in the refugee setting e.g. the safe disposal of excreta, clean up and safe management of wastes, contamination of water resources, or management of disease vector breeding sites.
- ☐ Mobilisation of the community to take action concerning the design and proper use and management of WASH services.
- ☐ Ensuring that the refugee population has the basic knowledge of preventing disease e.g. basic personal hygiene, environmental hygiene, safe collection, transportation, storage, and treatment of water, and basic food hygiene practices.

28. In the medium and longer-term hygiene promotion programmes should follow a hygiene promotion approach more in-line with development settings based on: continuous assessment, analysis, design, implementation, monitoring and evaluation of hygiene related risks as described in the hygiene promotion cycle below.

- **Step 1:** Obtain an understanding of WASH related problems by carrying out an assessment. The assessment should identify what the specific risks are, how people understand the problem, what might motivate and enable them to do things differently, in addition to the communication channels they trust.
- **Step 2:** Identify potential areas for intervention. This might involve providing or improving access to 'hardware' such as water systems or hygiene items but it will also involve communication to mobilise, educate or advocate for action.
- **Step 3:** Identify the different at-risk target groups (young children, mothers etc.) and the various strategies for improving hygiene practices. It may be helpful to create a list of statements i.e. *In order to help group "A" carry out practice "B", we will concentrate on removing barriers "X1" and "X2" and encouraging motivational factors "Y1" and "Y2" through*

the following interventions "Z1", "Z2" and "Z3".

- **Step 4:** design a hygiene promotion strategy and plan. The strategy should focus on the use of WASH facilities or might also involve information related to controlling WASH related diseases or ensuring that people know when to seek medical help.
- **Step 5:** regularly monitor, evaluate, and redesign the strategies if necessary.

Communication methods in refugee settings

29. In the early stages of a disaster, it may be necessary to rely on mass media to ensure that as many people as possible receive important information about reducing health risks. Communication may use either 'top-down', 'bottom-up', or a combination of both strategies:

- ☐ **'Top-down'** public awareness raising type mass-media campaigns.
- ☐ **'Bottom-up'** type behaviour change activities which work to change individual practices by building on key motivational factors such as convenience, dignity, security, disgust, peer pressure, privacy and livelihood.

30. Using methods such as loud speakers or radio can reach large numbers of people but may not be effective at influencing change. More interactive communication methods (such as street drama) can often be more effective in terms of persuading individuals to take action and should be used in addition to mass communication methods.

Box: Hygiene Communication - Key Principles

1. Target a small number of risk practices
2. Target specific audiences
3. Identify the motives for changed behavior
4. Hygiene messages need to be positive
5. Identify appropriate channels of communication
6. Decide on a cost-effective mix of channels
7. Allocate sufficient resources
8. Hygiene promotion needs to be carefully planned, executed, monitored and evaluated.

Source: Curtis, V. (2005) WELL Hygiene Promotion Fact Sheet

31. Relevant hygiene promotion messages should be targeted at different groups through the most appropriate and relevant communication channels, so that information reaches all members of the population. This is especially important for those who are non-literate, have communication difficulties and/or do not have access to radio or television. Popular media (drama, songs, street theatre, dance, etc.) might also be effective in this instance. Coordination with the education cluster will be important to determine the opportunities for carrying out hygiene activities in schools.

Figure 7-10 Hygiene Reminder at Latrines

32. Communicating good hygiene in refugee settings requires the use of multiple strategies and approaches. It should not be focused only on individual behaviour change but also on mobilising groups of people to take action to address the determinants of poor hygiene. Influencing public policy and legislation can also play an important part in promoting better hygiene and advocacy and lobbying are important aspects of hygiene promotion. For example, motivated refugee households might agree to compost their waste or dig household latrines. Individuals might volunteer to help manage a community water point or visit other refugee households to inform them about ways to prevent and manage diarrhoea. WASH programmes in refugee settings should take a community based approach to improving hygiene by working supportively and respectfully with refugee communities to identify the most appropriate way to meet their needs for water, sanitation and hygiene. The overall aim of WASH interventions is not only to combat infectious diseases but also to maintain people's dignity and ensure that their living conditions contribute to, rather than undermine, their adaptation to a new environment.

Figure 7-11 Mother with Small Child

33. Care should be taken to ensure that those involved in hygiene communication do not convey very judgemental attitudes towards people who struggle to maintain hygiene and this can undermine effectiveness. The first step to successful hygiene communication is to understand the individual and community perspective on the issues that are being addressed.

Working in different refugee contexts

34. UNHCR and WASH actors work in many different contexts but wherever there is a need to provide water and sanitation facilities there will always be a requirement to ensure that they are used in way that will ensure better hygiene and health. In an acute emergency, people may be severely traumatised and bereft of any sense of purpose and simply listening to people's concerns and empathising with them will be a necessary first step to gaining their trust and collaboration later. Enabling people to help make decisions about the response can also give them a sense of purpose and meaning in their lives once again.

35. In urban areas, where refugee communities may be diverse, interventions may need to focus on mobilising smaller neighbourhoods or groups that have shared interests and target host communities and refugee communities at the same time. Hygiene promotion efforts may need to work closely with community services and local authorities to provide common meeting areas.


NAP
SANITARY
CLINIC

Box: Five fallacies about hygiene promotion

1. **Behaviour change is easy.**
   Getting people to change the habits of a lifetime is difficult, takes time and requires resources and skill.
2. **Knowledge = behaviour change.**
   It was thought that education about hygiene would be enough for people to change their behaviour. However, many people already know about germs, but still do not wash their hands at critical times.
3. **Experts know how to change behaviour.**
   Hygiene promotion programmes cannot be designed by experts in an office. They have to de designed around the real needs, wants and contexts of the actors themselves i.e. a consumer-centred approach.
4. **A whole variety of hygiene practices should be encouraged.**
   Only a limited number of key high risk unhygienic practices are responsible for most diarrhoeal episodes. Since behaviour change is difficult, efforts should not be diluted by targeting too many practises or too many target groups.
5. **Hygiene promotion is a cheap add-on to water programmes.**
   Serious efforts to change behaviour require serious investment and professional skill.

Source: Curtis, V. (2005) WELL Hygiene Promotion Fact Sheet

36. Whilst there are numerous approaches and methods used to communicate with people about hygiene, many traditional health promotion methods fail to acknowledge the perceptions of the target groups and try to influence change by providing information alone. Whilst this is important, especially in an emergency, a better understanding of the barriers and motivations for change will usually be required.

Stages of behaviour change

37. All individuals, including refugees, go through different stages in changing our behaviour. These stages include:

- Not being aware
- Becoming aware
- Becoming motivated to try something new
- Adopting a new behaviour
- Sustaining and 'internalizing' a new behaviour so that it becomes part of our normal
- Everyday practice.

38. In order to have an effective hygiene promotion programme it is often first important to understand where there the refugee target groups are along this continuum of behaviour change. For example, moving people from 'not being aware' to 'being aware' can be achieved via IEC (information, education, communication) materials. However moving people to 'becoming motivated to try a new behaviour' or 'adopting a new behaviour' requires a different approach such as understanding the barriers and motivational factors towards behavioural change.

A practice is a regular action that takes place at a certain time and place and can be directly observed or measured. UNHCR field staff and their partners must focus all hygiene promotion activities around the changing of hygiene practices - not just increasing hygiene knowledge or changing attitude.


Practice Good Hygiene In Little Wlebo Camp

39. Sometimes refugees who appear to have adopted a new behaviour reject it and return to their former behaviour. For example, a mother may stop washing her hands with soap before food preparation if her soap stocks are running low, or there has been a long time between distributions.

40. Individuals rarely change all by themselves. Their behaviour often depends on and is influenced by the views and practices of their families, friends and communities. Sometimes these are positive, as when everybody washes their hands with soap and water after using the toilet or latrine. Other times they may be harmful, as when parents refuse to have their children vaccinated. To change social behaviour means changing the everyday views and practices of families and communities. What parents, other caregivers, children and adolescents decide to do is often influenced by what others are doing around them.

41. Resistance can be expected when social norms are challenged. This is because change involves shifting the dynamics of a group on fundamental issues related to gender roles, power relations and many other factors within the family or community. But acceptance can become contagious when society begins to see the economic and social benefits of adopting a new behaviour. An example is when families using mosquito nets no longer have to cope with sickness or death caused by malaria. Their energies can be directed to sustain their children's learning and the family's productivity. People begin to see and hear about the change, and interest spreads, prompting others to adopt the new behaviour that can benefit their lives. Eventually, the behaviour is considered normal practice by everyone.

Participatory learning

42. Participatory methods, on the other hand, encourage the development of problem-solving skills. Participatory approaches are also called learner-centred approaches because they encourage people to express their ideas freely about understanding and solving problems. Some people might resist freely expressing themselves in participatory ways. Some people, particularly women, might not be confident about their ideas particularly if they are not used to freely expressing them. Some people might want to avoid conflict with others and others might feel that their opinion will never make a difference. Despite these obstacles, participatory methods can produce great enthusiasm and involvement the more they are used and the more facilitators allow participants to direct and shape their own learning and exploration.

43. Under some circumstances, didactic approaches are best to use and in other situations, participatory methods or a combination of both might be more suitable. Whether didactic or participatory methods or a combination of the two are used depends on each particular situation. For example, during the acute emergency phase or during an outbreak, it is critical to disseminate basic health information to the entire community

as quickly as possible. Such information might include how disease is spread, early signs of possible infection and danger signs for seeking immediate medical attention particularly for children. During such circumstances, participatory methods might not seem appropriate because of the time investment needed. While time constraints are an important factor, engaging participatory methods can lead to lasting changes and, therefore, efforts should be made to use these methods wherever possible.

Hygiene promotion interventions at the household level

44. UNHCR field staff and their partners must promote hand-washing after toilet use as part of household toilet construction programmes. Budgets and workplans should ensure that hand-washing devices and soap are distributed as part of the ongoing hygiene promotion activities.

Piloting of hygiene promotion materials and interventions

45. UNHCR and WASH actors should ensure that all hygiene materials and activities including street dramas, plays, posters, banners, radio slots, jingles, songs, puppet shows and games introduced into the refugee setting are piloted on a small test group for clarity, comprehension and retention. The piloting programme should observe that the critical hygiene messages are clearly communicated and are readily understood by the target groups.

Figure 7-12 Hygiene Promotion Games

Human resources for hygiene promotion programmes.

46. The day-to-day operation and maintenance of toilets will require a substantial labour force. It is highly likely that the paid and voluntary positions, including managerial positions, can be recruited from among the displaced community. In most cases the community may be willing to help since it gives people something to do, prestige, and possibly a source of income.

47. As a general planning figure, one person per 300 should be recruited from among the displaced population for water, sanitation and hygiene related activities. Take care when selecting hygiene promotion staff to ensure that – respects culture and context. In many cultures it is not appropriate for young girls to be telling old ladies what to do.

Preparing a hygiene promotion strategic plan

Hygiene promotion strategic plan.

48. UNHCR and WASH actors should ensure that every site has a context specific document that clearly describes the hygiene promotion strategy in terms of WHO, WHAT, HOW, WHEN,

WHERE and WHY. The strategy should justify WHY and HOW the key hygiene risk practices have been identified, WHO are the priority at-risk groups and WHY, WHAT are the most effective hygiene promotion approaches and activities and WHY, HOW the target activities for each at-risk group will carried out and HOW the effectiveness of the plan will be monitored. The hygiene promotion plan should be prepared within the first three months of the displacement emergency and should be revised every six months based on monitoring.

Monitoring of the hygiene promotion strategic plan

49. A clear monitoring plan should be developed as part of the hygiene promotion plan that describes WHAT will be monitored, HOW it will be monitored, and HOW OFTEN it will be monitored.

Hygiene promotion tools for refugee settings

50. A significant amount of work has been carried out by the Hygiene Promotion Technical Working Group within the Global WASH Cluster in 2009 under an initiative to build global capacity for humanitarian response. UNHCR and WASH actors should use these materials in all refugee settings. The following tools can be found in Annex.

Hygiene promotion orientation materials

- Hygiene promotion in emergencies briefing paper and orientation package
- Facilitator's resources for orientation package

Training package for Community Mobilizers

- Training package for community mobilizers

Training package for Hygiene Promoters and Coordinators

- Training package for hygiene promoters and hygiene promotion coordinators

The Global WASH Cluster visual aids library

- Global hygiene promotion visual aids library

Indicators for monitoring hygiene promotion in emergencies

- Indicators for monitoring hygiene promotion in emergencies

List of essential hygiene promotion equipment

- List of essential hygiene promotion equipment and non-food items

List of hygiene promotion job profiles

- Generic job profiles